

Emotional Control and Premenstrual Syndrome: Subjectivity and Process.

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Acknowledgements

I would firstly like to dedicate this thesis to my late Grandmother, Muriel.

Although she died in 1985, it was her love and support that gave me the courage to undertake this process. To her I will always be grateful. Secondly, I would also like to mention my late Aunt, who again was a great source of inspiration. To my Mother I am also grateful.

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Emotional Control and Premenstrual Syndrome: Subjectivity and Process.

Terri Van-Leeson (2000).

Abstract

This thesis set out to establish a deeper understanding of premenstrual syndrome, focusing particularly on emotional symptoms. A combined methodological approach was adopted, which collected a variety of data. Firstly, from an interview study, it was found that strict emotion rules continue to govern the way inner feelings and outward emotional expressions are permitted to be experienced. Emotion is still gendered, with a core emphasis on maintaining emotional control. In contrast, subjective accounts of premenstrual syndrome portrayed premenstrual emotional experience as being expressive, often out of control, especially with regard to anger.

Self-awareness, particularly mood awareness, is important in issues for self-control. A diary study conducted over one complete calendar month revealed that a high mood monitoring tendency predicted less positive emotion across the menstrual cycle, than for low mood monitoring. High mood monitoring predicted more frequent attempts at active mood regulation. These results were in the expected direction. Yet high monitoring predicted a greater degree of reported success at mood regulation, which was not predicted. Finally the most successful ways of regulating negative emotions were reported to be diversion strategies, which directed attention away from the way the individual was feeling.

Timing through cyclical phase was not found to be significantly associated with any of the variables highlighted in two studies undertaken as part of this thesis. However when emotion was tracked over time, the premenstrual phase of the cycle was found to be important on emotional experience in that the interaction of this phase with mood monitoring predicted use of diversion strategies. Reasons for this were explored.

Overall premenstrual syndrome continues to have far reaching implications for women at both the practical and theoretical level. There is a risk that their emotional status may be undermined for some of the time, particularly when expressing negative feelings.

Preface

Two core themes provide the focus of this thesis, namely emotion and premenstrual syndrome. Of additional interest, and as part of the deeper underlying aspects of both theoretical and practical concerns of these two themes, attention has also focused on the issues of subjectivity, lived experience as fluid, time as a psychological variable and the impact of ideology on behaviour.

Emotion is a fascinating subject because it encompasses so many different aspects of what it means to be human. Attempts to define what constitutes an emotion immediately place us in the realms of physiological experience through to the social world for the way a person interprets meaning. Then there is the question of emotional well-being. Feelings and emotions in the sense of everyday lived experiences can, for some of the time, be problematic. Therefore, in order to seek a deeper understanding of what it means to be emotional or have particular emotional experiences, an approach was required which not only takes account of the material reality of an individual's biological functioning, but also the meanings assigned to given social events and social norms. Also of particular relevance to this thesis is the issue of gendered emotion norms, because of the second core focus on premenstrual syndrome. Premenstrual syndrome only affects women by the virtue of being a disorder linked to female biology. Therefore social norms governing emotional experience and expression require consideration if one is to gain a deeper insight into women's supposed cyclical changes in affect.

Premenstrual syndrome is a recently recognised phenomenon of this century, and the focus of enquiry and understanding has tended to focus on biological factors. However the construct also requires interpretation of cyclical changes by women themselves, in order that certain aspects of bodily and emotional experiences can be identified as problematic for some of the time, and labelled as a symptom of premenstrual syndrome. Despite a large concentration of research examining biological factors, in particular hormone levels, there remains no consensual definition of what constitutes premenstrual syndrome by the medical profession or elsewhere. Despite a large pool of symptoms, the main indications for which women seek help are disordered emotions such as negative feelings, mood swings and emotional lability. Therefore, it is argued in this thesis, premenstrual syndrome has a close association with emotion, and so requires consideration in parallel with emotion theory. However this is not to suggest such an association is straightforward, rather it is complex and multifaceted.

Chapter 1 examines the way emotion has been researched and defined by psychologists over the last hundred years. The conception of emotion as a static variable has led to certain aspects of the emotion process being overemphasised. Emotion as a static variable is examined for the impact on research at the practical level, which has often meant privileging consideration of biological and physiological processes. Recent developments in which emotion is defined as a fluid ongoing process are also examined, allowing for a more integrated approach to researching emotional experience. Finally the individual difference characteristics of mood

awareness and affect intensity are briefly considered for their potential impact on the individual's ability to effectively control and regulate emotion.

Chapter 2 outlines the historical development of the notion of premenstrual syndrome. It particularly draws out the issue of timing as an important factor, due to the last seventy years witnessing a developing preoccupation with the premenstrual phase of the cycle, in line with advancing technology allowing for the discovery and measurement of hormone levels. Also premenstrual syndrome is placed in an overall historical context to demonstrate the way women's supposed emotional lability has consistently been explained through biological functioning. Although a fuller explanation of premenstrual syndrome has so far eluded scientific enquiry, it still has a profound impact upon the lives of many women, and until more recently women themselves have not been permitted to contribute the debate of what constitutes the disorder. The chapter closes by outlining recommendations for a paradigm shift in order to allow subjective accounts to be a valid means of informing the research process.

Chapter 3 outlines the theoretical framework of this thesis, which takes a critical realist/material discursive perspective. Such a perspective allows for the acknowledgement of the physical dimension of women's experiences of the menstrual cycle, in parallel with the more personal and social meanings that are an equally important part of women's experiences. Next, implications for the impact of social meanings at the practical level of conducting the research for this thesis are discussed, providing an outline of the actual methods used. It was felt this was necessary because a combined methodological approach has been adopted, focusing

on language as data, as well as conducting an intensive time-sampling procedure to track and record a participant's mood and a number of other variables over one complete month. Focusing on language as data enabled the identification of some of the dominant ideologies impacting on the way the individual experiences the emotional self, which would not otherwise have been possible using conventional experimental methods. Using a diary approach allowed emotion to be tracked naturally over time, which enabled emotional experience to be researched as a variable process. This method was sensitive to the variability of emotion in a way that static methods cannot be, and clarified the variability of emotion across the menstrual cycle.

Chapter 4 begins the presentation of findings of linguistic data gathered from an exploratory interview study, which was conducted to establish what kinds of issues and factors participants believed were important as part of emotional lived experience. Dominant ideologies were interpreted and examined for the impact they had on everyday lived experience. Also the function certain types of discourses provided was discussed. This study generated a great deal of data, and for the purpose of this thesis, data relevant to the core aims, namely control, gender and the fragmentation of emotional experience, were utilised. Chapter 4 discusses evidence for the need to constantly be in control of emotion in order to both be accepted by, and maintain one's assigned place within society.

Chapter 5 goes on to consider evidence for the way gender assigns certain emotion norms to the individual, which determines how one is legitimately able to present, experience and express the emotional self. This, it is argued, is a vital aspect

of women's lived emotional experience and therefore frames the way they and others perceive them. Chapter 6 further examines evidence of the way dominant ideology, in this case rationality versus irrationality, can serve not only to separate emotion from thought and reason, but also to lessen the value and impact of certain emotions when deemed irrational. Thus emotional control is again found to be important to avoid being perceived as irrational.

Chapter 7 presents data from a study which set out to test how popular assumptions governing premenstrual syndrome may influence reporting on a number of emotion variables and regulation strategy variables. This was conducted so as to examine how reporting of emotional control may be affected more specifically by the knowledge of premenstrual syndrome. It was found that by manipulating participant awareness of the purpose of the study, those participants in the aware condition (who knew the study focus was about premenstrual syndrome) reported they used venting strategies for emotional regulation (meaning expressing feelings by shouting/letting them out) significantly more than the unaware comparison group. This study provided evidence for the impact popular assumptions and stereotypes governing premenstrual syndrome have on emotional control, allowing the expression of emotion when premenstrual syndrome was considered in parallel.

Chapter 8 presents findings from a study which examined the concept of emotional control and the significance of premenstrual syndrome further by investigating a number of variables thought to be important for successful emotional control/regulation, in parallel with personal accounts of what premenstrual syndrome meant for self-diagnosed sufferers. Results were particularly interesting because the

quantitative findings contradicted the qualitative findings on the issue of timing for cycle phase. The popular notion of the premenstrual phase being associated with symptoms and other negative factors was not confirmed, yet 50% of participant accounts utilised the concept of timing and the premenstrual phase to frame descriptions of their experiences of premenstrual syndrome. Further important findings from this study, in terms of personal experience, included discourses of biology, self-other, femininity and control. A fragmentation of the lived experience from emotions was also identified and discussed.

Following the contradictions evident from the previous study reported on in chapter 8, chapter 9 reports on findings from a study conducted to examine the issue of emotion, timing and cycle phase in more detail. This was achieved through tracking mood, regulation strategies, symptoms and a number of other variables over the period of one complete month in a group of participants who believed they suffered from some degree of premenstrual affective symptoms. Overall a certain style of mood awareness (mood monitoring) was found to influence results, predicting less happiness, calmness and energy across cycle phase for participants who reported to monitor their moods and feelings more highly compared with participants who did not. Therefore mood awareness, cycle phase and regulation strategies were examined in more detailed analyses.

Chapter 10 reports on the results of specific analyses on mood monitoring as an individual difference characteristic. It was established that high monitoring compared to low monitoring as a style of attending to emotions had consequences for the type and frequency of regulation strategies used. High mood monitoring predicted

a greater degree of active mood and emotion regulation, as well as a greater degree of success at changing emotion. Also behavioural diversion strategies were reported to be the most successful at regulating emotion. Finally the premenstrual phase of the cycle predicted active mood and emotion regulation by both high and low monitors, high monitors using cognitive diversion as was predicted and low monitors using behavioural diversion strategies. Neither of the other two phases predicted active mood regulation. Implications are discussed. Chapter 10 concludes the presentation and discussion of findings from the studies utilised for this thesis.

Chapter 11 goes on to discuss the overall findings and implications. It is argued that premenstrual syndrome remains a difficult issue to research and define in any traditional scientific sense. However this does not mean that we should not continue to seek a deeper understanding of what premenstrual syndrome constitutes for women. Although medical research has so far not been able to provide women with a definite explanation and treatment for premenstrual syndrome, the label provides a common ground which many women identify with and use in order to express some of the emotional distress which is real and problematic in their lives. It is argued that, rather than making further attempts to devise a 'pure' definition of premenstrual syndrome, subjective accounts of women's experiences should be sought. This would allow women to contribute to the meanings assigned to premenstrual syndrome. Also, although an intensive time-sampling procedure makes substantial demands on both the researcher and participants, it enabled mood to be tracked over time against experiential factors experienced by participants, proving to

be a reliable method for studying mood as a naturally unfolding process rather than a static variable.

Overall the main conclusions that can be drawn from the research reported in this thesis are that controlling emotion is still considered to be of overriding importance to be considered *normal*. Emotion is still often conceptualised within a negative frame of reference, such as signifying irrationality. Also some of the same defining characteristics that define emotion also define what it means to be a woman, and so women are disadvantaged within the wider society. In contrast premenstrual emotional distress means being emotionally uncontrolled, expressing negative emotions such as anger and dissatisfaction with personal roles and life events. Furthermore in order to be able to successfully control emotion an individual must have a degree of awareness of the way they are feeling. In particular a high mood monitoring tendency was found to have significant implications on the type of emotion experienced (more negative emotion) as well as the way active mood regulation was attempted. High mood monitoring predicted a greater degree of active mood regulation, and a greater degree of reported success at attempted regulation. In terms of active regulation, it was found that strategies used to divert attention away from feelings were more successful than strategies which directed attention directly towards the feelings. Finally although no straightforward associations between the premenstrual phase of the menstrual cycle and negative feelings were found, when emotion was tracked more naturally over time, the premenstrual phase was found to be important in the way emotion was experienced and regulated. Firstly cycle phase did have a predictive consequence on emotion for participants exhibiting a high mood

monitoring tendency, but not for low monitors. High monitoring also predicted less happiness, energy and calmness overall compared to low monitoring. The premenstrual phase predicted active regulation of emotion whereas the remaining two phases did not. In particular high monitors used more cognitive diversion strategies to regulate their emotions during this phase, and low monitors used behavioural diversion strategies. Thus it is concluded that emotional control, particularly of negative emotions, is an essential part of premenstrual emotional experience, and that mood monitoring has implications for the way negative emotion is actively regulated.

Contents

Preface

Acknowledgements

Chapter 1	Emotion and Emotion Regulation	1
	Darwin	3
	James	4
	Cognition	6
	Emotion as continuous	8
	Emotion and Mood Regulation	10
	Self-awareness and Mood Awareness	11
	Affect Intensity	17
	Emotion and Gender	18
	Social Constructionism	20
	Drawing Theoretical Ideas Together	23
Chapter 2	The Menstrual Cycle and Premenstrual Syndrome	26
	The Menstrual Cycle	27
	Premenstrual Syndrome	31
	Symptoms and Treatment	32
	Definition and Aetiology	34
	Further Considerations	37
	Historical Perspectives	39
	Socialisation and Prevailing Ideas	43

Cultural Beliefs and Attributions	46
Effects on the Research Process	48
Current Position on Menstrual Cycle Research	50
Summary	53
Chapter 3 Paradigm and Method	56
Method versus Paradigm	57
Paradigms	62
Positivism/Post-positivism	63
Critical Theory/Constructivism	64
Theoretical Position of the Thesis	67
Methods	68
Dialogic, Hermeneutic Research Process	69
Language as Data	71
Process Approach to Emotion and Emotion Regulation	74
Time as a Psychological Variable	74
Intensive Time Sampling Procedure	76
Summary	77
Chapter 4 Emotional Control and the Social Order	79
Method	86
Results/Discussion	89
Chapter 5 Gender and Emotion	99
Method	105

Results/Discussion	105
Chapter 6 Emotion and Rationality	115
Method	124
Results/Discussion	124
Chapter 7 Manipulating Participant Awareness	132
Method	134
Results	139
Discussion	143
Summary	146
Chapter 8 Mood Awareness and Women's Experiences of Premenstrual syndrome	148
Method	154
Results/Quantitative	162
Results/Qualitative	165
Discussion	184
Summary	194
Chapter 9 Mood Monitoring And The Menstrual Cycle	199
Accuracy of Emotion Reports	201
Affect Intensity	202
Emotion/Mood Awareness and the Menstrual Cycle	203
Emotion and Mood Over Time	204

Method	205
Instrument	208
Data Recording Design	209
Performance of Pocket computer	211
Measures	211
Response Compliance	213
Results	213
Use of statistics in the Analysis of Temporal data	213
Discussion	226
Emotion and Mood awareness	226
Emotion	228
Summary	229

Chapter 10 Mood Monitoring and Mood Regulation	231
Introduction	227
Method	238
Results	240
Overview of Analysis	240
Mood Monitoring and Strategy Use	241
Strategies and Affect	242
Phases and Strategies	245
Successful Regulation	247
Discussion	251

Summary	255
Chapter 11 Discussion and Conclusion	258
Summary of Main Argument	258
Findings and explanations	263
Conclusions Drawn	279
Implications	283
Reflexivity: An Issue for Interpretation	284
Limitations	287
Strengths	288
Suggestions for Future Research	290
Conclusion	292
References	294
Appendices	317

Chapter 1

Emotion and Emotion Regulation

“the emotions are integral to the conduct of social life and relationships with others. So too, emotions are integral to notions of embodiment, or the ways in which people live and experience their bodies. Rosaldo, for example, describes emotions as ‘embodied thoughts’; thoughts somehow “felt” in flushes, pulses, “movements” of our lives, minds, stomachs, skin (1984: 142). The emotions, therefore, present an area of inquiry which emphasizes embodied responses as well as their construction through culture”.

Deborah Lupton (1998)

The subject of emotion has dominated the quest for furthering an understanding of human nature for a long period of time, albeit often indirectly. Previously many scientists believed emotions were too subjective to warrant study, yet during the last fifty years there has been an upsurge of research (Cornelius, 1996; Harré, 1986). Not only has the scientific community become concerned with emotion, but interest is also reflected in popular literature. Lazarus & Lazarus (1994) note how television soap operas and chat shows are immensely popular because they provide the public with a forum to observe, enact, express and discuss emotions. Yet despite the boom of research in this area, the question of what constitutes an emotion is still a challenging one. On seeking a definition the answer will depend

on who is being asked and will reflect their particular interests in a methodological and theoretical sense, as well as the designated criteria for inquiry from the paradigm within which they work. Rather than providing an extensive review of the diverse psychological literature, this chapter aims, more modestly, to examine and compare the main theoretical orientations to emotion. More recent perspectives on emotion that view the phenomenon as dynamic rather than static shall also be considered, particularly in terms of the impact on current research and for this thesis. The individual difference constructs of emotional awareness and emotional intensity will be examined for their impact on emotion regulation, as well as the concept of emotion regulation itself.

For the purposes of this thesis it is necessary to establish the progression of emotion theory, placing current understanding within a socio-historical context. This is because apart from emotion, the second component of the thesis concerns premenstrual syndrome specifically in relation to emotion. Understanding of premenstrual syndrome reflects much controversy, and some researchers (Swann & Ussher, 1995; Ussher, 1991, 1996; Walker, 1997) believe it necessary to frame current understanding by tracing the progression of ideas. Emotion is a key aspect of dominant ideas concerning premenstrual women (Ussher, 1996; Walker, 1997), and so it is essential to ground any attempt to further understanding of women's emotional premenstrual liability within a framework of knowledge which expresses what being emotional represents. Cornelius (1996) proposes there to be four traditions in the way emotion has been conceptualized and researched: Darwinism, a Jamesian perspective, cognitivism, and social constructionism. Darwin (1890) conceptualized emotion to be for survival, and concentrated on physical displays as an indicator of the kind of emotion being experienced.

James's (1898) theory conceptualized emotion as consisting of bodily change. Cognitive theory has concentrated on the role of information processing as part of the emotional experience, and finally social constructionist ideas have focused more on the way emotion is constructed through language and cultural meaning. We shall begin with a brief examination of Darwin (1890).

Charles Darwin.

Darwin's (1890) work has been referred to often in explaining human behavior from a physiological as well as psychological perspective. One can find reference to his work in many texts (e.g. Plutchik, 1980) which reflects the profound impact his ideas have had on the research community this century. Indeed Segal (1999) argues that Darwin has provided the scientific credentials for the human sciences today. The key focus adopted by Darwin (1890) is on evolution through the process of natural selection. The function of emotion is survival, and people share a similar evolutionary history with other primates. He traced the origins of particular emotions back to primitive times when expression of instinctual patterns served a survival function. The first chapters cover monkeys, dogs, cats, and anatomy of the nervous system and facial muscles. The descriptions of different types of expressions is indeed very detailed, and is conceptualized in terms of engrained patterns of muscular and skeletal actions that have become associated with particular movements as ways of responding. When talking about emotions of hatred and rage Darwin describes in great detail the uncovering of the canine tooth on one side of the face which is illustrated by a picture of a woman sneering like a dog (page 260, table IV). Therefore he defines much physiological expression, with the emphasis being on biological patterns.

Such detailed description is extremely useful for an understanding of the muscular processes involved in emotional expression, yet Darwin's (1890) ideas do not provide a complete picture of what is involved in an emotional response. His work lacks reference to context to such an extent that his descriptions could be seen to cast human response in an isolated way without sufficient reference to social context (Hochschild, 1983).

Hochschild (1983) says Darwin's theory of emotion is merely a theory of gesture. She argues that his ideas are incomplete because he proposed there is no emotion without gesture, which is not the case. Also Darwin (1890) proposed that gesture is universal, which again has since been found to be influenced by a number of other factors, particularly culture (Kitayama & Masuda, 1995; Lutz, 1988). Clearly missing from Darwin's theory is any reference to context in terms of 'at the time' cultural beliefs, situational contingency, and subjective experience. Hochschild (1983) concludes Darwin's work is an organismic model of emotion, because it defines emotions in biological, reductionist terms. Darwin's work does, however, represent an important aspect of emotional experience, particularly physical display. It must be stated here that Darwin has been referred to only very briefly which does not mean to imply his theoretical ideas governing emotion are simplistic.

William James

A defining characteristic of William James' (1890) theory of emotion is that it focused on bodily changes as part of the emotional experience. Although this is not dissimilar to Darwin (1890) in the sense of concentrating on biological aspects, he did specify the causal nature of events. He offered one of the first

formal accounts of how physiological responses relate to emotional experience, proposing that emotion is primarily the experience of bodily changes. James (1898) used fear as an example to illustrate his ideas, suggesting a causal sequence of events in response to the perception of a ferocious bear. At the sight of a ferocious bear one experiences fear and runs away. However, according to James, you experience the emotion of fear because you *are* running. The act of running away causes the emotion. Thus visceral feedback causes emotion. Emotion is the result of experiencing a particular set of physiological responses and, according to James (1890), we are not conscious of the emotion until we become aware of these bodily changes. He believed that each emotion has a different set of physiological responses.

Although there was some support for James' theory (e.g. Hohmann, 1966), in isolation it neglects the role of human thinking within the process of emotional experience (Parkinson, 1995), and does not account for how many individuals with spinal cord injuries, who have reduced or blocked visceral feedback, do still lead fulfilled emotional lives. In an attempt to address the weaknesses of James' theory, Schachter (1964) proposed a theory of emotion that built upon James's ideas. He believed the idea of visceral feedback alone could not account for the large variety in different emotional experiences. Schachter's (1964) two-factor theory proposed that arousal combined with *cognition* results in emotion. An individual may feel a state of arousal or bodily change, which motivates them to be able to understand the nature of the change and so triggers a situationally appropriate cognition. Cornelius (1996) reviews the evidence for Schachter's theory, and concludes it to be largely unsupported and incomplete. However Schachter had successfully managed to introduce the idea of cognition into the

emotion debate and as Cornelius (1996) notes, his ideas have had a positive impact on emotion research.

Cognition

Cognitive-mediational theoretical approaches towards understanding emotion currently dominate thinking on how stress and emotions are aroused (Cornelius, 1996; Lazarus, 1995). A cognitive orientation examines the information processing processes that are believed to be involved in emotion in a variety of different ways. Lazarus' (1995) work on cognitive appraisal is particularly noted as a contribution to the field of emotion research (Lazarus, 1968, 1984, 1995; Lazarus & Lazarus, 1994). Lazarus (1968, 1995) argued that in order for an emotional response to be generated, some form of appraisal of the environment/situation/object is required by the individual. Appraisal refers to a form of assessment that leads to an evaluative judgment. The object or situation has to be appraised as affecting the individual in some way, which will initiate emotional feelings of happiness, joy, frustration, fear and so on depending on the appraisal outcome. Thus appraisal presents emotion as a direct response to an individual's evaluations, interpretations and judgements of what is occurring in their personal world. Indeed this addresses the aspect of context and personal significance that was absent in Darwin's (1890) and James' (1898) ideas.

Lazarus (1968, 1995) specified the causal nature of arousal, arguing cognitive appraisal must always occur first before an emotion. However this has become a controversial point and continues to generate debate (Parkinson, 1995; Parkinson & Manstead, 1992). Reisenzein (1995) argues the main problem with suggesting appraisal causes emotion is the temporal aspect. The order of appraisal

and emotion can not be distinguished because the time interval between appraisal and emotion onset is simply too short. Reisenzein (1995) says although many appraisal theorists claim that available evidence supports the hypothesis that appraisal causes emotion, they are merely engaging in an “analytic tautology”. A further controversial case in point is the issue of conscious and unconscious appraisal. Lazarus (1995) argues appraisal occurs at both a conscious and unconscious level. He proposes unconscious appraisal as being linked to automatic information processing and serves the function of ego-defence. Scherer (1995) agrees with Lazarus that much appraising is not conscious. However he believes the issue of ego-defence is less clear, whether ego-defense is the cause of appraising being unconscious in the sense of repression, or whether defence operates on appraising that would normally be conscious too.

Parkinson (1995) believes appraisal to be an extremely important aspect of emotion. However he argues that appraisal theory has been applied in an oversimplified manner in terms of the cause-effect relationship between appraisal and emotion. Parkinson (1995) argues appraisal does not just operate as a causal factor for emotional arousal. Instead he says that what we call emotions are actually means of conveying appraisals. The appraisal represents the content of the emotional communication and thus defines the quality of the emotion (Parkinson, 1995, p.37). Parkinson also proposes the nature of appraisal to be bi-directional in that an existing emotional disposition may influence the way an individual appraises a further situation. Thus he believes that emotions should not be conceptualized as static, direct, momentary responses to appraised situations, but as dynamic communicative syndromes, formulated as the result of an ongoing interpersonal dynamic. Emotion can influence appraisal and vice versa.

Parkinson's (1995) comments are important for the research question of this thesis because it is proposed that to gain a deeper understanding of premenstrual emotional distress, emotion needs to be considered as continuous yet changing over time.

Emotion as Continuous

The idea of emotion being a static response has prevailed. Often in order to research emotion, the starting point would be to define exactly which aspect of emotion is to be considered. However some theorists (e.g. Larsen, 1989; Parkinson, 1995) are now arguing emotion can not be conceptualized accurately in this way. Also the nature of emotion as being an entity which occurs only *within* the individual (physiologically) is being questioned. Parkinson (1995) argues instead that emotion is a process of dynamic communication with one's environment and other people. Parkinson, Totterdell, Briner, & Reynolds (1996) discuss a combination of factors they believe are involved in emotion and mood processes. They highlight external factors such as hassles and activities, and internal factors such as physiology and personality. Mental processes which influence, and are influenced by, mood and affect are encoding, evaluation and processing. Most significantly though is the addition of predictors that are seen as neither internal nor external to the individual, but rather are the consequences of the transactions occurring between the person and the environment. A social constructionist perspective (which shall be outlined shortly) would take this line further.

A social constructionist way of conceptualizing emotion not only assumes that more than one factor is responsible for emotion, but also considers the

relationship between factors to be interactive and bidirectional. Hochschild (1983) proposes a new social theory of emotion from an interactional perspective. She argues that although biology is presupposed, social factors enter interactively during the experience of emotion rather than before or after. Parkinson, Totterdell, Briner & Reynolds (1996) advocate a transactional approach for conceptualizing emotion by drawing upon the ideas of Lazarus & Folkman (1984). They argue a transaction refers to a description of a reciprocal relationship between the person and the environment. Rather than viewing the person and environment as two independently, the transactional approach suggests they overlap and interact to produce structure at a higher level. A property of the person and a property of the environment come together to produce an effect or outcome. However they are cautious to emphasize the idea of an interaction as not only incorporating the idea of cause and effect, but also the interacting properties of both the environment and the person as causes, causality being bidirectional. Thus a transaction considers variables not as separate, but rather as combining and overlapping to produce structure at a higher level. Finally, Parkinson et al. (1996) say a transactional approach emphasizes *process* rather than outcomes or effects, particularly processes in which both the environment and the person are constantly changing. This emphasis is in line with Larsen's (1989) approach to conceptualizing emotion.

Taking Parkinson's (1995) ideas further regarding the importance of cognition as part of the interactive, transactional nature of emotion, Parkinson, Totterdell, Briner & Reynolds (1996) proposed a four-factor control-based model of affect. The model is particularly useful because it provides an explanation of how emotion is controlled and regulated, setting out the components but not

placing any factor hierarchically above another. It involves four kinds of processes, the first being the unfolding of emotion itself. Secondly is a monitoring process which registers information relating to the affective process to check that regulation is working effectively. Thirdly is some kind of appraisal process which assesses whether current monitored affect (or recent affect change) conforms to goals. The final process concerns the regulation operation, which is intended to bring affect in to line with goals of one kind or another. Parkinson et al. (1996) stress that in reality the separation of these processes might not be as absolute as implied. Also the ongoing nature of affect and mood as an on-line process means that it is difficult to suggest which point of entry should be taken, instead focusing on the interactive nature of the processes. This echoes Hochschild's (1983) ideas, stressing *process* over individual factors.

Emotion and Mood Regulation

Common perceptions of emotions include the notion they are some kind of entity which controls the individual (Lutz, 1996; Parrott, 1995), and in some cases take the individual over completely by interfering with higher cognitive processes (Lazarus & Lazarus, 1994). Such a view obviously casts emotion and thought as separate. However the important consideration here is how the person is characterized as being at the mercy of their emotions. Much of the research on emotion now deals with issues that imply the individual can be consciously involved in various aspects of the emotion process, such as conscious appraisal (Lazarus, 1995; Lazarus & Lazarus, 1994). Some emotion theorists are now challenging ideas of lack of control more overtly, arguing that the individual is very often actively involved in the way they are feeling. The individual is now

believed to be consciously aware of their affective state for much of the time (Swinkels & Giuliano, 1995), and consciously engaging in efforts to change, modify or maintain particular feeling states (Parkinson, Totterdell, Briner & Reynolds, 1996). This casts a very light view over emotion, yet should not be taken to mean an individual always controls their feelings, whether the physiological aspect or the outer expression.

Parkinson, Totterdell, Briner & Reynold (1996) believe that individuals are, for much of the time, actively involved in the way they are feeling. Their control-based model of affect (outlined previously) accounts for such a view. The second aspect of the model refers to a monitoring process, which is believed to be a vital aspect of the control process. The monitoring process registers information relating to the affective process to enable the individual to check that regulation is working effectively. The third aspect of the model involves appraisal to see whether current mood/affect conforms to goals, and the fourth aspect actually concerns the regulation operation itself, aiming to bring mood/affect into line with various goals and intentions. This literally refers to the measures an individual applies in order to change or maintain an affective state, such as listening to upbeat music before a party to manipulate one's emotional state to be consistent with a 'party spirit'. Regulation can also be in a downward direction, such as when one is preparing to attend a solemn occasion like a funeral. It is important to note that Parkinson et al. (1996) acknowledge that automatic regulatory processes also occur. The issue of automatic and unconscious appraisal, processing and regulation are still not fully understood.

Self Awareness and Mood Awareness

A large number of different factors are believed to contribute to the manner in which individuals control their moods and emotions. Of particular interest to this thesis is the concept of conscious awareness, implicated in Parkinson et al. (1996) model of affect regulation. In order to be able to regulate feelings, it seems fair to suggest that one needs to have some awareness of the way one is feeling to begin with. Kirschenbaum (1987) believes that self-monitoring is a necessary condition for generalized self-regulation to be able to occur. After reviewing several studies he identified eight factors which contribute to self-regulatory failure, but most importantly he emphasized that self-monitoring underscores the vital role of attention in self-regulation. Consistently Kirschenbaum (1987) found that individuals who failed to self-regulate particular behaviors showed less self-monitoring than successful regulators. Also he noted that negative affect consistently precipitated full-blown relapse from target behaviors. Kirschenbaum concludes his review by advocating the development of 'obsessive-compulsive self-regulation', which involves the individual constantly attending to the self in a positive way. Thus in order to have a successful degree of self-control, self-awareness is necessary.

There are several different ways in which self-awareness has been referred to. Duval & Wickland (1972) proposed the theory of self-awareness, which refers to the way attention is directed inward toward the self, placing an emphasis on global inner state feelings. Kirschenbaum (1987) talks of generalized covert self-awareness. Swinkels & Giuliano (1995), on the other hand, proposed a form of self-directed attention that is specific to mood states, namely the mood awareness construct. They developed and validated the mood awareness scale, designed to assess the amount of attention individuals direct towards their mood states.

Principal Components analysis revealed there to be two distinct dimensions, a mood monitoring and a mood labeling dimension respectively. Individuals classified as high mood monitors have a tendency to scrutinize or focus on their mood states. Labelers, on the other hand, display the ability to identify the type of mood they are in by giving it a particular label or name.

Individuals level of awareness of their mood states has been found to have considerable implications for the type (positive or negative) and duration of emotion experienced. Swinkels & Giuliano (1995) found that a general profile emerged of mood monitors and mood labelers. Mood monitoring refers to the tendency to scrutinize or focus on one's mood state. In contrast mood labeling refers to the ability to identify and give a name to one's mood state (Swinkels & Giuliano, 1995). High mood monitors, in comparison to low mood monitors, tended to experience affective states more intensely, encounter more negative affect, report neurotic tendencies, have lower self-esteem, agree their moods are important in influencing their behavior, yet report a low rate of success at regulating their moods. High mood labelers, in contrast to low mood labelers, had higher levels of self-esteem, experienced more positive affect, reported tendencies of extroversion, were less socially anxious or neurotic, expressed greater life satisfaction and reported higher rates of success at self-regulating their moods. Thus the two aspects of mood awareness have very different emotional consequences. Further significant findings by Swinkels & Giuliano (1995) were that mood monitoring predicted judgments of ruminative response, supporting their contention that monitoring one's mood may actually promote a ruminative response style. Wood, Saltzberg, Neale & Stone (1990) found self-focused

attention encouraged a ruminative response style, and discouraged coping aimed at distraction. Swinkels & Giuliano's results appear to be consistent.

So far it has been acknowledged that in order to control and regulate emotion a degree of self-focused attention is required. However from Wood, Saltzberg, Neale & Stone's (1990) work there is also an issue of negative impact on an individual's emotional well-being arising out of self-awareness. Literature on self-focused attention reveals conflicting results, raising the question of whether self-awareness is good or bad for emotional well-being. Although Kirschenbaum (1987) advocates covert self-focused attention to be necessary for successful general self-regulation, Ingram (1990) conducted a broad review of the literature and found that self-focused attention was a significant factor across a wide range of clinical disorders. The key issue seems to centre on the impact at a cognitive level. Self-focused attention has been associated with a ruminative style of responding to emotion, particularly negative affect (Carver & Scheier, 1981; Scheier & Carver, 1977; Struck, Blaney, Ganellen & Coyne, 1985). Wood, Saltzberg, Neale, Stone & Rachmiel (1990) found that self-focused attention encouraged a ruminative response style and discouraged responses aimed at distraction. Nolen-Hoeksema (1987) examined the relationship between ruminative and distracting styles of responding to depressed mood and found that ruminating caused individuals to focus attention on the symptoms of negative affect, spending most of the time thinking about how badly they felt. Consequently attention is taken up by this symptom-focused style, making it less likely for the individual to engage in structured problem solving. Nolen-Hoeksema, Morrow & Fredrickson (1993) argue that responding to a depressed mood with a ruminative style prolongs the duration of the mood. This could help

account for the failure by mood monitors to implement measures to ameliorate particular moods (Swinkels & Giuliano, 1995). Swinkels & Giuliano (1995) themselves proposed ruminative responses as a partial explanation for prolonging negative affect in mood monitors.

Scheier & Carver (1977) investigated the effects of self-focused attention on emotion and found a high degree of private self-consciousness increased responsiveness to affect. Also persons high in private self-consciousness, as opposed to persons low in private self-consciousness, were more responsive to their transient affective states, this being the case for both positive and negative affect. Wood, Saltzberg and Goldsmit (1990) proposed the idea that emotion actually induces self-focusing, and found sad mood particularly to be an inducer, adding to the growing body of evidence that depression may lead to chronic self-focusing. Salovey (1992) also emphasizes the role of affective arousal in directing cognition. He found evidence to suggest self-focused attention is induced by both sad and happy mood, and consequently the affectively charged experience changes the way an individual organizes information about him/herself. Salovey explains that an individual is emotionally aroused, the experience causes the individual to become temporarily self-preoccupied, which in turn leads to a de-emphasis of external cues. Overall, then, it seems reasonable to accept that in some instances self-focusing leads to negative consequences for emotional well-being. Self-focusing on feelings can cause revolving thoughts on how negative one is feeling, which predisposes to prolonging the experience of the negative feeling state. The causal nature of the association between self-focused attention, emotion and ruminating is less clear. Perhaps it is more realistic to

accept that such processes can not be easily separated out, but they each have an impact on the other as part of an ongoing process.

With regard to self-awareness having both positive and negative consequences for emotional wellbeing, Kirschenbaum (1987) differentiated between a positive style of self-monitoring which can improve mood and affect, and a negative style of self-monitoring which can prove detrimental. Negative focused-attention, he says, occurs when an individual is self-focused on experiences of failure, leading to a reduction in perceived self-efficacy. Positive self-focusing, on the other hand, requires attention to be directed towards positive aspects of private experience and experience of success. It is suggested that Swinkels & Giuliano's (1995) findings of the two dimensions of the mood awareness construct represent a distinction between positive and negative self-focused attention at the level specific to emotion. The monitoring style of self-focusing towards one's moods was associated with negative factors. A labeling style, in contrast, predicted success at mood regulation and was associated with positive factors. These are important distinctions because they have varying consequences for private emotional wellbeing.

Because one of the aims of this thesis is to establish an understanding of emotional regulation by women who suffer with premenstrual syndrome the role of self-monitoring, mood awareness in particular, becomes an important factor for consideration. The reason is twofold. Firstly, premenstrual syndrome is often defined in the medical and lay community by time, which may lead to women becoming more self-focused during the premenstrual phase of the cycle. Secondly, as already outlined, the type of monitoring tendency displayed has

implications for the length of time a particular affective state is experienced and can lead to prolonging negative feelings.

Affect Intensity

Of additional interest to this thesis are a number of research findings concerning affect intensity. Reasons for interest focus around ways in which affect intensity can influence an individual's ability to regulate their feelings. Affect intensity refers to the typical strength of an individual's affective responsiveness, and generalizes across both positive and negative emotions (Flett & Hewitt, 1995; Larsen & Diener, 1987). The strength with which an individual experiences emotional responses can be assessed with the affect intensity measure, developed by Larsen, Diener & Emmons (1986) and is characterized by two poles; one from which only minor fluctuations are experienced to the other where emotion is experienced very strongly. Flett & Hewitt (1995) examined the criterion validity of the affect intensity measure and found dispositional levels of affect intensity predict subjective reactions to life stress, styles of emotional expression, interpersonal reactions, physiological reactions, and perception of physiological reactions. They conclude that the affect intensity measure assesses an important aspect of temperament in adults.

Larsen & Diener (1987) found evidence to suggest that individuals who are highly emotionally intense (i.e. that is experience emotional states more strongly) experience more frequent shifts in mood, report a greater frequency of somatic complaints, are at an increased risk of developing bipolar affective disorder, and are more likely to report neurotic symptoms. These findings have serious implications for overall emotional wellbeing. Of particular interest is the

frequency of change in moods against Larsen & Diener's findings that any changes in affect in high affect intensity individuals are experienced as more dramatic. This is because the change from one mood to another represents a greater change in affect. Such results seem in accord with Larsen, Diener & Emmons (1986) earlier claim that high emotionally intense individuals are at an increased risk from bipolar affective disorder. Furthermore Flett, Blankstein, Bator & Pliner (1989) found that individuals who were more highly affectively intense reported lower self-control over their emotional behavior. Consequently affect intensity carries implications for affect regulation. Emotional intensity can affect the way an individual experiences emotional states, particularly in terms of the stability and control over emotion.

Again, as with mood awareness, much attention has been given to the impact of affect intensity on cognitive style. Evidence suggests various aspects of cognition can be effected by the strength of emotional experience. Larsen, Diener & Cropanzo (1987) found high affect intensity was associated with a characteristic set of cognitive operations. Personalization, selective abstraction and overgeneralization, which are particularly prevalent in depression, were all used significantly more often by individuals who were high in affect intensity. Dritschel and Teasdale (1991) replicated these findings for overgeneralization and personalization. Also Basso, Schefft & Hoffman (1994) found that affect intensity moderated the influence of mood on cognitive performance. Therefore affect intensity not only has implications for the self-regulation of emotion, but also can affect the cognitive aspect of the emotion process.

Emotion and Gender

Throughout history women have been perceived as being the more emotional of the sexes (Lutz, 1996; Ussher, 1989), and gender differences are still revealed in research findings. Definite gender differences in affect intensity have been detected, women notably reporting to experience their emotions more intensely than men (Larsen & Diener, 1987). Fujita, Diener, & Sandvik (1991) found that not only were women more emotionally intense than men, but they experienced more negative affect than men whilst at the same time reported equal levels of happiness. They argue gender differences in affect intensity explain the paradoxical presence of both the greater prevalence of negative affect and the equal overall happiness reported by women. Fujita, Diener & Sandvik (1991) propose this is because women's more intense positive emotions balance their higher negative moods. So although women may be at greater risk of depression, women actually experience more intense joy than men. Therefore women are more likely to be less inhibited and more reactive to pleasant life events than men, which means they experience positive emotional events with greater intensity.

Nolen-Hoeksema (1987) draws attention to the issue of sex differences in prevalence rates of depression, notably that twice as many women are reported to suffer from unipolar depression than men. She found evidence which again implicated the cognitive aspect of the emotion process, and proposed a response set explanation for such differences in depression. Women were found to amplify their mood states by engaging in ruminating, whilst men engaged in distracting behaviors which lessened their depressed moods. Thus Nolen-Hoeksema (1987) concludes that how an individual responds to a depressed mood/affective state may contribute to the severity, chronicity, and recurrence of an episode. Therefore gender is an important consideration. It is important to note, however, there may

be a variety of reasons as to why women respond to their moods and affect in this way which are implicated by their gender, the relationship being complex and less straightforward. Emotion is still gendered (Lutz, 1996), and so various factors may lead women to be more predisposed to focus more on their feelings. Some of those issues are explored in chapter 5. However it remains to be stated that sex differences in emotional experience and expression can be accounted for in ways other than the purely biological, although the physiological aspects are not ignored.

To summarize so far, three of the key theoretical orientations addressing emotion have been outlined. Also affect and mood regulation have been mentioned, and mood awareness and affect intensity have been referred to in brief as important individual difference characteristics for the impact they have on the ability to control and successfully regulate emotion. Now it remains for consideration to be given to the fourth and most current theoretical orientation that has been put forward in the emotion debate, namely the social constructionist perspective.

Social Constructionism

The idea of emotion as an ongoing, interactive process involving transactions taking place between the individual and the environment underscores the role of social interaction, and can be identified to a degree in Parkinson et al.'s (1996) ideas concerning the transactional nature of emotion. Social interaction is taken further within the fourth movement in the emotion debate which Cornelius (1996) describes as social constructionism. This more recent way of conceptualizing emotion is based upon radical assumptions with far-reaching

implications. A social constructionist view of emotion challenges the assumptions made by previous theories, particularly rejecting the sentiment that emotions are merely physiological and cognitive responses/processes located within the individual. Averill (1980, 1992) is noted for promoting such ideas, stating that emotions can be more fully understood when a social level of analysis is incorporated because emotions are socially constructed. He argues that emotions are socially prescribed, learnt, sets of responses to be followed by an individual in given situations. The learned rules inform the individual how to appraise different situations and react to the appraisal as well as the bodily changes.

Central to Harré's (1986) position on emotion theory is the rejection of the idea that there is 'something there' which can be studied as a concrete object. This represents a clear constructionist view that emotion is socially constituted. He supports his argument by reviewing much evidence of cultural diversity and cognitive differentiation in the emotions. Harré says,

"But in the case of the emotions, what is there is the ordering, selecting and interpreting work upon which our acts of management of fragments of life depend. We can do only what our linguistic resources and repertoire of social practices permits or enable us to do. There has been a tendency among both philosophers and psychologists to abstract an entity-call it 'anger', 'love', 'grief' or 'anxiety'-and try to study it. But what there is are angry people, upsetting scenes, sentimental episodes, grieving families and funerals, anxious parents pacing at midnight, and so on. There is a concrete world of contexts and activities." (Harré, pp. 4)

This quote capture Harré's ideas extremely well. Emotions are seen as the *product* of the social interaction between people rather than a separate

concrete entity. The concreteness takes the form of the material world and physical material activity. Emotions are strategic and play roles in the form of actions. To understand anger, Harré says, one needs to examine how the word 'anger' and other expressions that cluster around it is used in given cultural contexts and episodes. The focus is, therefore, on how emotion vocabularies are used and in what given contexts and socially prescribed roles, rather than attempting to 'measure' some entity that is called an emotion.

Taking this line further, Shotter & Billig (1998) also argue that in to understand lived experience of a given phenomenon (in this case emotion) a focus on the use of language is necessary. They refer to the work of Bakhtin to clarify their argument. Shotter & Billig (1998) say of Bakhtin's work that he portrays the self as an embodied entity, situated in concrete time and space, and which is constituted in and through its dialogical relations with others. So to gain insight into emotional lived existence, one has to focus upon the dialogue that individuals use, rather than attempting to measure a concrete entity.

Harré (1998) conceptualises the self in three dimensions. He argues that the self is not fixed, but rather is a place from which the person perceives the world, and a place from which to act. Of particular interest to the thesis is Harré's (1998) ideas concerning self 2; the shifting totality of personal characteristics, what the person is in terms of the interweaving of dispositions and powers with the momentary psychological attributes discernible in the flow of private and public actions (Harré, 1998). However, it is important to note that, although Harré (1998) argues the self is multifaceted and fluid, the

self is also singular, which maintains an element of concrete material reality for the self.

Despite the constructionist line taken by Harré (1986), he also acknowledges the physical-realist aspect of emotional existence. He is firmly committed to realism (Harré, 1998a), and despite acknowledging the contextual aspect of emotional experience, sidesteps the issue of relativism. This is an important point because it is often assumed that the theoretical uptake of a social constructionist position means the theorist is a relativist in ontological terms. However this is not necessarily the case. Parrott & Harré (1996) attempt to bridge the gap between the functional aspects of emotion displays and somatic aspects. They not only explore ways in which emotion displays and feelings have a role in social control by expanding Harré's (1986) earlier proposals, but they also examine how learning new practices can reshape the human brain and nervous system. Thus in Harré's work a physiological element is retained.

Drawing Theoretical Ideas Together: A Complex Interactive Process.

The social constructionist view of emotion is particularly useful for the way it enables a variety of contextual factors to be considered as impacting upon the emotion process. Focusing on social interaction enables the researcher to take in to consideration context, personal meaning, cultural scripts, gender, physiology, ideology, language and many other factors for the way emotional experiences are constructed and subsequently relayed. Darwinian ideas allow the recognition that emotion displays play in biological terms. Jamesian ideas permit the role of visceral feedback in emotional experience, and cognitive ideas have acknowledged the importance of the way individuals process information within

the human mind. However Larsen's (1989) and Parkinson, Totterdell, Briner & Reynold's (1996) ideas on emotion as a transactional, interactive process enable the integration of these ideas. They do so by acknowledging how gender, culture, ideology and such factors influence and contribute to cognitive and physiological processes. A common theme evident in the work of Parkinson (1995), Harré (1986) and Hochschild (1983, 1990) is of emotion as a dynamic, interactive process constructed within and between people and the environment. It is on this theme which the thesis is based. A deeper understanding of emotion, in particular menstrual cycle related emotional distress, can be realized only if emotion is conceptualized as the multifaceted, complex entity that it is (Van-Leeson et al. under review).

The present chapter has outlined the main theoretical orientations governing the way emotion has been defined and conceptualized during the last one hundred years. Of particular importance is the way traditional ideas have separated emotion out and attempted to further understanding by studying mainly the physiological aspects of what is considered to be an emotional response. Scientific inquiry has attempted to fulfil the need to define emotion as a concrete entity which can be precisely defined. In particular Darwinian ideas have been highly influential on the scientific community in general this century. However more recently the focus of inquiry, particularly in relation to emotion research, has begun to examine the cognitive, social, contextual, and social interaction aspects that are involved in, and contribute to, an emotional experience.

It was necessary to trace the progression of emotion theory, albeit briefly, this century because the second component of this thesis incorporates premenstrual syndrome. As the development of the notion of a premenstrual

syndrome is relatively recent (Richardson, 1995), a parallel of knowledge of the progression of emotion theory was required if one is to be able to critically examine the affective aspects of the syndrome. This is because of the large number of symptoms which are known to be associated with premenstrual syndrome, affective symptoms, such as negative affect, liability of emotion and mood swings are those for which women most commonly seek medical help (Bancroft, 1993, 1995; Walker, 1997). Thus this suggests the emotion component of the syndrome is a very salient issue in terms of discomfort for many women. Also the separation of emotional experience as an isolated symptom is of particular relevance to this thesis. Chapter 2 shall now examine the development of, and current issues, surrounding premenstrual syndrome in more detail.

Chapter 2

The Menstrual Cycle and Premenstrual Syndrome.

“ The menstrual cycle is an endless rhythm, and, except during pregnancy, is ever-present from menarche to menopause for the majority of women”.

Anne Walker (1997, page 115-116).

The menstrual cycle has been the focus of much attention this century. The focus ranges from historical perspectives, hormonal fluctuations and cycle phase, to issues concerning the way the menstrual cycle is researched, not to mention the emergence of the notion of *premenstrual syndrome* during the last seventy years. Of particular interest to this thesis is speculation concerning a causal link between hormonal changes and variability in affect. There are over one hundred reported symptoms believed to be associated with the premenstrual phase of the cycle, yet women's variability in mood and affect has occupied centre stage in the research forum as well as the popular literature.

Much has been written about the menstrual cycle, yet it is apparent that understandings of the menstrual cycle are both complex and controversial. The aim of this chapter, therefore, is to review the key aspects of the literature. Firstly the menstrual cycle will be outlined, followed by a discussion of premenstrual syndrome. Historical perspectives, social norms and the way such factors may affect research into premenstrual syndrome will also be discussed, concluding with a discussion of current proposals for the way future research should be

conducted.

The Menstrual Cycle: What We Do Know.

Asso (1983, 1988) emphasises that the menstrual cycle is an integral part of the normal existence of women for a large part of their lives. Furthermore she says that although there are volumes of work on the premenstrual phase, investigation of many aspects of the menstrual cycle are still in their infancy, as two thirds of the cycle have hardly been studied. Walker (1997) states that menstruation is the only external physical evidence for the continual rhythm of a woman's internal environment. She goes on to trace a shift in focus from being on menstruation itself, to ovulation as being the most significant event, because the evolving advancement of technology has allowed the measurement of hormone levels. This has had far reaching implications on the way the cycle has been categorised into phases which relate to association of hormonal fluctuations. Asso (1988) prefers to conceptualise the menstrual cycle as a continuous intricate synchronised rhythm of interactive change involving the hypothalamus and pituitary gland, and the female sex hormones; a natural, continuous biological rhythm.

Timing is a key factor when we consider the menstrual cycle, because the continuous change in internal events are defined in periodic terms. The rhythmic changes that equate to one full cycle are the result of a negative feedback relationship between the ovarian hormones progesterone and oestrogen, and the pituitary hormones follicle stimulating hormone and luteinizing hormone. These are in turn controlled by gonadotrophin releasing hormone from the hypothalamus. Although the outset of menses and the last years prior to the

menopause see a broad variation in cycle duration, the average cycle lasts approximately 28-29.5 days (Asso, 1983; Severino & Moline, 1989). A brief description of the activities that comprise the cycle shall be given, based upon a 28 day cycle, although there are wide individual differences in women's cycles (Bancroft, 1995; Walker, 1997). This is not meant to detract from the vast individual differences evident in women's cycles.

There is considerable variation as to how the cycle is conceptualised and divided (Bancroft, 1995; Ussher, 1996; Walker, 1997). Asso (1983) defines five phases: the menstrual phase, days 1-5; the follicular phase, days 6-12; ovulatory phase, days 13-15; luteal phase, days 16-23; premenstrual phase, days 24-28 (Asso, 1983). However Severino & Moline (1989) talk of three phases: the follicular phase from day 1, the luteal phase consisting of the time from ovulation to the onset of menses, and the late luteal or premenstrual phase which consists of 5-7 days prior to the onset of menses. For the purpose of clarity of explanation Asso's (1983) phases shall be referred to, for the events which take place during each phase.

Menstrual phase/beginning of the cycle. Day1-5

The onset of bleeding is often seen as the simultaneous ending of one cycle and the beginning of another because there is a degree of overlap between the events of any two cycles. The menstrual phase is the time at which oestrogen reaches its lowest point and the shedding of the lining of the uterus ensues. During this time the negative feedback of declining oestrogen begins to initiate the events of the next cycle. Also follicle-stimulating hormone has already begun to rise just prior to menstruation, to sustain growth of new follicles. This is partly due to the

fall in oestrogen which stimulates the hypothalamic release of gonadotrophin release hormone to the pituitary gland, which then starts a rise in follicle stimulating hormone.

Follicular Phase. Day 6-12

The rise of follicle stimulating hormone acts on the ovaries and stimulates the growth of a group of follicles. It is during this part of the cycle that oestrogen begins to rise and reaches maximum saturation towards the end of the phase. The follicles continue to grow and maximise, which is the source of oestrogen. The rising level of oestrogen acts as a negative feedback on the hypothalamus, which then causes follicle-stimulating hormone to decline. It is important to note that although a group of follicles develops during this time, only one follicle survives for selection of the process of ovulation. The precise mechanisms for this are not known.

Ovulatory Phase. Day 13-15

Although during the follicular phase there is an increase in oestrogen which causes the inhibition of lutenizing hormone, around the middle of the cycle the increased level of oestrogen causes a sudden surge of release of lutenizing hormone and follicle stimulating hormone. Approximately twenty-four hours after the level of lutenizing hormone peaks (around day 15), this causes the release of a mature egg from the largest follicle, hence ovulation has occurred. Lutenizing hormone and follicle stimulating hormone also function to prepare the uterus for the implantation of a fertilised ovum.

The Luteal Phase. Day 16-23

Lutenising hormone and follicle stimulating hormone, which are present from the ovulatory phase, cause the remains of the follicle that expelled the egg to release progesterone. By this time the follicle has collapsed and transforms into the corpus luteum. Progesterone also prompts the uterus to prepare for a fertilised egg, and also inhibits further release of lutenising hormone. If the egg is fertilised, human chorionic gonadotrophin hormone is secreted from the placenta. Although the nature of the functions of gonatotrophin hormone is not fully understood, it does ensure somehow that the placenta secretes progesterone which is essential for pregnancy. If however pregnancy does not occur, the cycle enters the premenstrual phase.

Premenstrual Phase. Day 24-28

In the absence of a fertilised egg, there is a sharp fall in the levels of oestrogen and progesterone from around day 24. Such a drop causes the changes in the endometrial lining of the uterus, which culminates with menstrual bleeding. Thus one full cycle is complete and another begins.

It should be stated that although the menstrual cycle is understood to a certain degree, there is much ambiguity surrounding the knowledge of hormonal activity and specifics concerning the mechanisms which trigger secretory processes (Asso, 1983, 1988; Green, 1982; O'Brien, 1987; Warner & Walker, 1992). As Warner & Walker (1992) point out, much research interest has focused upon the fluctuating levels of hormones within the cycle in attempts to link endocrinological changes to women's behaviour and somatic complaints. This refers to behaviour perceived to be negative or not desirable, resulting from

lability of mood, negative affect, irritability and anger. Yet there is no consensus of evidence for such links (Warner & Walker, 1992). Walker (1992) argues there is no evidence that ovarian hormones within the cyclic changes are related to any symptoms which distinguish women with premenstrual problems from women who do not.

To summarise the brief outline of cyclic hormonal activity, oestrogen rises gradually during the early part of the cycle (follicular and ovulatory phases, and to an extent in the luteal phase), whilst progesterone gradually rises, but more sharply during the luteal phase. Towards the end of the cycle, both oestrogen and progesterone decline sharply. It is during this time of decline of these hormones that much speculation has been generated (Rodin, 1992). Therefore there has been a great deal of attention devoted to this particular time point within the menstrual cycle. The premenstrual phase is arguably the most well known of the cycle phases academically and in the lay community. This has led to the development of the notion of premenstrual syndrome, which has generated and maintained attention on one particular part of the cycle only, rather than conceptualising the process as continuous and rhythmic.

Premenstrual Syndrome

The development of a clinical syndrome associated with the menstrual cycle is relatively recent (O'Brien, 1987; Richardson, 1995; Ussher, 1989; Walker, 1997). The first mention of any problems experienced by women relating to cyclicity was by the gynaecologist Robert Frank in 1931. He noted, in a group of women referred to him, that they seemed to be experiencing a kind of 'tension' around the time before the onset of menses. Thus was derived 'premenstrual

tension', which Frank attributed to an accumulation of 'the female sex hormone', and recommended medical intervention. So from as early as 1931 the focus on hormones began to develop. Throughout the 40's, 50's and 60's the work of Dalton (1960,1961, 1968) made an important contribution to furthering interest and development of the concept. In 1953 Greene & Dalton renamed what has now become known as 'premenstrual syndrome'. This enabled them to acknowledge the broad array of symptoms which were beginning to be associated with the premenstrual phase of the cycle. Currently one hundred symptoms are documented (Dalton & Holton, 1994; Severino & Moline, 1989), which occur in no particular frequency of occurrence (Abplanalp, 1989; Dalton & Holton, 1994; Severino & Moline, 1989).

Symptoms and Treatments

The variety of symptoms associated with premenstrual syndrome have far reaching implications for women in terms of treatment, and for researchers in terms of which symptoms to use as research inclusion criteria. There is no specific pattern to the occurrence or frequency of symptoms (Severino & Moline, 1989). A woman may experience one or several symptoms one month, followed by a month of completely different, or no, symptoms. Symptoms fall into two main categories; somatic and affective. Somatic symptoms range from breast tenderness, weight gain, headaches, general aches and pains, backache, cravings, changes in bowel habit to difficulty in sleeping (Bancroft, 1993; Moos, 1991; Severino & Moline, 1989; Shreeve, 1983). Affective, or psychological, symptoms range from irritability, tension, mood swings, low self-esteem, to prolonged negative affect or depression (Bancroft, 1993; Moos, 1991). Out of the large

number of symptoms reported, those which women most frequently seek treatment for are affective: mood swings and prolonged negative affect (Bancroft, 1993; Walker, 1997). Changes in mood and affect, which affect women's behaviour, have been hypothesised to be causally linked with declining levels of oestrogen and progesterone during the premenstrual phase of the cycle. Such a hypothesis has not only occupied the attentions of the scientific world, but has also become part of an accepted notion within popular Western culture (Ussher, 1996; Walker, 1997).

An equally broad range of available treatments matches the large number of symptoms. Walker (1997) places them into three categories; changes in diet and lifestyle, control of the menstrual cycle, and management of specific symptoms. Diet based treatments include the reduction of salt in order to minimise bloating, yet as Walker (1997) points out there are no studies evaluating the usefulness of such advice. Treatment of specific symptoms include such measures as diuretics to relieve feelings of bloating believed to be associated with water retention, to prescribed tranquillisers such as Valium to relieve depression (Abplanalp, 1983). Green (1982) says that although diuretic therapy is sometimes helpful, much greater knowledge is required to establish hormonally related fluid and electrolyte changes throughout the cycle.

Dalton & Holton (1994) advocate a variety of treatments on the basis that women have to see which one works best. These range from Dalton's (1977) progesterone therapy in the form of suppositories or injections, a large variety of drugs including analgesics, prostaglandins, antidepressants, beta blockers, inhalers, and anticonvulsants, to surgical options such as dilatation and curettage, examination under general anaesthetic, sterilisation, oophorectomy and

hysterectomy. When reading in Dalton & Holton's (1994) treatment guide the rationale for the existence of premenstrual syndrome is based on social values rather than scientific evidence, and Dalton's description of a 'cure' is somewhat ambiguous (page 4). Bancroft (1993) argues that treatments are advocated on very uncertain scientific grounds. Given this, it is alarming that women may potentially be subject to invasive and high-risk surgery in the name of an entity that has not been fully evidenced or understood. As early as 1931, Frank advocated treatment of premenstrual tension in the form of radiotherapy on the ovaries, which is now known to be harmful.

Abplanalp (1983) conducted a review of treatments. She concluded there to be no single treatment which has withstood the test of double-blind controlled trials, and in reality the placebo effect of many drug trials is at least as effective as the drug under trial (Abplanalp, 1983). Green (1982) argues that although there has been a proliferation of treatments, no single treatment has achieved a unique standing. She goes on to say that although hormonal hypotheses of premenstrual syndrome have been the most prevalent, the roles of oestrogen, progesterone, aldosterone, and prolactin individually and interactively remain to be clarified. This supports Asso's (1983, 1992) assertion that knowledge of the menstrual cycle remains only partial. In summary, then, so far, there is no agreement as to what constitutes or causes premenstrual syndrome, or any one regarded treatment that has withstood scientific double-blind trials unequivocally.

Definition and Aetiology

Use of the term syndrome, Ussher (1996) argues, enables this diagnostic

label to be applied loosely, which raises the issue of what exactly is meant by premenstrual syndrome. Surprisingly, despite the large volume of research no consensus has been reached. The key focus in terms of medical aetiological explanation rests on endocrinological and hormonal foundations. The fluctuating hormonal levels throughout the cycle are the most commonly hypothesised cause of premenstrual distress (Parlee, 1988; Richardson, 1995), which was first instigated by Frank's (1931) work. However Richardson (1995) notes that research has failed to establish any specific relationships between the concentrations of hormones and women's mood or behaviour. Warner (1992) also concludes there to be no evidence to support such assumptions, and women who report premenstrual symptoms are indistinguishable, in terms of hormones, from women who are symptom free. Bancroft (1993, 1995) says that the assumed link between ovulation and fluctuating hormone levels is an oversimplification of the complex issues surrounding the way women react to menstrual cycle change, and that there is no conclusive scientific evidence to support such a simplistic proposition. Other aetiological explanations have included a deficiency of vitamin B6, high levels of monoamine oxidase activity, high levels of prolactin, or withdrawal reaction to beta-endorphin (Richardson, 1995). Again none of these explanations have been substantiated.

O'Brien (1987) concludes that premenstrual syndrome is not a 'true' syndrome because a syndrome is defined as a specific collection of symptoms. Many medical definitions now tend to avoid specifying symptoms, in favour of concentrating on the timing factor. This is because a woman may have one or more symptoms during one cycle, which are either absent or different during the following cycle. Apblanalp (1989) reviewed definitional and symptom issues and

concludes that there is one set of symptoms which is considered to be the standard criterion for defining premenstrual syndrome. One example of a definition is that of Dalton's (1964), "a group of physical and mental changes, which begin anything between two and fourteen days before menstruation, and which are relieved soon after the period starts". This not only incorporates a large span of time, but is also vague. Symptoms are not specified, but the commencement and alleviation of symptoms are time contingent. Her subsequent revised definition is very similar (Dalton & Holton, 1994, page 4).

From the confusion generated out of the large variation in the way premenstrual syndrome is conceptualised, there have been attempts to produce a 'pure' definition (Royal College of Obstetricians and Gynaecologists, 1983). Again however the key focus is on timing with non-specified psychological and somatic symptoms. The most recent attempt to clarify premenstrual distress culminated in the inclusion of Late Luteal Phase Dysphoric Disorder (LLPDD) in the Diagnostic and Statistical Manual (American Psychiatric Association, 1994). Rather than clarifying matters, this has raised a great deal of concern. Such a diagnostic category has the potential to label women mentally ill on account of a naturally occurring biological cycle. Gynaecologists have been critical of LLPDD because symptoms listed refer to affective rather than somatic experiences. This is somewhat surprising given that the syndrome is supposed to emanate from biological change, and eliminates women who suffer with physical complaints connected to their menstrual cycle. Ussher (1989; 1996) has pointed out how women's affective experiences and complaints have too often been open to subjective interpretation by the medical and psychiatric professions and labelled as a medical or mental problem, ignoring the social and gendered reasons within

society which contribute to women's complaints and distress. The inclusion of a diagnostic category in DSM IV has so far still not been able to provide a working framework for researchers who are investigating premenstrual distress, or given women reassurances or answers to the problems they experience.

Bancroft (1993) argues that attempts to define a 'pure' premenstrual syndrome have only served to complicate matters. A particularly good example of how definitional criteria can vary greatly in determining prevalence rates of premenstrual distress is a study by Hurt et al. (1992). With a sample of 670 women they used 4 different sets of criteria to establish the incidence of LLPDD. Depending upon the criteria used, the number of women meeting the LLPDD criteria ranged from 14-45%. This is an alarmingly broad variation. One implication for women at the practical level is that depending upon which criteria is used by a practitioner for assessment, a woman could be labelled mentally ill by one, or not by another. One implication for research is that some women may be included in research that would otherwise be excluded by other trials. This makes comparison of results across research difficult. Criteria by which research is conducted are so diverse that it becomes impossible to gain consensus of findings across the research forum.

Further Considerations

There are some important considerations many writers believe should be taken into account when evaluating the nature of premenstrual syndrome (Choi, 1995; Choi & McKeown, 1997; Parlee, 1974; Ruble & Brooks-Gunn, 1979; Swann, 1997; Ussher, 1996; Walker, 1997). Traditional hypotheses generated through bio-medical speculation have failed to place the emergence of knowledge

and medical diagnostic criteria within a social context (Ussher, 1989, 1991). This is still evident in reading Dalton & Holton's (1994) 'Clinician's Treatment Guide'. They are highly critical of psychologists and psychiatrists who have attempted to examine social and cultural factors (Introduction, xiii-xix), viewing such inquiry as an attempt to discredit biomedical knowledge rather than supplement it.

It is obvious that social and cultural context play a significant role in the way women experience their menstruating bodies. To believe otherwise would be scientifically naïve, as indeed Bancroft (1993, 1995) now argues. Women do not live in biological isolation. Rather their biology provides an internal environment which is interactive with socially lived experiences. A brief description of some of the core theoretical concerns shall be presented to demonstrate the importance of social factors, particularly for the potential contribution they make to the overall consensus of lay and academic knowledge of premenstrual syndrome.

Central to the integrity of this thesis is the question of epistemology. Premenstrual syndrome is concerned directly with women, and is therefore a gendered issue (Swann, 1995; Swann & Ussher, 1995). Gender raises social and ideological questions and so it becomes necessary to place twentieth century knowledge of premenstrual distress within a broader social context, to gain a fuller understanding of the origins of medical knowledge. The theoretical standpoint of this thesis (outlined in chapter 3) rejects the claim that facts exist in the world independently of any human or social action, instead accepting that knowledge is, to some extent, socially produced and shaped. The case of premenstrual syndrome is no exception. There is evidence that knowledge governing women's cyclicity has been shaped over time within the context of

contemporary beliefs and dominant ideologies. Rather than knowledge being a static 'fact', the focus of understanding has changed over time. Walker (1997) points out how prior to the twentieth century, menstruation was the main focus of speculation and enquiry. However once technology enabled the medical profession to identify hormones, the focus of interest switched to fluctuations in hormone levels.

Swann & Ussher (1995) highlighted how premenstrual syndrome is gendered. Whilst this requires that ideological concerns governing women, society and patriarchy demand acknowledgement, it does not mean that writers with feminist perspectives fail to acknowledge cyclical distress, or that biology and social context can not be given equal standing theoretically and practically in terms of a research agenda (Bancroft, 1993, 1995). Unfortunately Dalton & Holton (1994) appear to dismiss attempts to highlight gender and epistemological power issues within the way research has been conducted, and knowledge constructed, on premenstrual syndrome as a bid to discredit biology. The position taken within this thesis is that the addition of such knowledge can only serve to clarify matters and further understanding of the concept, as the following discussion shall demonstrate.

Historical Perspectives

Many writers (Rodin, 1992; Swann & Ussher, 1996; Ussher, 1989, 1991; Walker 1997) point out that women's sanity has been consistently tied to their biological reproductivity and role within society. There are interesting parallels between premenstrual syndrome, particularly for affective complaints, and ancient diseases such as hysteria and neurasthenia. During the times of pre-modern

societies abnormal behaviour was explained through the predominant beliefs in animism (Rosenhan & Seligman, 1995). The soul was the key to the body, and the common explanation for psychological disorder was possession by evil spirits. However during the 15th century, tolerance for abnormal behaviour became strained and perceptions began to change. During the period between 1400-1600's Europe was caught up in the frenzied fear of witches. The *Malleus Maleficarum* (written in 1494) is a well quoted text in much feminist writing for the way it, as a legitimate religious document, was used to label many thousands of women. Overwhelmingly most witches were women, as all witchcraft comes from carnal lust "which is women insatiable" (Rosenhan & Seligman, 1995). What it does demonstrate in terms of biology is that women could be blamed for men's impotence, infertility and a whole host of disasters (Rosenhan & Seligman, 1995). After this period in history attitudes again changed towards illness and abnormality, to focus on physical causes such as hysteria to explain women's behaviour.

Rodin (1992) and Ussher (1989; 1991) trace the origins of hysteria as far back as to the time of Hippocrates. According to Hippocrates, women's problems could be attributed to hysteria, which was a disease of the wandering uterus. Also there was a mention of time as a factor, in that the uterus wandered around the body in response to the lunar phases. Hysteria could cause a whole host of disorders ranging from women being too expressive, rebellious, independent, sexually active, or not sexually active within a heterosexual relationship, fitting, headaches, paralysis, loss of voice, lameness, pain in any part of the body, to melancholia (Ussher, 1989, 1991). The Ancient Greeks believed hysteria occurred primarily in women who did not engage in sexual intercourse, and so the

prescribed treatment was marriage and intercourse to establish reproduction (Rodin, 1992).

Ussher (1989; 1991) traces Victorian attitudes and beliefs towards women's complaints as being bound up with the female anatomy, again focusing on the uterus. She argues that the female body has historically been constructed as dangerous and problematic, from menarche to menopause, which represents the majority of a woman's life. A popular belief during the Victorian era was that women were prone to illnesses of all kinds because of their reproductive capacity (Ussher, 1991). The Victorians believed that any activity which detracted from preparing a young woman for marriage and motherhood had the potential to damage her health. Education particularly was thought to be detrimental, and would inhibit the woman's capacity to bear children. Ussher (1989) refers to the work of several, at the time, leading medical physicians and psychiatrists, such as Direx (1869) and Blandford (1871). According to Ussher (1989, page 3-4), Direx said that all women's illness could invariably be explained by their womb. She also referred to Blandford's work (1871, Ussher, 1989, page 4) which proposed that all women's complaints could be understood through the connection between their brains and their uterus. Prevalence rates of hysteria had reached epidemic proportions during the late Victorian era and recommended treatments ranged from injections into the rectum, placing ice into the vagina, applying leeches to the labia, to clitoroidectomy (Ussher, 1989; 1991). This parallels Frank's (1931) suggestion of radiotherapy on the ovaries, to the use of radical surgery that is advocated in the late twentieth century. Ussher (1989) also highlights the use of 'neurasthenia' that was used in the 19th century in America to explain women's complaints. Symptoms included discontent, insomnia and masturbation.

Interestingly she notes that most of the women given this diagnosis were young, single and educated.

Origins of the knowledge governing women's complaints during this century, many writers argue (Richardson, 1995; Walker, 1995; 1997), have been traced to Frank's (1931) work which began the speculation about mood disturbances and hormones around one particular time in the menstrual phase. Both Richardson (1995) and Walker (1995) believe the implications of this work have lead to research being conducted on the basis of testable hypotheses. Women who have a premenstrual disorder will display certain characteristics during this time in the phase, and will be treated with hormonal preparations to alleviate symptoms. This has provided the basis for much of the research which has been conducted during the last sixty years (Walker, 1995). The feminist health movement believes medical knowledge presents as a powerful force to women, and influences women's perceptions of themselves (Branson, 1992).

Branson (1992) argues that the role of the Doctor infiltrates almost every aspect of a woman's life due to her reproductive capacity and role as the carer within the family unit. Not only does the medical profession represent and uphold a powerful ideology of the twentieth century, but also has legitimate access to women's ways of thinking about their sexual and reproductive health. This raises the question of the impact of dominant ideology on the way men and women are socialised to think and behave, and what aspects of behaviour are construed as normal. Furthermore is the issue of who establishes societal norms. In the case of the menstrual cycle, it has been the medical profession (Ussher, 1991).

Dalton's work (1961; 1968) has been highly influential in the medical profession for setting the research agenda on the menstrual cycle. Unfortunately

her work was all negatively focused, setting out to 'prove' hypothetical links between menstruation and crime, and poor examination results. Richardson (1989) subsequently found that menstruation had no effect at all on academic performance when measured by quantitative tests and examinations. In answer to Dalton & Holton's (1994) more recent suggestion that we have to accept that premenstrual syndrome 'exists' because lots of women say they have it, consideration shall be given to empirical work which demonstrates the impact of socialisation and other factors.

Socialisation and Prevailing Ideas

The way an individual is socialised involves a complex matrix of factors (Bee, 1994; Golombock & Fivush, 1994; Landman, 1996). Traditionally menstruation has been portrayed as a private, natural, dangerous and shameful aspect of a woman's existence, characterised through many taboos (Laws, 1991; Ussher, 1989, 1991). It appears that such beliefs have been perpetuated through the generations. A menstruating woman was perceived by many cultures as dirty and potentially dangerous to others (Laws, 1990, page 24), and even during the Victorian era women were commonly confined to their beds and segregated from the rest of society. Throughout the twentieth century menstrual taboos have been maintained (Laws, 1990), with classic phrases like 'she's on the rag' or 'jam rag', and 'the curse'. There is evidence that women are still brought up to believe that menstruation is a negative, dirty, private, uncomfortable experience which should be concealed from public view (Laws, 1990). Prior to 1979, advertisements for sanitary wear were banned from British television. Within the present climate advertisements are only allowed after a certain time during the evening, and are

governed by strict criteria of what is and is not acceptable. Such words as 'odour' are not permitted (Laws, 1990, page 47) which reflects attitudes towards menstrual issues.

Laws (1990) conducted extensive research on attitudes of girls, boys, men and women towards menstruation. She found that boys and men used derogatory words to describe women and menstruation, often using the subject to ridicule a woman by way of offensive jokes. Also men often stated that they did not want to be in contact with menstrual blood, one man remarking that when he had seen some menstrual blood flow on some bed sheets of a woman with whom he was about to have sex, he vomited (Laws, 1990, page 34). Girls expressed that they had been taught sex education on the basis of reproduction only, with no mention of sexual desire or pleasure. Menarche was a time indicating potential for pregnancy, so that many girls became fearful of their bodies rather than wanting to explore their sexuality, and were more strictly controlled by their parents as a result. Lee (1994) examines issues concerning the sexualisation of the female body by the process of menarche, arguing that the female body acts as a 'text of culture' for which menstruation signifies a girls entrance into womanhood. Within this cultural script, she further argues, the female body is devalued in favour of emphasising sexual ability for the functional role of reproductivity. Finally, from Laws (1990) work, many girls and women expressed attitudes of shame concerning menstruation, believing they had to hide sanitary wear so to conceal menstruation from the public view.

Clarke & Ruble (1978) propose that women internalise at a young age the prevailing cultural beliefs concerning negative attitudes towards menstruation and mood. They found that young adolescent boys and both pre and post-menarcheal

girls held very similar beliefs about what girls are supposed to experience during the menstrual phase, which were all negatively focused. Such consistency in responses was not based solely on experience, and so had to reflect some social and cultural views. It would therefore seem that strong attitudes governing menstruation have not only prevailed from last century, but continue to exert a powerful force over women's lives for the way girls and women perceive themselves, and the way they are accepted by men.

An important source of information to which girls and women are also widely exposed is the media, both in the form of television and the press, which can exert a strong influence over attitudes. There is a tendency to believe that information published in the popular press or magazines must be accurate. Women's magazines also tend to have an editorial focus devoted to health issues. Therefore such a mode for transmitting information is particularly powerful, and has the potential to reach a large percentage of the population. Rittenhouse (1991) and Walker (1997) have noted an upsurge of articles on premenstrual syndrome. Walker (1997) highlights the dramatic increase in interest generated in women's magazines was particularly evident during the 1980's. Martin (1989) also notes a parallel marked increase in research on premenstrual syndrome from the mid 1970's onward. Rittenhouse (1991) traces such an upsurge to the focus on the trials of two women who used premenstrual syndrome as a defence against manslaughter charges. This generated much public debate about the existence of premenstrual syndrome on the one hand, and the potential danger posed by some women in society, on the other hand, if it does exist.

Lee (1998) refers to the work of Chrisler & Levy (1990) who performed content analysis of articles in women's magazines. They found that all of the

information presented on menstruation was negative, and contained a lot of inaccuracies. A whole host of symptoms were represented, including cold sores and tinnitus, as well as the more commonly assumed complaints like depression and feelings of worthlessness. Therefore it is hardly surprising that prevalence rates are estimated to range from 10-90% (Bancroft, 1993; Rittenhouse, 1991; Swann & Ussher, 1995). Premenstrual syndrome became part of popular culture, and as Walker (1997) argues, still is.

Cultural Beliefs and Attributions

A popular tool used for assessing the presence and severity of women's premenstrual symptoms by many researchers is the Moos Menstrual Distress Questionnaire (Bancroft, 1993; Parlee, 1974; Walker, 1997), more often referred to as the MMDQ. Parlee (1974) questions the reliability and validity of the MMDQ, highlighting there is no data available on its reliability or external validity. The questions from which it is comprised refer to negative change, with no place to record any positive changes. Parlee (1974) therefore conducted a study to evaluate the methodological soundness of the MMDQ using a sample of men (N=34) and women (N=25) aged between 18-27 years. Both groups completed the MMDQ on the basis of rating symptoms they believed women to suffer from at the different phases in the menstrual cycle. Correlational results found that the men and women rated virtually identical patterns of symptom change. The men actually attributed greater symptom severity to women than women themselves did for three of the scales on the premenstrual phase, and on six of the scales on the menstrual phase. Parlee (1974) suggests the results indicate that the MMDQ is measuring stereotypic beliefs about the psychological concomitants of

menstruation rather than measuring symptoms of premenstrual syndrome.

Koeske & Koeske (1975) argue the role of perceptual and social conditioning factors are influential on menstrual cycle mood change. They conducted a study using a series of vignettes, to isolate the attribution pattern linking negative moods to the approach of menstruation in order to assess any influence on attributions about mood and personality. Results showed that participants displayed clear-cut attributional patterns linking negative moods, such as depression and irritability, to the premenstrum. Participants made more internal attributions and reported that moods were inappropriate to the situation, and emphasised aspects of the situation when moods were appropriate. Koeske & Koeske (1975) argue these findings demonstrate the importance of premenstrual emotionality to an attributional chain relating the female self-concept to premenstrual distress. With regards to the main theme of the thesis, such findings are important for the implications of affect regulation. If a woman incorporates the concept of premenstrual emotionality, such as negative liability, in to her self-concept, this could result in a predisposition to a low negative mood regulation expectancy. This in turn may lead to a failure to engage in any attempt to regulate or change the way one is feeling, due to the belief that one can do nothing about negative mood at this time in the menstrual cycle.

Considering social expectancy further, Ruble (1977) conducted research on the menstrual cycle by varying participant's perceptions of cycle phase to establish whether this could affect symptom reporting. Indeed symptom reporting was found to vary with women's perceptions of where they perceived themselves to be, independently of where they actually were in their cycle, in line with popular social perceptions governing menstrual cycle change. Ruble & Brooks-

Gunn (1979) conducted a review of menstrual cycle research. They highlighted three main assumptions which researchers tended to work from: 1) women's behaviour and emotionality being adversely influenced by menstrual cycle phase and seen as a fully documented fact, 2) such fluctuations are believed to be hormonally based, and 3) cyclical changes are believed to be severe and debilitating. They summarise the outcome of their review by stating heightened saliency of certain symptoms associated with cyclicity affect social cognitions concerning menstrual cycle change. Such a system of beliefs about symptom associations cannot be fully accounted for by physiological factors alone. The origins and maintenance of such beliefs are explained in terms of biases in the processing of information about cyclicity. Socialisation processes influence and inform cognitive processing which can result in priming, associations and recall of events. Ruble & Brooks-Gunn (1979) conclude that they do not mean to suggest that menstrual cycle symptoms do not exist, but rather that beliefs regarding the association are stronger and more generalised than the evidence warrants.

Effects on the Research Process

Social expectancies about menstrual cycle change have been the focus of criticism as a potential confounding factor on the research process (Walker, 1997). Typical methods used in much traditional research have relied upon retrospective questionnaires. A key problem with retrospective measures is the reliance upon memory to recall symptoms, which may be directed by social cognitions, can act as triggers to schemas and stereotypes. Ussher (1989) argues that the idea of women being moody is part of the prevailing stereotype about women. Walker (1997) says that if women are asked if they are moody, they are

likely to say yes. Therefore the retrospective reporting of premenstrual moodiness is highly likely to occur due to social expectancy regardless of actual experience.

Large discrepancies in retrospective and prospective reporting of menstrual cycle symptoms have been found. McFarlane et al. (1988) studied mood fluctuations in women and men both prospectively and retrospectively. They found that recollections of menstrual cycle mood changes differed from actual changes. Women reported more pleasant moods in the follicular phase and more unpleasant moods in the premenstrual and menstrual phases than were reported concurrently. Women's moods were also found to fluctuate less over the menstrual cycle than over days of the week.

AuBuchon & Calhoun (1985) point out the lack of correspondence between retrospective reports of menstrual cycle variation and actual reports during the cycle. They conducted a study involving three separate participant groups; a group of women who were informed the study was about menstrual cycle change, a group of women to which no symptoms in menstrual cycle change were communicated, and nine men as a control group. All participants were screened using the general health questionnaire, and reported their menstrual cycles to be regular with no dysmenorrhoea. Results indicated that the group who were informed menstrual cycle change was the focus of the study reported significantly more psychologic and somatic symptoms at the premenstrual and menstrual phase, compared with the other two groups. Ainscouch (1990) also conducted a study which involved diverting participant's attention away from the focus of the study. The true purpose of the study was not revealed, and instead participants were informed they were taking part in a comparison study of symptoms in an ordinary psychiatric population. Participants had to rate somatic

and affective experience using a modified version of the MMDQ for an eight-week period. The data revealed no pattern of increase in symptoms of negative affect during the premenstrual or menstrual phases, yet the majority of the women retrospectively reported having experienced premenstrual tension during the study. Hence when such pencil and paper, retrospective measures are used, the influence of social expectancy can not be controlled for.

Current Position on Menstrual Cycle Research

Evidence for premenstrual syndrome has so far eluded scientific enquiry, yet this does not mean that for some women, menstrual cycle changes do not pose problems for some of the time. This does, however, indicate that menstrual cycle change has been inappropriately defined and conceptualised to fit positivist, medical research criteria (Bancroft, 1993, 1995; Swann & Ussher, 1995; Ussher, 1996; Walker, 1997). Walker (1997) argues for a paradigm shift, questioning whether premenstrual syndrome can continue to be conceptualised as a disease. She argues that there has been a more recent shift from pure endocrinological theories, to interactive or biopsychosocial explanations. She points out this new way of theorising by some medics and psychiatrists would suggest premenstrual changes are the result of an interaction between the various different systems, rather than a dysfunction in any one particular system. Also Walker (1997) questions whether complex theories are required in every case to explain mild premenstrual changes such as a headache or breast tenderness.

Bancroft (1993) also argues there needs to be a paradigm shift in the way menstrual cycle change is both defined and researched. He argues the menstrual cycle varies so considerably from woman to woman that individual differences

need to be taken into account, rather than treating women as one homogeneous group with a common set of problems. Indeed Walker (1997) argues there are so many differences reported in menstrual cycle patterns, symptoms and research which has led to confusion, because women *are* so different. Longstanding attempts to define and research a 'pure' premenstrual syndrome have excluded many women from research, which has meant limiting knowledge. Ussher (1992) proposes a multifactorial approach with a focus on identifying sources of stress that may alter women's experience of the menstrual cycle. Bancroft (1993, 1995) advocates a three-factor model as a way forward. Firstly a *timing factor* should be considered, which would take in to consideration timing imposed by the ovarian hormonal cycle, and to possibly include cyclical changes in central nervous system neurotransmitter activity. Secondly, a *menstruation factor* should be given consideration for the impact the processes involved in the build up, as well as shedding of the endometrial lining, have on a women's wellbeing. Thirdly a *vulnerability factor* should be accounted for which would cover a variety of characteristics, such as constitutional, situational, psychological as well as biological, that are not in themselves functions of the menstrual cycle but which will determine how vulnerable a woman is to the first two factors. Bancroft's (1993) three factor model is particularly helpful because it incorporates physiological changes, in terms of hormone fluctuation and neurotransmitter activity, as well as an individual woman's 'at the time' overall wellbeing. Also the vulnerability factor allows for consideration to be given of the individual woman's social circumstances, such as if she is experiencing major life events or situations that are demanding of personal coping resources. This model does not attempt to separate biology or social factors, but rather provides a framework for

examining the transactional nature of the two.

Parry (1994) argues that premenstrual syndrome can not be explained by biological factors alone, as up to 75% of women presenting with premenstrual syndrome have been found to have other problems when full assessment is completed. Blake (1995) emphasises psychosocial factors have been found to be important in women who are presenting themselves for treatment of premenstrual syndrome. She says that often menstrual cycle changes can act as the 'straw that breaks the camel's back', with other factors being present at the time of referral such as financial difficulties, sleepiness, illness, or bereavement. Blake (1995) says these issues can act as triggers to respond negatively to menstrual cycle change, and advocates cognitive therapy to help women identify issues that might be causing them distress around their cycle.

Swann & Ussher (1995) propose that because premenstrual syndrome is a gendered issue, there needs to be a widening of the research agenda to enable examination of the relationship between female subjectivity and identity to premenstrual syndrome. Ussher (1996) promotes the use of qualitative methods as a way of tackling the current crisis in premenstrual syndrome research. Results from a discourse analytic study found that premenstrual syndrome could not simply be attributed to faulty hormones, but results from a complex interplay of biological, psychological and social factors which had to be continuously negotiated by individual women (Swann & Ussher, 1995). Ussher (1996) argues that because premenstrual syndrome has been conceptualised diversely in the media and by the medical profession, it holds different and exaggerated meanings for different women. Meanings of premenstrual syndrome are not fixed, representing many different aspects of a woman's life. This lends support to the

argument that a paradigm shift is required.

Summary

Walker's (1997) summary of the progression of the theoretical debate surrounding the subject is most useful. She concludes that many psychologists have been sceptical of using a disease-based model to describe and explain women's experiences of a normal biological cycle. Premenstrual experience is seen by psychologists as 'real' and rooted in biochemistry, but is potentially manageable through psychological interventions. She argues the work of psychologists such as Parlee have helped bring about the realisation of the effects of stereotypes on perception of cyclical changes and symptom reporting. Psychologists have made attempts to explain the variability within premenstrual experience and have used a variety of methodological approaches to do so. Walker (1997) further summarises the main psychological theoretical approaches as ranging from trait studies of personality, Karen Horney's psychodynamic ideas, social theory to biological rhythms (the classic example being the circadian 24-hour rhythm). She also summarises the contribution of social constructionist ideas, the main thrust being to question the label of premenstrual syndrome for the different ways it can be constructed and used to dismiss any form of unfeminine behaviour as abnormal. The label of premenstrual syndrome can potentially disempower all women regardless of their actual premenstrual experiences.

Bancroft (1993, 1995), working within the medical profession, argues for consideration of social factors and individual women's experiences. In terms of mood variability, he states that mood fluctuation is a very normal part of existence for both men and women, and so attempting to find a woman with consistently

neutral or positive affect and mood premenstrually, or otherwise, is unrealistic. This prompts us to question the nature of what has been conceptualised as abnormal.

Asso (1988) believes the menstrual cycle is for the most part, a normal healthy, natural, highly synchronised rhythmic cycle with many positive changes that have not been permitted to be acknowledged, because it has been defined in terms of a disease based framework. Women should be permitted to evaluate their bodily changes as part of their normal, healthy existence. Instead young girls are socialised to perceive their menstruating bodies as problematic, prone to disorder and abnormality. Nichols (1995) points out that questionnaires used for menstrual cycle research are all negatively focused, with no space to record any positive changes. She conducted a study using a questionnaire consisting of 39 possible premenstrual changes, of which 19 were positive. She found that up to 50% of the women who took part rated some positive changes from personal experience. However the women actually perceived their experience of positive changes as 'a bit odd', which supports the argument that women have been socialised to believe the premenstrual phase of the cycle is a totally negative experience.

On reflection it would seem the way forward in informing an understanding of the menstrual cycle is to acknowledge there is a broad variation in women's hormonal levels, biochemistry, duration and pattern of cycle and overall wellbeing. There are no classic patterns of experience of symptoms or changes in moods. Rather individual experience of change is determined in part by the vulnerability of each individual woman, through her own set of social and physiological circumstances. The menstrual cycle should be conceptualised as a backdrop to women's lives (Asso, 1988), as part of the ongoing nature of lived

experience. Asso (1988) advocates that any woman being investigated for premenstrual distress should be supported with counselling to determine whether any menstrual disorder is a central problem or possibly an exacerbating factor.

It is argued that a material discursive approach to researching menstrual cycle issues would provide a way forward both epistemologically and methodologically, and serve to address some of the problems highlighted from previous research (Ussher, 1996). A theoretical framework such as this would allow an examination of the way meanings surrounding the premenstrual phase of the cycle have been constructed and maintained, yet also accept the material reality of biological changes within a woman's bodily existence. It would also enable women's accounts of their experience of menstrual cycle change to be legitimately considered. In conclusion a paradigm shift is required if we are to go beyond the current impasse in menstrual cycle research (Ussher, 1996). This leads on to consider the theoretical framework of the thesis, which has taken account of such recommendations. Ways in which this has been achieved shall now be outlined in chapter three.

Chapter 3

Paradigm and Methods

“How can one who espouses social (linguistic) constructionism avoid slipping in to relativism? How can a realist avoid slipping in to essentialism? Surely the answer is ‘By making enough distinctions’!”.

Rom Harré (1998)

The aim of this chapter is to outline the theoretical position adopted for the thesis in both paradigmatic and methodological terms. It is necessary to do so because a combination of research methods have been utilised for conducting the research, crossing the divide of quantitative and qualitative methods. This is because the research process for the thesis has been developed in the light of recommendations for future research into premenstrual syndrome. Also, from an emotion theory perspective, the starting point adopted when planning how to carry out the research had to incorporate the concept of *process*. Therefore paradigm differences shall be briefly examined for the impact they have at the methodological level, followed by the theoretical position adopted; a material discursive or critical realist approach. A rationale and description of the methods used in the thesis will then be outlined.

Both emotion and the premenstrual syndrome are complex and multifaceted, as the previous two chapters have illustrated. Because the symptoms for which women most frequently seek medical intervention are affective in nature, there would seem to be potential for a close, interactive relationship between women’s menstrual

cyclicity and the way they experience emotion. As phenomena premenstrual syndrome and emotion pose issues at both the lay and academic level. At the level of women's everyday lived experience, emotionality and cyclicity are closely interwoven and can be experienced as problematic and dysfunctional. At the academic level, issues relating to emotion and menstrual cycle are difficult to research due to the many potential confounding variables. Also other issues such as socially constructed knowledge and stereotypes may influence perceptions and reporting of symptoms, as well as the problems associated with static methods of conducting research which are often of little ecological validity. Also in the absence of an agreed or consistent form of premenstrual syndrome, it has become necessary to attempt to get closer to an understanding of women's experience of their cyclicity; what premenstrual syndrome means to them within an individual difference context. Consequently it was necessary to conduct the research process for this thesis by utilising a variety of methods in an attempt to address some of these problems.

Method Versus Paradigm

The question of which method(s) to select, according to Tashakkori & Teddlie (1998) should be dictated by the nature of the research question one is seeking to answer. This was certainly the case for this thesis. However the question of method almost immediately raised a question of paradigm. This was because the methods utilised range from the application of a multiple regression model adapted for use with time sequential data (see West & Hepworth, 1991), associated with postpositivism, to a discourse analytic interpretative technique (Parker, 1999; Potter

& Wetherell, 1987), often located within a constructivist or critical paradigm. As stated, such a range in use of methods across paradigms was the result of consideration of the research questions posed by the thesis, combined with attempts to account for and address recommendations from previous and current research in the area of emotion (Larsen, 1989) and premenstrual syndrome (Choi, 1999).

Guba & Lincoln (1998) highlight how method and paradigm are two separate issues. They argue the question of method may not necessarily mean one has to contemplate changing one's affiliation to a different paradigm. However they also point out that due to the nature of the differences between paradigms being so fundamental, they have important implications at the practical, everyday, empirical level (Guba & Lincoln, 1998). It is necessary to justify and explain why such a change, and mix, in method(s) was essential, which requires setting out the epistemological position adopted for the thesis. Also in terms of impact at the empirical level it is of fundamental importance to the integrity of the thesis to demonstrate the theoretical framework, and paradigm, upon which the research process is based. Indeed Guba & Lincoln (1998) maintain that because the issues raised by paradigm differences are so crucial, no inquirer should go about the business of inquiry without a clear understanding of what paradigm guides their research inquiry. Finally it has to be acknowledged that although Tashakkori & Teddlie (1998) advocate a pragmatist approach, there are also those theoreticians who believe the question of paradigm is of ultimate importance. Which paradigm one is affiliated to will therefore dictate the way in which research is undertaken (see Hammersley 1996 for a review).

The previous chapters drew attention to some of the conceptual difficulties surrounding the conduct of research into premenstrual syndrome. Of particular bearing is the epistemological basis upon which much of the previous research has been conducted. Bancroft (1995) is highly critical of the way that scientific experimental rigor within the positivist paradigm has only served to increase the confusion surrounding premenstrual syndrome, particularly because of its insistence on the use of conventional mathematical formula on which women's cyclicity has had to be closeted and analysed. Thus an examination of method became essential. Also if one is to take current debate and perspective into consideration, there are questions being posed within psychology which relate to ontology, epistemology, and method (Burt & Oaksford, 1999).

A current debate relates to the epistemological basis of psychology as a scientific discipline (Harré & Stearns, 1995; Newman & Benz, 1998; Smith, Harré, & Van Langenhove, 1995, Tashakkori & Teddlie, 1998). The traditional epistemology of psychology has been grounded in the positivist paradigm, which looks for causality and establishing laws that are generalisable to whole populations. This has certainly been the form of much research conducted on premenstrual syndrome from psychological, as well as biomedical perspectives. However it has now been recognised for some time that both the positivist paradigm and the corresponding set of methods is not always adequate for answering certain questions posed by psychologists (Smith, Harré, & Van Langenhove, 1995). Increasingly psychologists are acknowledging that human nature and the way people behave are more diverse and difficult to predict than originally thought. The menstrual cycle and individual

differences within the way women experience their cyclicity, Bancroft (1995) argues, are difficult to conceptualise and research from a purist-realist position. Rather there needs to be some integrated approach to researching premenstrual syndrome which acknowledges the vulnerability of women not only in terms of hormonal and endocrinological changes, but also including socio-cultural context and personal situational factors as vulnerability factors. Bancroft's (1993, 1995) three factor model (outlined in chapter two) would facilitate this.

The case for a combined methodological approach is strengthened by the difficulty of defining emotion, the question of the validity of researching emotion as a static variable (Larsen, 1989), and the current impasse in menstrual cycle research (Bancroft, 1995; Ussher, 1996; Walker, 1997). Tashakkori & Teddlie (1998) argue for a pragmatist approach for conducting research, stressing that some of the conceptual and practical issues raised across paradigms are more similar than originally thought. Newman & Benz (1998) advocate a continuum approach for conceptualising and conducting research, rather than positioning the research process and question within one paradigm. They point out how the use of several different types of methods across paradigms only serves to strengthen the quality of research beyond triangulation, and placing a greater emphasis on 'validity'. Modern day science is both inductive and deductive, and the overall common purpose is for the advancement of knowledge, discovery, meaning and greater understanding. Again, as with Tashakkorie & Teddlie (1998), this implies a pragmatist approach.

In order to demonstrate the theoretical position taken within the thesis, firstly

positivism and postpositivism shall be critiqued. Constructivism and relativism shall then be considered, particularly for their usefulness in evaluating the nature of lived experience of phenomenon, and the construction of meaning, yet also highlighting the problems that relativism presents. This will lead to the integration, or interweaving of some of the ideas from both relativism and realism to demonstrate a critical realist, or material discursive perspective (Walker, 1997; Yardley, 1997); the theoretical position upon which the thesis is based. However it needs to be stated that by the term 'critical realism' the position of the thesis does not completely fit with Guba & Lincoln's (1998) conceptualisation of critical realism, which they say holds an objectivist epistemology. Rather Guba (1990) says of 'critical theory' that there is a logical disjunction created out of coupling a realist ontology with a subjectivist epistemology. The theoretical position taken within this thesis does acknowledge that nature is seen and portrayed by the research process through a value window, and that there are multiple ways of constructing social reality. This is particularly important in view of the complex notion of premenstrual syndrome for the way socio-cultural factors have contributed to current understanding of the menstrual cycle. Thus a subjective epistemology is positioned as valid within this thesis; taking women's experience into account.

It is accepted within the qualitative forum that at times it is difficult to find one's theoretical position within the core debate of what reality is, and whether or not it is measurable; reality is a social construct, or rather there is a common objective reality across individuals. Parker (1998; 1999) states that theoretical

position(s) can also be fluid, and that sometimes one can not say exactly that there is only one theoretical position accepted, or used by a researcher. He argues that at one given point in time a feminist perspective is the most appropriate, whereas at another time it may be that a Foucaultian, political framework is necessary. Thus within the process of the research for this thesis the paradigmatic position taken is located between critical realism and critical theory, if one has to go by such definitions as those proposed by Guba & Lincoln (1998).

Paradigms

Guba (1990) talks of the use of the term of paradigm, arguing for an unfixed statement of its meaning, in order that we can reshape it as our understanding of its many implications improves. Thomas Kuhn (1977, page 294) notes how it has been used in 21 different ways. Guba & Lincoln (1998) offer this definition,

“a set of basic beliefs (or metaphysics) that deals with ultimates or first principles. It represents a worldview that defines, for its holder, the nature of the “world,” the individual’s place in it, and the range of possible relationships to that world and its parts.” (Guba & Lincoln, 1998, page 200)

This is a particularly useful definition because it can be applied to both lay and scientific inquiry. The scientist pursues a line of inquiry that is conducted within a framework of beliefs which determine the research question, the manner in which the investigation is to be pursued, and the methods or tools for such purposes. Yet paradigm is also important in terms of the everyday life world. Landman (1996) refers to a “worldview” as being the culturally shared beliefs which influence the

way society functions, and that although difficult to identify in a material sense, it exerts a powerful influence over an individual's life. The paradigm under which psychology as a scientific discipline has pursued inquiry is positivism, having important implications for lay conceptions in the way the body of knowledge has been created which governs premenstrual syndrome and emotion. Such implications will be discussed by assessing the ontological, epistemological, and methodological assumptions.

Positivism/Postpositivism

Positivism is often referred to as the "received view", because it has dominated the social and physical sciences for some 400 years (Guba & Lincoln, 1998). In terms of ontological belief, positivism is grounded in realism, which asserts there is a single reality to the nature of existence. The epistemological implication is that an objective, separate reality can be identified and understood. Truths and facts can be established because the inquirer/researcher is separate from the object under scrutiny (Tashakkori & Teddlie, 1998). At the practical level, the inquirer/researcher will adopt methods of an experimental manipulative nature, so the object of inquiry can be isolated from both the researcher and possible confounding variables, in order that a causal relationship can be established. Through the testing of hypotheses, laws and facts are established that are generalised to whole populations.

A problem that has been recognised and acknowledged within the past few decades is that scientific inquiry can not be completely objective (Guba & Lincoln,

1998). Latour & Woolgar (1979) studied scientific culture, and demonstrated the way that scientific knowledge, even when strictly controlled in a laboratory, is still subject to a large component of socially constructed influence and meaning. The scientific world does not exist outside of the social world. The researcher is a social being, operating within a socially charged context. This leads to postpositivism, which retains a realist ontology, but accepts that reality can only be imperfectly and probabilistically apprehensible. The corresponding epistemology is one of a modified dualist/objectivist position (Guba & Lincoln, 1998). Consequently postpositivism is just that, a modified version of positivism.

Critical Theory/Constructivism

Critical theory is a term which incorporates several alternatives of paradigm, such as participatory inquiry, neo-Marxism, and standpoint theory (Alcoff & Potter, 1993). Such alternatives are placed under this heading because of their shared rejection of positivism's claims to value-free scientific inquiry (Guba, 1990). Critical theorists highlight how inquiry is value laden and therefore political in nature, and can often be disempowering for participants. For many critical psychologists part of the purpose of the research process is to empower, or give voice to those groups who have been marginalized in some way, so that 'their' reality of a phenomenon can be presented and acknowledged (Fox & Prilleltensky, 1997). For example, Swann & Ussher (1995) highlight how traditional research into premenstrual syndrome often failed to present women's experiences and understanding of the menstrual cycle, instead emphasising

biological process which can disadvantage women depending upon the manner in which findings are presented. Therefore critical theory draws upon a realist ontology, but with a subjectivist epistemology.

Now to consider constructivism or constructionism. According to Guba (1990) constructivism can be seen as an alternative to the conventional paradigm; positivism. The breakaway assumption lies in the move from ontological realism to ontological relativism (Guba & Lincoln, 1998). This is because relativist ontology proposes that the nature of reality is not fixed, but rather is continuously shifting and being reconstructed through time. Therefore there are no fixed truths or facts, and no one objective reality. Instead there are multiple ways of constructing meanings and interpreting an event or situation, and that all interpretations and accounts are unique. Burr (1995) says of relativism, that there exist no truths, but only numerous constructions of the world. According to her which construction is labelled as a 'truth', is dependent upon cultural and social factors (this is a particularly salient comment when considering traditional menstrual cycle research). Thus the ontological basis of this paradigm is in stark contrast to that of positivism. The nature of reality is seen as a constantly shifting multiple mental construction, rather than there being one fixed objective state. The epistemology of constructivism is subjectivist, and the methodology is hermeneutic. Individual constructions are dialectically elicited and interpreted to achieve substantial consensus (Guba, 1990).

Constructivism allows for the interpretation of meaning. It also permits the identification of the processes at work in the constructions of meaning. By

processes this can mean a number of different factors or entities. For example Parker & Burman (1993) draw upon Foucault's ideas to account for the way certain ideologies can be at work in a political sense, which can be detected through analysing the discourses of people's accounts of an event or phenomenon. Ideology refers to 'the 'totality' of forms of social consciousness' (Gardiner, 1992, page 70). Gardiner (1992) says that ideology operates as a material segment of reality. Therefore 'it' must have a profound effect upon lived experience, and the nature of realitie(s) for the individual, whether reality be fixed or fluid.

Constructivism enables the researcher to be able to identify which ideologies are influential in an individual's experience, and which ideological concerns occupy the more favoured, or powerful positions within discourse, which reflects lived experience. A conventional psychological research process, based upon a postpositivist framework, would not be able to uncover and gain an understanding of the way certain ideologies are at work in people's lives. This is because a causal reasoning process for conducting research only attempts to measure what can be seen, or to measure certain attitudes through a rigidly structured questionnaire that does not allow for a deeper level exploration of underlying meanings. Yet ideology has a material consequence in people's lives (Burr, 1995), and so therefore it is important for psychologists to be able to uncover and understand ideological concerns in order to gain a deeper understanding of the nature of human existence. For example, masculine and feminine ideologies in Western culture have had a profound impact upon the way women are socialised to experience and interpret the menstrual cycle. In order to gain a deeper

understanding of premenstrual distress, it is vital that ideology is incorporated into the broader picture in psychological terms.

Theoretical Position of the Thesis

Although a constructivist paradigm offers the researcher much, there are drawbacks associated with a relativist ontology in a theoretical sense. Relativism holds that there is no absolute reality and that all experience is a one-time construction. However many psychologists struggle with such an argument, which bears witness to the ongoing, unfolding debate within psychology (Collier, 1998; Harré, 1999). This brings me to consider the theoretical position taken within the thesis. Although it is important to be able to consider the way the reality of an experience is constructed, it is also equally important to be able to acknowledge the material consequences evident in individual experience. Indeed Burr (1995) also stresses how ideologies have a material nature. Also in terms of premenstrual syndrome, the importance of acknowledging physiological processes alongside ideology is crucial. For women the experience of physiological change is what locates the embodied self in a concrete reality. Yet it is the ‘experience’ element which is subjective and open to individual interpretation. The common element of being a woman is the menstrual cycle. However the experience of this commonality is diverse and fluid. Thus a critical realist perspective is taken, but which leans heavily on constructionism for reasons already outlined.

Harré (1998a) argues that if anything is a hard ‘fact’ about human beings it is their embodiment. In addition, lived experience is not static, but fluid and

consisting of multiple, fixed and changing meanings and social ideological structures. In terms of the material consequence to the nature of existence, there are two constituents that have been raised within this chapter; embodiment and ideology. Concerning embodiment, the physiological status of what it means to be a woman is very important when considering premenstrual syndrome. Of ideology Landman (1996) says, that although as such it cannot be identified in a material sense, ideology has a profound material impact upon the way people act and behave. Thus a critical realist paradigm would seem most appropriate.

Collier (1998) argues of critical realism that it provides a practical theoretical framework in which to conduct research (also see Ussher, 1997). For this thesis a critical realist perspective is used to frame the overall research process on a general level, so that language could be used as data alongside more conventional numerical data that required statistical analyses. However it needs to be stated that in terms of ontological realism and ontological relativism, the different forms of data gathered do not neatly share these two elements.

Methods

A combined methodological approach has been utilised for the research process within this thesis (Tashakkori & Teddlie, 1998). Both qualitative and quantitative techniques/methods were used to collect a variety of data, and several different types of analyses were applied where appropriate. The key aspect of the research question concerned the regulation of feelings. It was therefore firstly felt necessary to attempt to gain a deeper understanding of why people believe they

should regulate or modify their feelings, and the kinds of issues that are most salient for the individual in an emotional sense. To achieve this research aim it was decided that a hermeneutic, qualitative approach would be the most suitable, which shall now be outlined.

Dialogic, Hermeneutic Research Process

One way of attempting to gain a deeper understanding of an individual's experiences and ideas of emotion is to ask them. Therefore an interview process was decided upon. However the interview process was different to a traditional highly structured situation where a participant would be asked a series of questions in a straightforward manner. Rather the interview was adopted as a tool for learning about people's thoughts and feelings concerning the emotional self. Rubin & Rubin (1995) say of the qualitative interview that it serves to enable the researcher to procure a rich understanding of other people's lives and experiences. It enables people to describe how they understand their world. It also enables the researcher to be able to understand, or get closer to, events in which they did not participate. Attached to the qualitative interview is a whole philosophy, incorporating a set of necessary skills as well as a way of perceiving and valuing subjectivity. One should endeavour to empower and encourage the individual to be able to describe their worlds in their own terms (Rubin & Rubin, 1995). To achieve this the researcher also needs to acknowledge the potential of the power imbalance between the researcher and the researched (Bhavnani, 1990), to ensure the process is carefully managed, ethically as well as academically.

King (1996) advocates a counselling style approach within the qualitative interview. It was felt that by adopting her ideas one would be able to empower participants, encouraging them to take the lead role within the process. Such skills as empathy and active listening (Sanders, 1994) were particularly important, enabling myself as interviewer to check with the participants that I had understood their accounts and their realities as closely and accurately as possible. Also it was necessary to protect participants' positions within the process due to them talking about strong emotional issues. Coyle & Wright (1996) argue that employing a counselling interview to research sensitive topics is a very useful, practical way of protecting the participant, against balancing out the collection of data for research purposes.

As stated 'giving a voice' to the participant was a key factor in this part of the research process. This is because I wanted to gain as much understanding of what 'being emotional' meant to the individual, and the issues that arose for them rather than my own research agenda. I endeavoured to restrict the interview process as little as possible so that the agenda was mainly set and managed by the participants themselves. However it has to be acknowledged that it was I who set the focus by defining the topic to be discussed, namely emotion, which was necessary for the research aims. In order to manage the academic/research aspect of the interview it was necessary to devise a small interview schedule. This was comprised of eight questions (see appendix 1, page). The schedule was used in a semi-structured fashion (Breakwell et al., 1996; Rubin & Rubin, 1995). Each participant covered all of the questions, although not necessarily in the same

sequence. The schedule was used as a framework only to ensure the process remained within the appropriate forum.

The interviews were tape recorded and subsequently transcribed in full. This enabled the dialogic accounts to be read and re-read many times in order that an interpretative, discourse analytic technique could be employed (Parker, 1999). Many writers would argue there is no 'right' way of conducting discourse analysis (Parker & Burman, 1993; Parker, 1999), and err away from labelling it as a 'method' due to the philosophical implications which are tied to discourse analysis. The analysis of discourse involves interpretation, and is often underpinned by a philosophical set of assumptions concerning the nature of reality. I will however say that I have used a discourse analytic interpretative approach (Parker, 1999), based upon the ideas of Parker. This involved identifying the different types of discourses that were used to construct accounts.

Language as Data

Potter & Wetherall (1987) argue that language constructs social reality, which is indicative of a relativistic orientation. Contained within dialogue are the meanings we construct of events and situations, which construct our socially lived experiences of them. Shotter & Billig (1998) also argue that words are a living social process, which reflect peoples' social practices. Bakhtin claims "each word tastes of the context in which it has lived its socially charged life", (Bakhtin, 1981, page 293). Therefore to gain a deeper understanding of a given phenomenon, one can turn to language as a data source to examine and interpret the dialogic

accounts of individuals; in this case talk concerning what it means to be emotional.

In terms of the way language can be used for research purposes, Parker & Burman (1993) draw attention to the way particular types of discourses hold more favoured positions within dialogue over others. Parker (1992) defines a discourse as “a system of statements which constructs an object” (page 5). He talks of the political nature of language, of how people use language discursively to construct a particular account of the self and their worlds, and how language itself can hold power over the user due to all language having many shifting and pre-given meanings. Therefore it is possible to distinguish particular types of discourses being utilised by an individual, and identify the positions certain discourses occupy within an account to establish the conflicting and contradictory nature of existence. Potter & Wetherell (1987) concentrate more on how language performs various functions and *constructs* reality. Parker (1999) on the other hand talks of power relations between language and the user. Not only do we actively use language to construct an account, but we are also used by language itself. Parker argues that words and phrases have meanings that are organized into systems and institutions that position us in relations of power. By looking at the construction of an account one can, therefore, identify intimate connections between meaning, power and knowledge (Parker, 1999).

In terms of issues of power and knowledge, the use of language within research enables one to identify dominant and private ideologies which govern peoples' lives. Some ideologies occupy a more favoured position within society, which is reflected in talk. By identifying the connections between certain

meanings and the degree of power afforded by the position occupied within an account, it becomes possible to identify and explore the impact of ideology.

Ideology is a difficult concept to define, and has been used in many different ways (Billig, Condor, Edwards, Gane, Middleton & Radley, 1988). Burr (1995) talks of the different ways in which ideology can be conceptualised. The way the concept of ideology has been used for this thesis draws upon Burr's (1995) notion of ideology as lived experience. She refers to Althusser's (page 83) view. Ideology is 'lived experience' and so is present in the way we think, what we think about, our behaviour and the way we conduct our social relationships. van Dijk's (1998) assertions governing ideology are also useful, in that he proposed a discourse-cognition-society triangle in order to demonstrate how each component is affected by and manifested within the other. He argues that ideologies characterise the mental dimension of society, and so have a definite impact on social cognition, which are represented and reproduced through language. Consequently one of the aims of the thesis was to identify ideologies which have an impact upon the way an individual experiences emotion.

A discourse analytic interpretative approach was adopted for analyses of data, drawing particularly on Parker's (1999) work for the ability to be able to identify the positions various discourses occupied within language. The utilisation of language as data relates to chapters 4, 5 and 6. Chapter 8 also utilises language. The accounts upon which chapter 8 are based are written narratives of women's experiences of premenstrual syndrome. Now consideration shall be given to the other main methods utilised to collect data.

Process Approach to Emotion and Emotion Regulation

The regulation of mood and the menstrual cycle are the two core aspects of this thesis. Chapter one outlined some of the theoretical perspectives governing emotion, drawing attention to the difference between emotion being conceptualised as static versus fluid. For the purpose of this thesis a process approach to affect has been adopted which acknowledges the fluid nature of emotion (Larsen, 1989). Such an approach refers to the study of 'behaviour and experience in the ongoing stream of time' (Larsen, 1989, page 178). Thus it involves comparing individuals with themselves at different points in time, rather than comparing individuals with each other at the same point in time. Participants are studied over a designated time period in order to capture daily life events as they unfold. Such a way of researching emotion is also more amenable to a critical realist theoretical perspective. This is because a process approach does not measure participant responses at one point in time or in an artificial environment, nor attempt to manipulate various aspects of participant emotions. This represents a more critical way of attempting to research emotion, and has implications at the methodological and statistical level.

Time As A Psychological Variable.

Larsen (1989) draws attention to the way that participants are embedded within time, arguing that time is fundamentally important to life as it is lived. He is particularly concerned with personality processes, believing them to be stable but

non-static, consistent patterns of change. Larsen says of a fluid approach that it emphasises the unfolding of patterns in living. Tennen, Suls & Affleck (1991) argue that research needs to shift from examining a single individual difference on one isolated occasion to examining patterns of relationships as they unfold over time. People's dispositions, goals and commitments can influence daily emotional well-being and health, their inner experience and their reactions to events (Tennen et al., 1991), all of which cannot be accurately captured with use of a static measure. They argue for the consideration of time as a psychological variable for several reasons, particularly as the relationship between events and emotions is so complex. Tennen et al. (1995) support the call for multiple assessment time periods when studying affect, particularly depression, so that individuals can be studied on a daily basis.

Tennen, Suls & Affleck's (1991) argument that the complexity of the dependence between emotions, relationships and events can not be captured by a static one-time measure is particularly important when considering the nature of the menstrual cycle for its effect on women's lives. Totterdell (1996) argues that people are influenced by time, and the sensations that accompany their bodies through time. Both body time and experiential time are influenced by the temporal constraints of the social world. As outlined in chapter 2, the timing of the premenstrual phase is exceptionally meaningful for women, and may effect the way they interpret their emotional and physiological responsivity. When considering the cyclic nature of the menstrual cycle, one therefore has to take into account the distinctive role time plays as a psychological variable. Therefore part

of the task of this thesis was to track affect over time (one complete month) in a group of women, rather than sample affect at only one time point, to investigate the impact of the relationship of time on emotionality. The way this translated into method was with the use of an intensive time sampling procedure (Tennen et al., 1991; West & Hepworth, 1991).

Intensive Time Sampling Procedure

The method used in this thesis for investigating affect and affect regulation is referred to as an intensive time-sampling procedure (Tennen et al., 1991), and draws upon the work of Totterdell (1996). A key advantage of this method is that it allows for the measurement of many variables on many occasions from people, and so enables stronger inferences to be made about causal relationships. Also the investigation can take place in real time, which leaves the order of natural events undisturbed. This method may also be known or associated with a diary technique due to the daily reporting of events/variables. However, rather than using a pencil and paper technique which has a number of potential problems (see Totterdell, 1996 for a review), a computerised diary was used. This records the times at which participants report on their emotions, emotion regulation strategies, daily hassles and a number of other variables so eliminating the potential for participants to miss reporting times and complete multiple recordings at one time only. Specific detail of this method will be outlined in the method section of chapter 9.

Additional methods which have been used as part of the research process incorporated the use of conventional questionnaires in order to gather certain types

of information, or fulfil a particular aim. The study reported in chapter 7 was conducted for the specific purpose of manipulating participant awareness of the study's aim, and so used a static questionnaire. The combined methodological study (reported in chapter 8) was comprised of a set of measures in a static questionnaire format. Although this method was not ideal, the constraints of contacting and recruiting women nationally for the study had to be offset by the method selected, which meant sampling participants on one occasion only in this way.

Summary

The present chapter set out to examine some of the conceptual issues surrounding paradigm and method, specifically attempting to provide a way forward when using constructivist ideas alongside a realist ontology. Firstly assumptions governing the main paradigms were examined. Secondly the methods and corresponding analyses that were selected for use within the thesis were outlined, which range from a hermeneutic approach through to an intensive time sampling procedure. Although the methods used can be seen as belonging within different paradigms, it is believed a critical realist theoretical framework allows for their integrated use within this thesis. Furthermore by drawing upon a process approach and conceptualising emotion in terms of lived experience that unfolds over time, lends itself amicably to a critical realist perspective. The hermeneutic approach relates to chapters 4, 5, 6 and 8. The intensive time sampling procedure relates to chapters 9 and 10. Chapter 4 will begin the presentation of findings from

a qualitative interview study which utilised a hermeneutic, interpretative analytic approach towards analysing the data.

Chapter 4

Emotional Control and the Social Order

This chapter reports on the findings from a qualitative interview study which was conducted to establish a deeper understanding of emotional lived experience, particularly for the types of issues individuals thought to be important, or relevant, when considering their own emotions. The rationale for this study grew out of the belief that in order to reach a greater understanding of the complex relationship between emotion and emotional experience as part of premenstrual syndrome, it was necessary to firstly establish social perceptions of emotions for what is considered to be *normal* emotional experience. The study generated a substantial amount of data. Therefore the findings are set out across three separate chapters for clarity. This chapter concentrates on the findings that strict criteria still govern what kinds of emotions can legitimately be expressed in given social contexts. Emotional expression is still subject to tight control for much of the time. Chapter 5 will concentrate specifically on the impact of gender ideology on the emotional self. Finally chapter 6 will examine the ways in which rationality and reason can frame emotional experience.

Consideration shall firstly be given to how the social order impacts upon the individual at the micro level. Biological explanations have traditionally defined emotionality, framing the person as a passive recipient to biologically driven processes. However it is now widely accepted that in order to understand how emotions impact on the individual, a multitude of factors need to be considered. Being emotional is a combination of one's physiological existence as part of ongoing lived experience within society, embedded within cultural norms and beliefs. Also impacting upon emotional

existence is the position a person occupies within the order and structure of society. This determines which set of emotion rules the individual is governed by. In terms of lived experience, these rules mean that the individual has to actively manage both inner feelings and outer expressions to retain their place within the social order. There are times when either changing inner feelings and/or suppressing the outer expression of the way one feels, poses problems at the individual level. Relevant work which demonstrates how the individual is socially embedded within society, which influenced the planning of the present study shall briefly be reviewed.

As noted in chapter 1, defining emotion in biological terms has had a major impact upon the theoretical underpinnings for research. This has meant that emotion has often been defined as a static variable in terms of cause or effect (Parkinson et al., 1996). Also, the domination of one theoretical position has often meant rejecting, or failing to acknowledge factors that are equally important when considering the nature of emotion. Hochschild (1983) proposes an interactional approach to emotion research. She particularly highlighted that the interactional model accepts biology is always involved in emotional responses, but also takes social factors into account. Also social factors do not simply enter before and after the biological response, but interactively during the experience of emotion. Hochschild (1983) states that each feeling takes its shape, and in a sense, becomes itself only in a social context. The social world, then, gives meaning to a physiological existence.

Parkinson et al. (1996) advocate that emotion should be considered in the context of an unfolding relationship between people and their environment. Emotion needs to be considered not only in terms of physiological and cognitive processes, but also requires investigation at the social level.

Denzin (1984) states that emotion is a social, linguistic, interactional, and physiological process that draws upon the human body for its resources, from human consciousness, and from the world that surrounds the person. He says, “people are their emotions”, and that whatever form emotional experience takes, it locates the person within the world. Denzin’s explanation of emotion proposes that emotion, the person, and the social world cannot be defined as separate in the way traditional research has suggested. Denzin (1984) proposes that we should seek to understand the phenomenon from within itself. Kemper (1993) also argues that the individual *is* the locus of emotion, so emotion can only be measured *within* the individual. It does seem reasonable when conducting research into people’s feelings that an understanding at the subjective level needs to be sought.

The present study draws on Parrott’s (1995) work for theoretical justification. He argues that when viewing emotion as a psychological state, little is known of what it means for people to be emotional, and that “being emotional” is worthy of study within its own right. On examining everyday talk about emotion from two sources he found that lay conceptions differed from the academic. In contrast to being functional, the lay interpretation portrays emotions as dysfunctional, maladaptive, irrational, and in need of control. In fact the one theme conspicuous by its absence, Parrott (1995) argues, is that of the usefulness of being emotional. This distinction carries substantial implications for the way emotion impacts upon people’s lives at a social, everyday level, an issue of interest to the present study. Parrott (1995) does point out, though, that both conceptions can co-exist, their apparent contradiction not implying error.

Lutz (1996) emphasises how emotion, in Western culture, is defined as being natural rather than cultural, chaotic rather than orderly, irrational rather than rational,

physical rather than mental or intellectual, unintended and uncontrollable, and hence often dangerous. She declares such conceptions disadvantage emotion, which further underlines the need to actively regulate and control emotional expression, particularly as some of the defining qualities are attributes that are viewed negatively by Western society. Whether male or female, we try to distance ourselves from being perceived as irrational or out of control.

Control was one of the elements of meaning given to being emotional in Parrott's (1995) study. Participants justified the term "being emotional" by the fact that they did not feel in control of their emotions. Feeling out of control implies a striving for the need to feel in control. Lutz (1996) highlights the association between being emotional and being out of control, because in Western culture self-control is fundamental. The potential for conflict between cultural values and personal interest arises, as there may be times when suppressing the expression of a particular feeling is problematic to the individual for a number of reasons. Therefore conscious management of one's feelings is central when considering how emotion impacts upon people's lives, as it is important to appear controlled. Parkinson et al. (1996) noted, that for much of the time, people use a variety of different strategies to actively regulate the way they are feeling.

Hochschild (1983) uses the term "emotion work" when explaining how people manage their feelings. She argues that we all have to do a certain amount of emotion work because we have to abide by feeling rules, which are varying kinds of social scripts on how to behave in given social situations. Hochschild (1983) says that feeling rules are one of culture's most powerful tools for directing action. She is particularly noted for her appraisals of how feeling rules apply in the work environment. She found

that people at work have to ‘manage’ their feelings for the purpose of benefiting the institution, even when this goes against self-interest, and that feelings often become a commodity in the case of service industries.

The term ‘emotion work’ (Hochschild, 1983) is particularly important to the present chapter. It implies the individual has to actively make an effort to manage their feelings. Hochschild (1983) says, in order to conform emotionally to the social order, people engage in emotion work on two levels: a surface and a deep level. Surface acting refers to actions such as gesture, smiling, or eyebrow raising. One engages in surface acting to appear outwardly consistent with social norms governing a particular situation. However deep acting involves changing the actual feeling being experienced, drawing on a variety of personal resources. A person may engage in deep acting when their feelings are not consistent with a situation and they identify this as problematic to themselves. Hochschild (1983) argues that feeling rules guide emotion work, they highlight a gap between “what I do feel” and “what I should feel”. This is particularly relevant, as it indicates the need for great personal effort within the individual to overcome emotional dissonance. Also, by the nature of the way society functions through collective rules and belief systems, emotional dissonance is likely to be experienced several times a day, so is a highly salient factor as part of lived experience.

The concept of emotion rules insinuates a need for order. People are the locus of their emotions, and emotions are produced through social relations (Kemper, 1993). Consequently emotion serves as a medium through which people are required to be controlled at both the social and individual level. Furthermore, at the individual level specific rules apply. Landman (1996) argues that emotion rules differ significantly depending on one’s assigned place within the social order. Kemper (1993) also argues

that the social matrix determines which emotions are allowed to be expressed, by whom, where and when, on what grounds, and by what modes of expression.

Hochschild (1983) declares there are different groups in society, which are assigned different sets of emotion rules. Consequently our gender (Lutz, 1996), social class, career choice, place of work, situation, and other such factors, determine what types of emotion rules we are subject to and, therefore, what kinds of emotions we are allowed to express.

Being able to control feelings so that they are consistent with socially accepted emotion norms can be difficult. Hochschild (1983) emphasises the arduous nature of deep acting. However if one does not conform to social norms, then one runs a risk of rejection at the social level. From infancy the process of socialising the individual begins. Children learn guidelines for where and when to express particular emotions in a socially desirable manner, including display rules (e.g. Saarni, 1993). Saarni (1993) refers to such guidelines as display rules, which encompass much of the accepted stereotypes and social norms.

Landman (1996) refers to the social control of emotion, arguing that parents are the wielders of social control through the process of socialisation. She suggests that elaborate emotion norms are passed down the generations, and because Western society views emotion with distrust, part of the socialisation of children involves transmitting the command to regulate the inner experience and expression of emotion. Landman (1996) also refers to what she describes as a “worldview”, being the “fundamental values, beliefs, and sentiments about reality which are tacit and often taken for granted”. Her notion of a worldview refers to culturally shared beliefs that influence the way society functions. She says that, although a worldview is difficult to

identify in a material sense, it is just as powerful and influential as parents. One can argue it is this worldview which dictates parenting.

The material reviewed presents a representation of emotion being located within the individual, and the individual being located within and through the social order. In order to be allowed to participate in the social order, the individual has to be acceptable to it, which involves accepting the norms and beliefs of a shared society. One's place within the social order determines which sets of emotion rules one is governed by. These will determine what types of emotions one is legitimately permitted to feel and express. More importantly, though, the material demonstrates how the person cannot be separated from emotion or society, as all three are interactive and influential upon each other. This supports Denzin's (1984) view, "there is no division between people, their emotion, and the world".

Emotions provide a way of locating the person in the social world. Therefore it seems reasonable to understand and value the functional aspect of emotion. Feelings are fundamentally purposeful and should be valued. Even negative emotions such as anger and sorrow can be justified. Occasionally one feels particular emotions more intensely, and can feel out of control or overwhelmed, but there may be justifiable reasons for this. Hochschild (1983) argues against emotion being perceived as irrational, arguing that if all factors are given consideration, the connection between emotion and behaviour is more often rational. However there remains a fundamental problem facing people in terms of lived experience, the need to suppress feelings at both the level of the experiencing of inner feelings, and outward expression.

The aim of the qualitative interview study was to establish an understanding of what it means to "be emotional" as part of lived experience. Issues covered included

various types of emotion categories, definitions of emotion, personal experiences of strong emotions, conscious awareness of feelings, and ability to change the way one feels.

METHOD

Participants

Ten men and ten women agreed to participate in the study. Unfortunately two of the audiotaped interviews were not transcribed due to mechanical failure of the equipment, resulting in the loss of data. The lost data was from a male and a female participants' interview, leaving a remainder of nine women (average age 36.7 years) and nine men (average age 32 years) as usable participants. All of the participants were British, and all were heterosexual except for one man who was gay.

The participants were recruited from a variety of sources that ranged from Coventry, Leicester, and Warwick University, the police service, a local hospital, and an accounting firm. Contact with each participant was made through colleagues, asking them if they knew of any family member or friend who might agree to be interviewed about emotions. Colleagues passed names of potential participants to the researcher, after obtaining their consent, who then made formal contact.

Design

A semi-structured interview schedule was devised to gather information from a group of people about their thoughts concerning emotions and moods. The schedule comprised eight questions, which were compiled to generate accounts of personal emotional experiences (appendix 1). Each participant was asked all of the questions,

although not necessarily in the same order. However each interview began with questions one and two.

Participants were asked how they would describe emotions, or feelings, thus introducing the subject. The second question encouraged discussion of different emotion categories, and was used to prompt participants if they were having difficulty with the first question. The third question expanded upon discussion of what it meant, for each participant personally, to experience emotions. They were asked to recall a recent experience when they had felt particularly strong emotion or feelings. This generated much discussion. Questions four, five, and six asked participants to describe moods and emotions, whether they thought about their mood states at the time of experience, and if they employed any regulatory strategies in an attempt to change moods. Question seven asked about the expression of emotion, whilst question eight asked whether participants had any thoughts about gender differences concerning emotion.

Choice of interview style adopted for this study was of particular importance. The focus for the interviews concerned the experience of strong emotions, each participant being encouraged to recall a time when they had felt highly emotional. This had the potential of raising unresolved issues for participants, which could raise their vulnerability. A safeguard against the potential abuse of the participants' position was therefore necessary requiring that the style adopted would enhance the researchers' understanding of herself within the research process. The approach adopted utilised counselling skills, based on the work of Rogers (Sanders, 1994), which enabled a constant re-working of the power relations existing between interviewer and interviewee (King, 1996). The technique encouraged empowerment of the participants,

whilst at the same time enabling the process to be carefully managed to safeguard the emotional status of the participants.

Procedure

Participants were informed of the aims of the research project and each gave verbal consent to be interviewed for such purposes. The same researcher interviewed each participant and each interview lasted between 20-60 minutes. At the outset of each interview it was stressed that, at any time during the process, participants could withdraw from the study if they wished to do so. However none did. Also to ensure participants' anonymity, all names have been changed.

The interviews were conducted on a semi-structured basis utilising the questions, where appropriate, according to individual responses. The process was different for each participant in that each person had a lot of control over what they discussed, in relation to the topic, resulting in participants discussing the emotion categories and issues most important to themselves. To complete the interview process each participant was debriefed. This involved asking the person if they were happy with their contribution to the interview and thanking them for such a personal and valuable contribution.

Twelve of the interviews were undertaken at the homes of participants, whilst six participants expressed a preference to be interviewed at work. All of the interviews were conducted in privacy with only interviewer and interviewee present. Each interview was audiotaped, using a standard cassette recorder, then transcribed.

Analysis

Discourse analysis was employed to examine the data, based upon the ideas of Parker (1999). Parker draws upon a Foucauldian perspective (Kendall & Wickham, 1998) in order to be able to identify and examine the position ideological structures, and various types of discourses, occupy in language. By fragmenting the way in which an account had been constructed, the various types of discourses that had been used to construct an account could be identified and examined, particularly for the power relations between the speaker and certain ideologies. This enabled insight into the way the participants used language to construct accounts of their emotional realities, and to examine some of the deeper social meanings involved in what it meant to 'be emotional'.

Analysis involved reading and re-reading the transcripts, making interpretations based upon establishing the key types of discourses that were being used in the construction of accounts. Theoretical interpretation of the data was open at the beginning of the process of analysis, the transcripts being read and re-read with an open mind. Many themes began to emerge. Moving between analysis and coding, seven core categories were identified.

Results/Discussion

The seven core categories which emerged from the participant's accounts were control, expression, socialisation, gender, work, rationality and dysfunction. This interpretation was the result of the theoretical sensitivity of the reader, which was largely dependent upon the way in which the reader has interacted with theory and the material referred to throughout the thesis (discussed under 'reflexivity' in chapter 11).

These categories were not mutually exclusive and were constructed through the utilisation of several types of discourses. For the purpose of this chapter control shall be concentrated upon. Both the men and women drew upon discourses of masculinity, femininity, and biology when explaining how they believed they should behave emotionally. This provided the function of locating the self within the social order. Socialisation was also frequently used to explain participant's feelings and emotional reactions, and closely linked with discourses representing a worldview. Discourses of control and expression were also closely linked. Control was referred to at two levels; firstly to remain 'in control' of inner feelings, and secondly, to control outward expression. Finally, the participants often talked about the consequences of the experience and suppression of emotion by drawing upon discourses of dysfunction and irrationality.

A discourse of control was frequently used by all of the participants. It seems that for both the men and women, being in control of one's emotions is essential. Indeed control was found to be pervasive throughout the other categories. Participants expressed the need to control their feelings to be consistent with social norms governing both gender and social context. Also positive emotions were favoured, the participants endeavouring to control or change negative feelings more often than positive feelings. Control was required on two levels. Participants recognised that they had to control their inner feelings as well as outward expressions. This meant, for much of the time, participants had to work hard at controlling and regulating the way they felt. Rena, a thirty-one year old, professional woman said,

224 "dear an' it's like to be irritable and () I can't relax physically I'm all wound up

225 and um' () intolerant generally () an' I have to work really hard at it when I
226 talk to people () look () recognise it () it does help to recognise it () this is
227 happening () at the moment, you know () um' an' I can keep an eye on it".

It is important that negative emotion is suppressed, so that others are not made aware of it. Use of the term 'it' provides the function of separating the self from the feeling.

The concept of emotion being separate from the individual promotes the idea of emotion as an entity that can take the individual over. Being taken over implies danger and loss of control, therefore recognition and close monitoring is necessary. The individual is required to monitor the feeling so that 'it' does not become outwardly apparent to others. If negative emotion is not outwardly expressed, the individual will not be perceived as being out of control. Suppressing negative emotion, then, is very important and is demanding on personal resources. This is consistent with Hochschild's (1983) view. Rena is involved in both surface and deep acting here, so she is attempting to recognise and control her inner feelings as well as her outward expression.

Control of emotional expression provides the function of allowing the individual to maintain their place within the social order. Further on in Rena's interview she talks specifically about expressing feelings,

248 "very very recent () you know () my counsellor did sort of talk about it () un'
249 said well you know () give yourself permission its alright to just let these
250 feelings out () its okay. An that did help cause I'd felt like I shouldn't be doing
251 this () out of control".

Controlling the expression of her feelings is so ingrained that Rena welcomed the external source of permission to express her feelings outwardly. It is interesting that she almost requires some form of authorisation, demonstrating how important control is. Control almost takes on the status of a sacred rule, which should not be contravened. Expressing feelings outwardly implies the individual is doing something wrong. Also emotional expression is clearly associated with being out of control. To express one's feelings, then, has negative implications at the social level.

Controlling positive emotional expression was also implicated, although not as often as negative emotional expression. Adrian is a 35-year-old, married man with two young children. His account of the emotional self is centred on friends and work, and is dominated by emotion avoidance. In response to the interviewer asking him whether he is emotionally expressive he says,

130 "No () no never I don't () no I never no. Doesn't matter who I'm with you
131 know I just. You know I'm not one for sayin' oh () I'm really troubled or
132 really happy or () you know I'm just () I feel uncomfortable when I have these
133 conversations".

The account is very definite about control of emotional expression, even with positive emotion. Expression in any context would create unease or discomfort for the individual. Use of the word 'uncomfortable' implies negative personal consequences, framing emotion as dysfunctional. Emotional expression, then, also can have negative implications at the personal level.

Although controlling emotion on both levels is perceived as vital, all participants believed there to be negative personal consequences. This places the individual in a double bind; one has to control emotion, yet at the same time this can have a detrimental effect on the individual. Adrian says,

225I. “you say storing up trouble, what do you think could be the consequence?

226A. Well () you know it will become so stressful () you know you’d have

227 stomach complaints, things like that you know without a doubt”.

A link between emotional control, stress and illness is made. Suppressing emotions can lead to physical illness. To suppress emotion, then, can have negative consequences at the personal level. This supports the emotion as functional viewpoint. To ignore one’s emotions can mean risking one’s health, as emotion serves as a signal function to enable the individual to adjust to the environment (Plutchik, 1980). The personal self and the wider society are placed in direct conflict. This means the individual has to control emotion in order to avoid negative social consequences, yet risks incurring negative personal consequences.

Discourses of control were pervasive throughout accounts of participants’ social experiences. Adrian says,

191 “You wouldn’t bring it up anyway so () an’ I think one comment from my

192 friends was if his wife left him, he () his reaction would not be oh disastrous,

193 end of the relationship kids gone house, mortgage, maintenance. His

194 immediate reaction would be Christ what do I tell me mates you know. That
195 un' that's pretty much sums it up really"

The wider social order is impacting directly upon the individual. Adrian mentions a major life event, relationship breakdown, which carries serious emotional consequences, yet says the chief concern is maintaining control and thus peer acceptance. Peer consistent behaviour is given priority. This type of reaction is consistent with the male emotion norms. To appear unemotional, when faced with an event that clearly has far reaching personal emotional and material consequences occupies a favoured position within the dialogue.

Accounts by the male participants were focused around work, social activities, and friends, which highlights the position they occupy within the social order. However the female participants' accounts were constructed out of experiences dominated by the family, home, and relationships. Discourses of femininity and biology were frequently used to construct the self. Debbie, a 42 year-old woman, married with two teenage children said of her emotional experiences,

111 "but if I'm looking at it from a PMS point of view () I've had to do it ()
112 because because of protection actually cause you have to work out the level of
113 medication you have to take an' I have to do a lot of monitoring".

A biomedical discourse is used, which performs the function of locating emotion in a disordered biology. The self is being constructed through the female biology. Associating emotion with a medically defined syndrome implies that emotion is

disordered in some way. Having to do a lot of monitoring suggests a potential threat. There is talk of requiring protection, which again implies danger. Emotion, then, is seen as dysfunctional and in need of control by medication. A biomedical discourse has been found to be utilised by many women when accounting for their emotions (Ussher, 1989; Walker, 1997) for a variety of reasons.

In the closing part of Debbie's interview she says,

193 "when my husband's around, however I am () has such a dramatic effect on
194 him that I can't read myself very well () an' he becomes, he can become nasty,
195 quite a problem, actually. Its difficult to say whether I need it for him () or I
196 need it for me () but I do know in an ordinary day to day family interaction
197 with the children and Peter () if I haven't had the medication it's a recipe for
198 a major disaster".

The legitimacy of the reason for why medication is sought is questioned in this account. Previously it was implied that biologically disordered emotions needed to be controlled with drugs. However there is the suggestion that control through the medication is required in order for Debbie to be able to function within a problematic relationship with the husband. Use of the word 'nasty' implies a potential threat of something harmful. Also the use of 'nasty' and 'major disaster' implies negative material consequences. The account of emotionality is framed within an ordinary day to day family interaction. Ussher (1991) argues that a biological discourse is the only language available for women to be able to express negative emotion such as anger,

which may be justified, but is not permitted under the emotion rules governing femininity.

Finally, here is an extract from a powerful account of emotional expression.

Rena is talking of a time when she was 18 years old, and expecting her boyfriend round at her parents' house for tea. It was to be the first meeting between the parents and the boyfriend. They were teasing her in a persistent manner, and being very uncooperative,

104 “they were both behind me in the kitchen saying “you’re so selfish” () very
105 critical , this real critical energy an’ I felt very vulnerable and they were right
106 behind me. It was like I was being hit () an’ I remember it was like a flash of
107 anger () an’ I was totally out of control. I didn’t think “I’m angry” or “I’m
108 going to do this” an I just remember *incr’ incredible* frustration an’ it was a
109 raw energy, physical very physical manifestation which went through my body
110 () like lightning or something. The next thing I remember my arms going up
111 an’ just *crash down* () an’ I really hurt my arms, water went everywhere. I
112 mean it was frightening because it was, I actually felt very ill afterwards, very
113 drained. I felt ill cause () I felt very white () drained, frightened. They both
114 didn’t move they didn’t speak, I remember turning around an’ I thought “oh
115 my god help, what happened there?”. I’d never done that before, ever and they
116 just stood there () didn’t speak () an’ we never talked about it since. An’ then
117 Dad said ur’ “come on we’ve got to go and pick so an’ so up” and I said “I
118 can’t go like this” and I felt completely de-sexualised, cause I’d put a dress on
119 an’ () you know I was trying”.

(Italics represent strong verbal emphasis by the participant.)

The situation occurs in a traditionally female domain, and the individual has been engaged in a traditional female duty. The parents were standing behind her. In line 107 there is a reference to being completely out of control, feeling an intense sense of anger. There is an outward display of anger at the situation. The reaction that followed was a sense of shock at the expression, from both the self and the parents. They did not react to her behaviour. Also Rena says that she felt 'desexualised' by the incident, whilst in the same sentence highlighting her dress. Gender politics are particularly powerful in the sense of location, activity, and clothes. Displaying anger is not consistent with the female emotion norms (Lutz, 1996). Also because Rena was engaged in a traditionally female task in the kitchen, and had put a dress on especially, all serves to reinforce her femininity. Thus she expressed emotion that is not consistent with the female emotion norms whilst occupying a traditional female position.

A further issue contained within Rena's account is that of personal negative consequences resulting from outward emotional expression. There is reference to feeling very ill and drained, which implies that allowing the self to express emotion, as opposed to active suppression, can also be demanding on the individual's personal resources. Earlier accounts, such as Adrian's, implied that suppressing emotion runs the risk of physical illness. Yet in Rena's account there is also an association between expression and illness. As Parrott (1995) noted, the lay and academic view of emotion, although standing in opposition to one another, can co-exist. A tension is created between emotion as functional, emotion as dysfunctional.

The aim of the study was to seek a deeper understanding of what it means for the participants to 'be emotional' as part of everyday lived experience. From the accounts it is evident that the emotional self is deeply embedded within a wider social

framework. The emotion rules governing each participant were determined by the position they occupy within the social order. The social order functions to maintain, and is maintained by, such rules. Control is a key priority, and preventing inner feelings from being outwardly expressed is required in order that the individual can maintain their place within the wider society. Also it was evident that emotion work requires much personal effort and resources from the individual, and can be exhausting when suppressing emotional expression as well as sometimes outwardly expressing powerful emotions such as anger (e.g. Rena's account).

The lay view of emotion seems to be in contrast with the academic view, which is consistent with Parrott's (1995) findings. Participants were placed in a double bind, requiring them to re-work the gap created between social norms, as part of the wider social order, and the private self. This may partially explain why they viewed emotion as being dysfunctional. Chapter 5 sets out to examine further some of the ways in which gender ideology specifically exerts control over what is designated as acceptable emotional experience.

Chapter 5

Gender and Emotion

The continual growth in the emotion literature now asserts that a multitude of factors are involved in the experience of emotion (Brody, 1997; Levine & Feldman, 1997; Lupton, 1998; McContha et al., 1994). Gender identity, particularly, has been found to have a significant effect upon the way the individual is permitted to experience emotional states (Brody, 2000; Lupton, 1998; Lutz, 1996). This could be due, in part, to the way emotion has been so closely tied to biology (Averill, 1974), with gender status being awarded through anatomical and biological difference. There have also been persistent attempts, by the scientific world, to find evidence of differences between men and women, due to biology. Such persistence, it is argued, has contributed to the exaggerated sense in which masculinity and femininity are sometimes used in both the lay and scientific world.

This chapter examines the relationship between the gender ideologies of masculinity and femininity, and the emotional self. The data on which this chapter is based are taken from the qualitative interview study (see method section of chapter 4). Outward gender identity locates the individual within the realms of masculinity or femininity, and therefore associates the individual with characteristics typical of the respective gender emotion norms (Golombok & Fivush, 1994). Hochschild (1983, 1990) highlights how men are subject to different emotion rules than women, which illustrates how gender impacts upon emotional experience for both men and women. Lutz (1996) argues there is such a close link between femininity and emotionality, that the two are almost

synonymous. She points out that the same organizing categories, which are used to define emotion, also define women. Western culture defines emotion as natural rather than cultural, chaotic rather than orderly, irrational rather than rational, physical rather than mental or intellectual, unintended and uncontrollable, and hence often dangerous (Lutz, 1996). Lutz (1996) further adds that by being constructed through emotion, women occupy a disadvantaged position within society.

Lupton (1998) points to the way emotion has been gendered through different associations with the public and private spheres. The public sphere is associated with paid employment and is affiliated with masculinity. The private sphere, in contrast, which incorporates the home, has been and still is to a large extent (Acker, 1991), under the realm of women. Duncomb & Marsden (1998) highlight how it has been considered the woman's responsibility to maintain emotional equilibrium within the home for both the husband/partner and the children. Thus there appears to be a clear distinction between the public and the private domain, for which men and women have styles of emotional responsibility respectively.

Hochschild's (1983) work on feeling rules and 'emotion work' is particularly useful for clarifying how gender identity can influence the way the individual has to actively manage and regulate emotional experience. Such rules (referred to in chapter 4), it is argued, are partially constructed out of dominant ideologies. Also one's position within society, particularly the position that gender affords, determines the types of rules one is subject to. Indeed Landman (1996) argues that emotion rules differ significantly depending on one's assigned place within the social order. In particular Hochschild (1990) has explored the way emotion rules impact upon men and women in marital relationships. She argues

that women are forced to live a continued family myth because of the continued gender emotion imbalance of power in the marital relationship. She further argues this is due to the 'transitional man', who pays lip service to egalitarian ideology, but remains traditional underneath. Consequently gender role identity has a large part in determining what types of emotion rules we are subject to in the personal/private, as well as public arena.

Golombok & Fivush (1994) declare that gender identity is largely organised around the gender stereotypes of masculinity and femininity. They point out, though, it does not follow that just because an individual subscribes to some traditional feminine traits, they will subscribe to all of the feminine traits, and vice versa. However Golombok & Fivush (1994) say that assumptions are still made about men and women in that direction. They also suggest that gender stereotypes are not changing, despite the immense changes that have taken place in society during the last thirty years. This has potential of creating problems for the individual, as even though the structure of society is changing, dominant gender ideology is not. Also Golombok & Fivush (1994) reviewed evidence suggesting that masculine characteristics are still preferred over and above feminine traits.

Fischer & Manstead (2000) evaluate sex role ideology through Social Role Theory, which asserts that the cultural division of labor is sex-specific. Therefore the associated sex role ideology is an important determinant of what constitutes masculinity and femininity. Fischer & Manstead (2000) discuss how cross-culturally, there has been a predisposition of the sexual division of labor to be based on biological factors. Women are the primary caretakers of children, and men more often occupy the provider role. They argue sex role ideologies provide

rationales for the division of labor between the sexes and refer to normative beliefs about the roles of men and women, and therefore about how men and women should relate to one another. Yet they also go on to point out that an objectively more egalitarian position of women in a given culture may not necessarily be accompanied by a modern sex role ideology. This can help explain the mismatch in Western society, for how more women are now working in paid employment in the public sphere, yet deeply rooted cultural values concerning ideas of masculinity and femininity can lag behind such changes in the economic, political and social status of women (Fischer & Manstead, 2000). This is in line with Hochschild's (1983) notion of the egalitarian man.

The gender ideologies of masculinity and femininity represent a powerful force, which demand unity and order in society. Lupton (1998) says that part of women's emotional work is to preserve and reproduce social norms and order from one generation to another, by overseeing and supporting the emotional status of their children. In particular, Brody (2000) refers to how parents emphasize the control of emotional expression for their sons, and the control of aggression for their daughters. Display rules are passed down to children to ensure that existing cultural values governing gender roles are maintained. Thus one can identify the emotion rules by which we are governed are perpetuated.

Discourses on emotion serve to reproduce the dominance and inequality of masculinity over femininity in Western society. Lupton (1998) identified how the discursive nature of accounts concerning emotion contained meanings that contributed to the binary opposition of the 'emotional woman' and 'unemotional man'. Gender stereotypes had a significant impact.

However Lupton (1998) also points to a more recent shift of the boundary between feminine emotionality and masculine unemotionality, particularly in the media. Men are now expected to have greater emotional presence in the home and the family. She talks of the upsurge of 'masculine emotionality', a portrayal of men as benefiting from being more in touch with their emotions, especially in the context of personal relationships. Such conceptualisations, however, suggest the presence of a tension for men when negotiating their emotional selves, because the Western conceptions of control and reason are still highly influential (Van-Leeson et al., 1998).

The idea of a shift in the way emotion norms are constructed adds substance to the argument that emotion is not solely in the hands of biology. However that is not to suggest that the gender ideologies, which are partially constructed out of biological discourses and have persisted into the late twentieth century, will not continue to have an impact upon emotional identity for both men and women. Shotter and Billig (1998) refer to the work of Bakhtin and Voloshoniv, and argue that discursive work needs to address the links between discourse and ideology, an issue of interest to the present study. The theoretical position taken within the thesis draw partially upon Shotter and Billig's (1998) appraisal of Bakhtin's work, Shotter & Billig's own ideas, and the work of Harré (1998). The present chapter proposes that the emotional self is a combination of one's physiological existence, as part of ongoing lived experience within society, embedded within cultural norms and beliefs. Gender ideology is one of the most powerful shapers of this combined ongoing experience.

Shotter and Billig (1998) emphasize how Bakhtin's work parallels a current move towards interest in the everyday life-world, rather than the

theorisation of general laws. This is consistent with Parrott's (1995) argument that that 'being emotional' is worthy of study in its own right. In order to gain an understanding of how the individual experiences the emotional self, one has to examine the discursive nature of lived experience. Shotter & Billig (1998) argue that the move to the dialogical enables us to focus on peoples' social practices, saying that words are a living social process. Also Bakhtin stresses the powerful nature of ideologies upon peoples' lives, which are evident in language. These factors are highly relevant to the present chapter, which seeks to understand how the dominant gender ideologies impact upon the lived experience of emotion.

Bakhtin talks of the contradictory nature of language (Shotter & Billig, 1998). Each word has the potential to contradict other words. This suggests the possibility of tensions arising within language, which reflects social reality. Indeed Bakhtin refers to centripetal and centrifugal forces at work. Centripetal forces push towards unity and order, whilst centrifugal forces push outward towards multiplicity and diversity (Shotter & Billig, 1998). Such conceptions are extremely relevant to the present study, as one is attempting to understand the discursive and contradictory nature of emotional reality. One can argue that mainstream gender ideologies represent a centripetal force, over and above the more personal or marginalized ideologies, the centrifugal forces.

To be allowed to participate in the wider society, the individual has to be acceptable to it, which involves negotiating the emotional self through the norms and beliefs of the shared society. One's assigned gender status determines which sets of emotion rules one is governed by (Hochschild, 1990; Lutz, 1996). These will determine the way in which the individual has to present their emotional self, both publicly and privately for much of the time. It would seem that tensions exist

for the individual in the way one is to negotiate the emotional self through the dominant gender ideologies of masculinity and femininity. Of particular interest is the contention that women are subject to tighter social control through their emotions, than men, because of their association with the same characteristics that define emotion. This is due to the close link between biology, emotion, and gender, and that emotion is disadvantaged to cognition and reason (Lutz, 1996). Furthermore, the individual is not permanently located within the sphere of either masculinity or femininity, but rather is actively negotiating his or her gender identity (Duncombe & Marsden, 1998), and therefore emotional identity. Most importantly, though, the material demonstrates how the person can not be separated from emotion or society, as all three are interactive in a constant flow of social interaction.

Method

Refer to the method section of chapter 4. The presentation of findings from the qualitative interview study, in this chapter, concentrate on the gender ideologies of masculinity and femininity for their impact on emotional lived experience.

Results/Discussion

Several patterns of discourse were evident within the data, being used discursively to construct accounts of the emotional self. However this chapter concentrates on discourses of gender, particularly focusing upon the links between the gender ideologies of masculinity and femininity, and the participants' dialogue. Both the male and female participants made use of discourses of masculinity and

femininity when talking about the emotional self, which led to much conflict and contradiction within individual accounts. Indeed there is evidence, within the discourses, of a tension created by the dominant ideologies of masculinity and femininity and the marginalised, private, singular experiences of the emotional self. When constructing their accounts, both the men and the women negotiated their experiences of emotion between masculinity and femininity, which was experienced as a conflict for much of the time. This shift between masculine and feminine emotion rules was apparent for the men and the women, but the shift was qualitatively more pronounced for the women. It is argued this is partially due to masculinity being given more authority over femininity, within Western culture. Firstly, evidence of the use of masculine and feminine discourses shall be presented and explored. Then, evidence of the shift occurring between the masculine and feminine emotion rules shall be presented and discussed, with particular reference to the links between ideology and discourse.

Discourses of masculinity were pervasive throughout accounts of participants' social experiences. Also the participants used the masculine and feminine stereotype in an exaggerated, dichotomous manner. Mike, a 32-year-old professional man, says,

171 *"Men don't cry. Men don't do this men don't do that. Um (.) what I mean*
 172 *actually you've got all that but, but it takes a lot to break away from that*
 173 *(..) and (..) and then its sort of if you, if you break away from it un' like (.)*
 174 *un' that's like you know, you're called being a woman [laughs] and that*
 175 *shouldn't be an insult (.) but it is".*

Here the male stereotype represents the social norms by which Mike is governed, and is highly influential over the way he feels he is able to express himself.

Emotion rules governing masculinity demand emotional suppression. To be accepted as a man one must not be emotionally expressive, which is in line with the conceptualization of the 'unemotional man' (Lupton, 1998). This is insinuated by the phrase 'men don't cry'. This example given for being emotional is indicative of highly visible emotional expressiveness, serving to highlight the need for suppression. Thus men must not be *that* expressive. Further examination of this account discloses two key issues; the inequality of power that masculine ideology has over feminine ideology within Western culture, and associating emotion with negativity. The demands on personal resources are high if the singular self is to go against the dominant masculine ideology, and carries a risk of being rejected by the social order. In this case rejection takes the form of an insult, notably to be called a woman. Emotional expressivity is part of the feminine ideology, and is clearly associated with being a woman within the text.

Lutz (1996) argues that women are defined by the same organising characteristics which define emotion, particularly being biologically driven, irrational, and out of control. Incorporated into dominant Western cultural ideologies are the conceptions of logic and rationality, which advocate control. This account clearly contains the need to disassociate with women, and therefore any of the defining categories, which serve to devalue all that is, and represents, the female.

Although the dominant ideologies of masculinity and femininity are apparent in the lived experience of the emotional self, masculine characteristics are still framed as the more desirable of the two. A tension is evident in the text, present in the dialogue "it takes a lot to break away from that". The dominant masculine

emotion rules exert such a powerful force on the emotional lived experience of the individual that it becomes almost impossible to go against them. If one manages to succeed, then one is marginalised, and incurs negative personal consequences.

An extract from one of the male participant's account illustrates how the gendering of emotion affects the way the individual has to manage emotions in the public domain. Adrian, a 35 year old married man, is talking of a time when he worked in a factory. The workforce is all male, apart from the secretarial and cleaning staff. He says,

208 “you know fifteen years I worked in a factory where you just (.) you were
209 an easy target if you showed any type of weakness in that respect so (.)
210 you know if you had n’ I mean a couple of them did have nervous
211 breakdowns. You know that was it then, finished then you know (.) they
212 were the brunt of everyone’s jokes”.

Within this account emotion is framed as a weakness in the workplace. Lupton (1998) discusses how the workplace is culturally associated with masculinity, rationality, and self-control. Emotion has to be tightly controlled in such an environment so as not to destabilize efficient management and production. To be a man and express emotion, which is associated with femininity (Lutz, 1996), in a traditionally defined male environment, contravenes such dominant ideologies. The consequence is to be rejected by the social order, which takes the form of ridicule. So emotion, or the expression of it, is not valued here. The personal, private experience of emotionality, which takes the form of a nervous breakdown, is marginalised to favor the mainstream ideologies.

A feminine discourse was used frequently to highlight the lived experience of the emotional self. Interestingly, the female participants' accounts were constructed out of experiences dominated by the family, home, and relationships. This was the case even for professional working women. The male participants' accounts, on the other hand, were focused around work, friends, and social activities. This reflects both the positions they occupy within the social order, and therefore the reality of their lived emotional experiences. Jenny, a 38-year-old professional woman, frames her account of emotionality with discourses that utilise such conceptions,

166 “the other thing I find is that my mood effects the entire family (.) you
167 know if I’m in a bad mood, then it sort of filters through everythin’ else.
168 But if I’m in a good mood the whole atmosphere of the house changes. I
169 feel quite guilty about that sometimes cause its cause its quite a
170 responsibility sometimes really. Knowing I’ve got to keep this good mood
171 it going because it affects everybody else. Its sort of like a waterfall its
172 like, moves down through the family. If I get angry with my husband (.)
173 then he starts shouting at the kids and the kids start shouting at each other.
174 An’ then they come back an’ blame me because I’ve made him angry”.

Jenny constructs an account of herself as being responsible for the emotional welfare of the entire household. Ideology exerts an external pressure over Jenny to maintain a positive mood, in order to benefit the family, because of Jenny’s role as wife and Mother. This position is reinforced through the children locating blame in Jenny if their Father shouts at them. The waterfall metaphor is a

particularly powerful illustration of Jenny's emotional impact upon the rest of the family. This is consistent with Hochschild's (1983, 1990) argument that women are assigned a heavier emotional burden in society than men are. Duncombe & Marsden (1998) also highlight how it has been considered the woman's responsibility to maintain emotional equilibrium within the home for both the husband/partner and the children. The account locates the woman's place within the home as having chief responsibility, as carer and nurturer, irrespective of whether she is working in paid employment. Again Hochschild (1990) has emphasised how, despite the change in patterns of women working outside the home in paid employment, the union of marriage still means that the woman has to take chief emotional responsibility for the interpersonal relationship dynamics within the home.

The construction of the emotional self consisted of a constant process of negotiation between the gender ideologies of masculinity and femininity. It is argued that this creates a tension, which constitutes part of the lived experience of the emotional self. Alice, a 48 year old divorced professional lady, is talking about her emotional experiences and says,

329 "I think I always control. Like, no I'm not in control, but I always try to
330 make it as though I'm in control (..) an' that sort o'thing. I don't. Cause
331 I've got this thing about work, being professional, and how it's seen as a
332 man's world a profession (..) and ur' I'm not about to sort of (..) be
333 breakin' down (..) at those times (..) because (..) that's what's expected of a
334 woman an' I refuse to fall into that sort of thing an' I I hold my
335 professionalism above it (..) sort o'thing".

This account contains much conflict and tension for the individual. Outward emotional expression has to be denied in order to maintain the illusion of control. Appearing in control of one's emotions is clearly very important in this context (work) which is in line with Western cultural values, and the male emotion norms (Lutz, 1996). Lupton (1998) points out that the workplace favours rationality and order over disorderly emotions. Within the text the workplace is clearly aligned with a traditional dominant masculine ideology. Professionalism, in the text, is located within the realms of masculinity. Professions, and the infrastructure of corporate organisation, are part of the public domain which have traditionally been occupied, and therefore controlled, by men (Acker, 1991). Thus Alice has to adopt a masculine emotion style if she is to be taken seriously in the workplace. To occupy the place of 'professional', Alice has to construct the emotional self through masculine characteristics. Within the text dominant masculine ideology, combined with the framing of emotion in negative terms, disadvantages Alice in the workplace.

A tension is evident in the shift between Alice's private experience and the demands of dominant ideology. Alice begins by saying that she is always in control, then to immediately contradict herself by stating that she works at maintaining an illusion of control. The illusion is for the benefit of the public emotional self, rather than the private, singular experience of emotion. Reasons given for this are located within the need to conform to the mainstream worldview of the man's working world. Furthermore Alice draws upon the dominant feminine ideology, setting it in opposition to mainstream masculine ideology, which creates further tensions. She refers to what is expected of women, 'to be

breakin down', stating that she wants to distance the way she is perceived at work from such conceptions. The female emotion characteristics, which Alice draws upon, frame women as being prone to emotional lability. 'Breakin down' serves to reinforce the popular concept of women being emotionally unreliable, and unable to control emotional outbursts (Ussher, 1989, 1991). Again, to be a woman immediately disadvantages the individual, which means that one has to 'work' at presenting the self through the more favoured dominant, accepted view.

Golombok & Fivush (1994) point out how traits associated with masculinity are more highly regarded than traits associated with femininity, even by women.

Within the text, Alice positions dominant masculine ideology above feminine ideology, by striving to construct the emotional self through masculine characteristics, even if this may be an illusion.

Negotiating the shift between masculine and feminine characteristics was evident for the male participants as well. David, a 35-year-old professional single man, is talking about how emotionally expressive he is. He says,

126 "I'm pretty renowned for bein' [laughs] well, just I say it as it feels and
127 urr', an' I but then, but then I do suppress that sometimes so because it's
128 like well. You know certain things don't upset me, but then I do feel.
129 Sometimes I don't think that would be appropriate to express that,
130 because, because it would either give, it would give things away that I
131 don't really want to talk about or, or to um' (.) awkward room un'
132 situation you are (..) that's not (.) the manly thing to do.

David begins by implying that he is outspoken and expressive. However he then proceeds to contradict the claim, which indicates the presence of tension within his lived emotional experience. The text continues with a theme of hidden agendas. This is implied by the use of the words 'give things away'. It is suggested that as a man, there are certain constraints, which are actively regulating the degree to which David can be emotionally expressive. It is implied that David wants to be perceived as an individual who is emotionally expressive, yet at the same time has to be inhibited. The reasons for having to suppress one's emotional expressiveness are located within situation and context. Significantly though, direct reference is made to masculine ideology. David uses the words 'manly thing to do' to frame his explanation. This serves the function of presenting the self as a man, which has a direct impact upon situation and contextual factors when constructing the emotional self. This, one argues, is clear evidence for not separating the self out from society or emotion, by casting emotional experience through isolated biology. The shift apparent in the text is between David's desire to be emotionally expressive, which is marginalised by the dominant masculine ideology.

The aim of the present chapter was to present a deeper understanding of what it means for participants to 'be emotional' as part of everyday lived experience, with particular emphasis on gender ideology. Gender status has a profound impact upon such positions and locations which the individual occupies within society. This is because gender identity itself is discursively constructed and experienced as a location, at given moments in time. To occupy the place of woman or man, through a variety of roles that are assigned to men and women determines which types of emotion norms one is subject to. However it is also

evident from the text that the emotional self is not arrested, or contained, within masculinity or femininity. Rather, the emotional self is actively negotiated between the dominant ideologies of masculinity and femininity, for both men and women, which creates a tension between the two. Furthermore, tensions were created for the participants, between dominant ideology and the more private, singular, marginalised experience of the emotional self.

Findings presented in this chapter provide evidence for the way ideology impacts on lived experience, thus affecting the way an individual may feel and behave for much of the time. The link between ideology and lived experience is, therefore, given further consideration in chapter 6. However it must be stated that within the thesis no one ideology is being presented as the 'correct' or favored ideology. Rather the intention is to present evidence for the way in which ideology does indeed influence the way people think, feel and behave.

Chapter 6

Emotion and Rationality

The key dominant ideology identified from the qualitative interview study and presented in this chapter is one of scientific rationality, and will conclude the presentation of data from this study. Ideology was found to be represented in the dialogue in several ways. Rationality and reason were associated with cognition and controlled thought, whereas emotion was affiliated with being irrational and ‘not of the mind’. For much of the time emotion and thought were constructed as separate, rather than interactive and continuous. Also subjectivity and emotion were frequently combined within the dialogue, and rational thought was associated with objectivity. It is argued such dialogic antinomies represent the contradictory nature of lived emotional social reality for the individual, experiencing such conflict as tensions within lived experience.

The present chapter is concerned with the concept of rationality and reason in relation to the way emotion has been defined and conceptualised, particularly for the separation of emotion from reason. For thousands of years emotion has been defined in opposition to rationality and reason (Barbalet, 1998; de Sousa, 1987). Despite there having been tremendous changes in society this century (Lupton, 1998), it seems the conventional view of emotion still positions rationality as the preferred ideology (Barbalet, 1998). It

is argued that this contributes to the tension evident in emotional lived experience (Parrott, 1995; Van-Leeson et al., 1998).

There has been much debate as to what constitutes emotion, and the function it serves. Although the focus has varied over time, there has been a tendency to conceptualise emotion in a variety of negative ways. This seems to be the case with the present day, Western culture viewing emotion with caution and suspicion (Lutz, 1995). Historically rationality and reason have been positioned both in opposition and preference to emotion (Barbalet, 1998; de Sousa, 1987). Barbalet (1998) argues that the conventional view of emotion is still resolute in its conviction that rationality and reason are superior to emotion. He outlines three key perspectives through which emotion is conceptualised; the conventional approach, the critical approach, and the radical approach. The critical approach promotes the idea that emotion supports reason, and the radical approach that emotion and reason are continuous. However the conventional approach of emotion undermining reason continues to have the widest and most powerful impact, despite there being little evidence to support such a position when more closely scrutinised (Barbalet, 1998).

The idea that emotion and reason are independent of each other, and that emotion is incompatible with intelligent judgement, has prevailed throughout the centuries. The Ancient Greek word for emotion was “passion”, which was applied to give meaning that emotion was a powerful, uncontrollable force, capable of compromising thought (Robinson, 1999). In

contrast, reason was conceptualised as a voluntary activity of the self-directed mind. Thus emotion was construed as a natural chaotic force affiliated with the body, and representative of the animalistic characteristics within us. Reason, on the other hand, was characterised as being of the mind (Ellsworth, 1995). Barbalet (1998) traces the origins of such mind body dualism back to Descartes, who proposed the idea that thought was the defining characteristic differentiating humans from the lesser animal species. Lazarus & Lazarus (1994) have traced the historical trends in this classical tradition, through periods of Romanticism to the present day. They argue that Ancient Greek thought became mediaeval and Euro-American thought. Despite the Romanticism of the late eighteenth and early nineteenth century, nineteenth and twentieth century ideas were, and still are, dominated by the quest for an objective science based on rationalism. The underlying philosophy of the Enlightenment (also known as the Age of Reason), has survived into the present day and is now identifiable within scientific positivism (Lazarus & Lazarus, 1994; Robinson, 1999).

Lutz (1995) notes how emotion is still conceptualised as irrational and disadvantaged to cognition. Ellsworth (1995) argues that such a preoccupation with emotion being 'not of the mind' has led to an obsession within experimental psychology to focus on bodily measures, thereby stultifying the research process. However there are now challenges to this conventional view of emotion as irrational and separate to reason. Lazarus & Lazarus (1994) argue that emotion and reason are synonymous. They emphasise the

importance of the subjective experience of emotion, because without understanding an individual's goals, values and beliefs, context and nature of an event or situation, they argue that one can not fully understand the logic, or appraisal process, which leads to a particular emotion. Furthermore, they argue that to label emotion as irrational is actually expressing the lack of understanding by the external observer, as every emotion has its own implacable logic. Hochschild (1983, 1990) also argues for the usefulness and logic of emotion, in that if context is considered, the emotion being experienced and expressed is justifiable to the individual.

Lazarus & Lazarus's (1994) proposal of implacable logic raises the issue of subjectivity, in that one has to value and attempt to appreciate subjective experience in order to understand the nature of emotions. They argue that emotions are a product of personal meaning. Each emotion has a distinctive dramatic plot that reveals the personal meaning an individual has assigned to an event, which in turn arouses a particular emotion. They go as far as to argue that this implacable logic is rarely violated, even when someone is mentally ill. An individual who manifests paranoid behaviour may become angry and afraid in the belief that someone wants to harm them. However irrational their emotions might seem to the external observer, the link between the judgement and the feeling is sensible, even when the judgement is erroneous (Lazarus & Lazarus, 1994).

Despite the domination of the conventional view of emotion, some psychologists now argue there is a large component of thought and meaning

in all emotional reactions we construct (Averill, 1995; Ellsworth, 1995; Salovey & Sanz, 1995): that there is no emotion without thought or reason, and that emotions are indeed a product of the way we personally construe what is happening in our lives. Appraisal involves intelligence and reasoning (Lazarus, 1995), and if this is not considered and acknowledged then it would be difficult to ever understand emotions. When referring to appraisal, it is generally meant that evaluations which contribute towards an emotional state are representative of a circumscribed stage in an information-processing sequence that leads to emotional reactions (Parkinson, 1995).

Considering appraisal further, there appears to be a problem in determining its temporal nature; does appraisal precede emotion, or does emotion precede appraisal (Reisenzein, 1995). One could rephrase this to ask is emotion determining thought or vice versa, which places one in danger of separating thought out from emotion in definitional terms. This raises further important theoretical considerations. Due to the nature of traditional research design, there has been the need to determine cause and effect which requires identifying and labelling appropriate variables. However Parkinson (1995) argues appraisal theory should not be applied so simplistically. Rather than starting with appraisal to determine a causal process, appraisal continues as emotion occurs and is part of that emotion, so avoiding separation of the phenomenon (Parkinson, 1995). The four-factor model proposed by Parkinson et al. (1996), outlined in chapter 3, not only locates emotion as part of the cognitive process, but also suggests that emotion is communicative rather than

merely reactive.

The aim of this chapter is to consider emotion and reason as interactive and continuous, rather than separate and in opposition. It is therefore necessary to focus upon and examine subjective experience. Of particular interest is the impact the conventional view of emotion has upon the emotional self. Lazarus & Lazarus's (1994) argument that emotion has an implacable logic implies that subjective emotional experience makes sense to the individual for much of the time. Understanding of the appraisal history can help the individual to make sense of their feelings, particularly for emotions that have been unconscious and have then crossed over to conscious awareness (Lazarus, 1995). Therefore, it would seem there is a potential for tension to arise between private subjective emotional experience and such a prevailing worldview (Landman, 1995). As previously stated Bakhtin argues ideology has a profound impact upon people's social lives, and that there is a clear need to develop a more thorough understanding of this (Shotter & Billig, 1998).

To be able to access the subjective, it was necessary to focus enquiry upon the language people used when talking about emotional lived experiences. Shotter & Billig (1998) say the move to the dialogical enables us to focus on peoples' social practices, as words are a living social process. Bakhtin states that ideology is reflected in language (Bakhtin, 1981). As previously noted, through focusing on language Parrott (1995) found lay and academic conceptions of emotion differed considerably. It is argued his

findings represents an antinomy, as often do the philosophical conceptions of emotions and the language used to represent them (de Sousa, 1987). de Sousa (1987, 1995) talks of the ambivalence surrounding emotion, as there are often two interpretations for the same emotion; pride, jealousy, anger can all be conceptualised as good or bad at different times. Thus the language used to represent emotion categories has fluid meanings, reflecting the antinomy in emotional existence (de Sousa, 1987, 1995). It is argued that tension could be created through such antinomies in both the language used to represent emotion, and the dominant ideology governing emotion, in this case emotion as irrational in parallel with emotion as functional.

Method

Refer to the method section of chapter 4. The presentation of findings from the qualitative interview study, in this chapter, concentrate on the dominant ideology of rationality and reason for the impact on the way emotion is conceptualized, and thus experienced. Of particular interest is the way emotion has traditionally been separated from and defined in opposition to rational thought and cognition.

Results/Discussion

Several core patterns of discourse were evident in the participants accounts, but for the purpose of this chapter, rationality shall be concentrated upon with reference to separateness from emotion, and the subjective-objective divide.

Discourses of rationality were referred to frequently to imply that particular emotional experiences were irrational, and therefore in need of being 'rationalised' in some way. Irrationality is a particularly powerful discourse in Western culture, as it immediately removes credibility from that with which it is associated. Therefore to construct emotions as irrational can potentially position them as unimportant and inconsequential. Objective and subjective discourses also frequently accompanied discourses of rationality, which it is argued are linked to the conventional values associated with mainstream science. Also there was evidence of much contradiction in the accounts; emotion was positioned as separate from thought and cognition, and also represented in dialogue as being bound up with reasoning processes. These issues shall be explored with reference to selected extracts of transcribed text.

As mentioned discourses of rationality were frequently utilized. Bill is a twenty-nine year old manager, and he says,

254 "I mean if someone's lookin' at the situation from the outside
 255 what would they see and () try an' rationalise. Cause generally
 256 speakin' moods are pretty irrational they're very personal ()
 257 sort of subjective () so you need to try an' () try an' grasp an
 258 objective angle on it".

By referring to emotion as irrational the dialogue performs the function of positioning it as an entity that cannot be understood, or that which has no

legitimate meaning. In mainstream science, based upon a positivist paradigm, the key aim is to be able to understand and to know (Guba, 1990). Possession of knowledge in a form of that which makes sense is therefore paramount. Mood here is referred to as being irrational, which therefore is in need of being made sense of, or 'rationalised'. This suggestion implies that, in its natural state, mood is lacking or somehow insufficient. Also the subject and object are alluded to. The way the words 'irrational', 'subjective' and 'personal' are interwoven performs several functions. Linking irrationality to the personal renders private emotional experience as an entity that has no legitimate meaning, and so is devalued. This is reinforced by use of the word 'subjective'. Again conventional science attempts to eliminate subjectivity as far as possible in the quest for knowledge that can boast truths and facts, which is validated by independence from the object under scrutiny (Guba, 1990). As science does not value subjectivity, associating moods with the subjective serves to de-emphasize its importance in the hierarchy of knowledge and experience.

Within this text there is evidence of tension in the lived experience of emotion. Bill refers to mood as a private, subjective experience. Here private experience is associated with the irrational, and maybe it is experienced in such a manner for some of the time for Bill. However the dialogue positions the self as being required to cross the divide, to an objective *preferred* reality, which will give a more valued sense of meaning to the private self. Several lines further in the same transcript Bill says,

262 “the more you do it the easier it gets () t’ to be sort of more
263 objective an’ stand un’ sort of stand away from yourself an’
264 not an’ not wrap yourself up in the in the person.

The dialogue locates the subject and object in opposition, and advocates that the self should somehow be able to view subjective experience from an objective position. Here we can see the impact of dominant ideology upon lived experience, reflected in the link between discourse and the conventional view of subjectivity. Such a suggestion upholds a purist-realist epistemology (Guba, 1990). In the text this belief is transferred to the self as being able to gain ‘real’ or a more valid understanding of emotion through somehow casting off or standing outside of the inner private self. This implies that the individual should reject private reality and seek a more detached existence, leading to increased greater self-awareness, which is in itself contradictory and could lead to tension within the self. However the need to somehow apply and uphold objectivity, over and above private subjective experience, occupies the favored position in the dialogue.

For the women participants who took part in the study, emotional experience was also frequently referred to through discourses of rationality and reason. Millie is a thirty-three year old professional woman. She is talking of emotion generally and the kinds of things that might make her emotional, and she says,

247 “You know all the women in my family are fairly emotional
248 about sort of () but all the men seem to be very level-headed
249 about () don’t worry about it until you know what’s going on”.

In the text level headedness is contrasted with emotion. ‘Level-headed’ carries several meanings. Level implies a sense of balance, that something is uniform and equal. Headed refers to being of the head. Level-headed carries meanings such like calm, composed and self-possessed. The authors’ interpretation of head in this particular word context implies reference to thinking and cognition, and level meaning balanced. Thus was derived the meaning of balanced thinking, or balanced cognition. Within such an interpretation one can see how emotion is again contrasted with cognition and balanced reasoning, and conceptualized as being not of the mind. Therefore emotion is positioned as both separate and opposite to reasoning or thinking.

Interestingly the individual makes reference to gender distinctions. Women are affiliated with emotion and men are associated with level-headedness, which is consistent with Western conceptions of masculinity and femininity (Golombok & Fivush, 1994; Lutz, 1995; Ussher, 1989).

Dominant ideology is influential throughout much of the dialogue. Joe is a twenty-five year old man, and he says of feelings,

7 “a feeling is kind of separate maybe from a thought or it

8 may actually be () generate a thought or it might influence that
9 thought () um” in the sense that you can () you can feel
10 perhaps () um’ low or depressed and that may influence your
11 thinking in a sense of what kind of what kind of thoughts are
12 going through your head at the time”.

Thought and emotion are positioned as two separate entities, which is consistent with classic Mediaeval and Euro-American notions. This is consistent with the way Lazarus & Lazarus (1994) and de Sousa (1987) traced the origins of such notions. The dialogue maintains that emotion is detached from thoughts and thinking. However there is also an element of ambiguity present within the text, which can be detected through use of the words ‘maybe’, ‘might’, and ‘perhaps’. This, it is argued, is representative of tension within the lived experience of emotion for the individual. Conventional ideology strongly influences the way the individual believes emotional experience should be conceptualised and defined, yet it is not necessarily the actual lived reality for the self. *Generate* and *influence* imply that the emotional experience is not as disconnected as first conceptualised, that emotion is linked to cognition. However it is interesting to note that the link is constructed within a causal framework, namely that emotion influences thinking. This raises some important considerations. Firstly appraisal theory holds that cognition has to precede emotion (Lazarus, 1984), which is not the case in the dialogic meaning. The discourse does, however, lend support to

the ideas of Parkinson et al. (1996) that emotion can precede cognition and vice versa. Secondly, there is no alternative discourse available for people to be able to talk about the rich, interactive nature of emotional experience. This, it is argued, is because the cause-effect, separate conventional view still occupies the most powerful position in Western society.

Although emotion is conceptualised as irrational and separate from reason for much of the time, the eventual reality can be quite different, which is reflected in the contradictory nature of the dialogue. Fred, a 31 year old man is talking about a particularly intense emotional time in his life when he had split up from a girlfriend. The relationship was very superficial, but it had rather more of an impact upon him than he expected. He says,

46 “ It was really quite strange () um’ because it just *hit me* ()
47 harder than probably anything’s ever hit me before but () for no
48 apparent reason. It was really strange it was a relatively short
49 relationship it wasn’t something that () wasn’t something that
50 should have hit me as hard as it did () if that makes sense. So the
51 feelings associated with it were really quite bizarre and difficult
52 to cope with () um’ but () having () gone away an’ thought
53 about it a little bit () I mean () purely my interpretation of things
54 but it seemed to work out for me”.

The dialogue is clearly very rich and powerful. Firstly the individual

constructs the emotional experience as not having any logical or reasonable meaning attached to it, as is evident in use of the words ‘no apparent reason’. As a result of this seeming lack of understanding, the individual experiences the emotional self as problematic. Such meaning is evident in the interweaving of the use of the words, ‘strange’, ‘bizarre’, and ‘difficult to cope with’. No apparent reason and bizarre implies that the experience does not ‘make sense’. The self is having difficulty understanding just that, subjectivity. However because emotional experience is not separate from cognition (Lazarus & Lazarus, 1994), the individual does eventually locate and identify the personal meaning attached to the experience. Use of the term ‘thought about it a little bit’ is interpreted as the point at which the individual finally experiences the emotional self as a totality, the interpretation identifying with Harré’s (1998) notions of the self being singular, yet experiencing multiple aspects. When the interaction between the actual emotional experience and the mind are constructed as synonymous, the emotional experience no longer seems nonsensical. This is consistent with Lazarus’ (1995) argument that once the emotional experience is considered within the evaluation of the appraisal process, emotion does make sense. Again there is still tension evident in constructing the self through subjectivity, evident in the dialogue “purely my interpretation of things”. Yet subjective introspection does lead to understanding of the emotional self in this case. Indeed in the remainder of this text Fred constructs himself as an individual who makes sense of emotional life events and reactions by

allowing the subjective self legitimate voice.

Parallels between dominant ideology and the subjective-objective divide represent a complex interplay between traditional ways of conceptualising emotion, and the influence of modern scientific values on emotional experience. The interweaving of rationality with objectivity locates subjectivity with emotion. The preferred way of 'being' in Western society is to be rational and objective, because these are representations of the more valued view; awarded their privileged status through mainstream science. Objectivity is construed as rational, and emotion as irrational because of its subjective nature. However, the antinomy lies in the discourses of emotional experience, in that subjective private experience of emotions are not irrational. Once the individuals allowed their selves a sense of reflected totality, they placed the emotional reaction into a context of personal meaning within their life. Emotions did make sense to the participants, which is consistent with Lazarus's (1995) ideas of emotion being a manifestation of personal meaning. Yet they still maintained throughout much of the dialogue that emotions are irrational, and were experienced as such for some of the time.

The separateness of emotion from reason was also evident for much of the time in the dialogue. Yet participants also used conflicting language to represent the interactive nature of the two entities when giving various accounts of how they thought about their feelings to make sense of their lives, and feelings were part of their thinking. These accounts reflected the constant interplay of forces active within lived experience (Bakhtin, cited in Shotter &

Billig, 1998). Thus emotion may be experienced as irrational for some of the time, until the individual allows a sense of value to be attached to their private singular experience. In conclusion, the separation of emotion and reason is erroneous. Emotion depends on reason and thought, thus supporting Barbalet's (1998) proposition of a radical approach.

The key dominant ideology identified is one of scientific rationalism, which has survived for several thousand years (Robinson, 1999). The dominant ideology of reason, accompanied by a dialogue of objective emotional reality, occupied the favoured position within participants' accounts. Such discourses represent the tensions, created out of antinomies, evident in emotional lived experience. The main dialogic antinomy concentrated upon in this chapter was that of emotion as subjective, singular and private versus an objective view of self. Emotion was positioned as being subjective and private, reflecting personal meaning. Yet participants also talked of a need for an 'objective' emotional reality, which should somehow be separate from subjective emotional experience.

Participant accounts contained references to representations of meaning for different, shifting levels of awareness of emotion. For some of the time participants were consciously aware of their feelings. At other times they could not understand the nature of the emotion until they had located the feeling from some past experience, which had been seemingly unconscious to them. There is much debate surrounding the impact and significance of conscious and unconscious appraisal of emotion (Anderson, 1995; Kitayama

& Masuda, 1995; Lazarus, 1995). Further investigation in to the nature of emotion that has been retrieved from the unconscious would be valuable, particularly from a subjective view point. Types of triggers and the point of recognition at which the individual registers an emotional experience from some previous time could help us to gain an understanding of both the impact such realisations have upon the individual, and the way they manage such processes within lived experience.

This concludes the presentation and examination of findings from the qualitative interview study, which was conducted to gain an insight in to what it means to be emotional as part of everyday lived experience (Parrott, 1995). It was believed that attempting to describe emotional experience, rather than merely quantifying it was particularly necessary as part of this thesis, to be able to meet the objective of furthering understanding of emotional experience in relation to premenstrual syndrome. Ideology was found to have a profound impact on individual experience, which strengthens the argument that it is not enough to merely suggest biology equals emotional liability in a traditional causal reasoning sequence. Attention now turns to the more specific focus on assumptions surrounding the concept of premenstrual syndrome itself.

Chapter 7

Manipulating Participant Awareness

The last three chapters have explored ways in which dominant ideologies can impact on emotional lived experience. Now the focus begins to turn to the influence of popular assumptions surrounding premenstrual syndrome. This chapter reports findings from a study that involved comparison of two participant groups on a number of variables known to be important in emotional control. The main purpose of this study was to establish whether participant responding would be affected by manipulating participant awareness of the purpose of the study. Part of the way research findings are critically evaluated should take in to account the impact of the research process on respondents. Often just being a participant in a study can affect the way an individual responds to questions. Sometimes, for example, participants may attempt to respond to questions in a manner believed to please the researcher, or in a way which reflects current socially acceptable or politically correct attitudes and beliefs, often referred to as response bias (Breakwell, Hammond & Fife-Schaw, 1995). This chapter is specifically interested in the way popular assumptions governing premenstrual syndrome may influence participant reporting when taking part in research about premenstrual syndrome because previous research has found participants can respond in ways which are tapping popular beliefs rather than actual experience.

There is much evidence to suggest that participant response is based on popular assumptions rather than personal experience when taking part in research about premenstrual syndrome, which was outlined in chapter 2. For example, Koeske & Koeske's (1975) work found evidence to suggest social conditioning that upholds cultural beliefs can strongly influence the way participants report on menstrual cycle related mood change. They found that participants displayed clear-cut attributional patterns linking negative moods, such as depression and irritability, to the premenstrual phase of the menstrual cycle. Also Ruble's (1977) work on social expectancy found that participant reporting was distorted in line with popular social perceptions governing premenstrual syndrome.

Aubuchon & Calhoun's (1985) work is also of particular relevance. They found evidence to suggest women's reporting of psychological and somatic symptoms was influenced by awareness of the purpose of the study in line with the premenstrual stereotype. All participants were screened using the general health questionnaire (Banks, Clegg, Jackson, Kemp, Stafford & Wall, 1980), and all reported their menstrual cycles to be regular with no dysmenorrhoea. Women who were informed the study was about premenstrual syndrome reported more somatic and psychological symptoms in the premenstrual and menstrual phase than the comparison groups.

Given previous findings and the continued persistence of beliefs upholding premenstrual stereotypes (examined in chapter 2), it is reasonable to suggest that participant awareness of study aim can significantly influence responding. Therefore using two separate groups of participants (group 1 = informed the study was about

mood/ affect and premenstrual syndrome, group 2 = believed the study was about mood and affect over a typical working week), it was hypothesised there would be differences on reporting between the two groups as a result of study awareness. Affect, mood awareness (Swinkels & Giuliano, 1995), negative mood regulation expectancy (Catanzaro & Mearns, 1990), mood regulatory strategies, menstrual cycle phase and premenstrual symptoms were assessed for both groups. These variables are known to be important in the experience of affect and mood regulation, and were examined in chapter 1. The specific predictions are that participants in the aware condition will respond in a manner that is in line with premenstrual stereotypes. The reporting of positive and negative affect will be affected by cycle and condition; the aware group will report more negative affect, and less positive affect, by cycle. Also the reporting of mood monitoring across cycle will be affected by condition; the aware group will report more mood monitoring. Finally reporting of the use of mood regulation strategies will be affected by condition; the aware group will report using less regulation strategies. This is because if a participant believes a negative mood is due to the menstrual cycle, they are less likely to attempt to change the mood if they believe the cause is biological.

Method

Participants

A total of 76 participants took part in the study. Their average age was 20 years, ranging between 18 – 47 years (most frequently occurring age = 18). The sample consisted of undergraduate students from the University of Leicester. For

participation they each received course credits as part of their degree program. At the time of the study 19 participants were taking some form of medication, leaving 56 participants not taking any form of medication (1 missing case). 14 Participants were male, and were included in the unaware condition, leaving 62 female participants who were divided randomly between the two conditions.

Design / Materials

Awareness of the purpose of the study and gender in the unaware group were the independent variables: the dependent variables being the responses of participants, which are dependent on awareness. A questionnaire was compiled for the specific purpose of the study, and consisted of five sections (see appendix 2). Section one concerned personal details such as age, gender, and a declaration of whether any medication was being taken at the time of the study. Section two was concerned with general information about moods and emotions. The first part of section two utilized the Positive and Negative Affect Scales (PANAS, Watson, Clark & Tellegen, 1988). These are two ten-item mood scales which have been shown to demonstrate a high internal consistency, and good test-retest reliability. The scales are each comprised of ten adjectives that describe different feelings and emotions. Ten words relate to positive affect: interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, active. Ten words represent negative feelings: distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery, afraid. The twenty words are placed in a mixed order with a small space next to each word. Participants were instructed to think about how they were feeling 'now', and to

respond by placing a number next to each word in the space provided. Response options given for participants to select from are 1 = very slightly or not at all, to 5 = extremely. Scoring the scales involved summing the ten items for positive affect to obtain an overall measure of positive affect, and the ten items for negative affect to obtain an overall measure of negative affect.

Mood awareness was assessed in section two by utilising the scale developed and psychometrically validated by Swinkels & Giuliano (1995). The scale consists of two 5-item dimensions (monitoring and labelling) scored on a 6-point Likert scale (1 = disagree very much to 6 = agree very much). Each of the respective five items relating to the two dimensions were summed separately, with four items being reverse scored prior to being summed (3 items relating to mood monitoring, and 1 item relating to mood labelling).

Finally within section two, expectancy of negative mood regulation was assessed using the negative mood regulation scale (Catanzaro & Mearns, 1990). This is a thirty-item scale which taps the belief that some behaviour or cognition will alleviate a negative mood state. Participants were required to respond by selecting the most appropriate response on a Likert scale ranging from 1 = strongly disagree, to 5 = strongly agree.

Section three concerned information about moods and emotions from ‘yesterday’. This was so that a measure of emotion on at least two occasions could be obtained. Again the Positive and Negative Affect Scales (Watson, Clarke & Tellegen, 1988) were used to assess affect, but with instructions to think about the extent to which participants were experiencing the particular feelings and emotions

‘yesterday’. This was followed by the mood awareness scale (Swinkels & Giuliano, 1995) again, but with instruction to think about and answer for ‘yesterday’.

Section four consisted of eight mood regulation strategies, concerning which participants were asked to rate how much or little they used each when attempting to regulate their mood. Responses were required as a mark placed along a line from 0-----+. For the purpose of analysis the line was divided into ten units in order to convert responses in to a numeric form, 0 = indicating zero, and + indicating ten. The strategies were devised as part of a larger, separate research project undertaken by Parkinson, Totterdell, Briner & Reynolds (see Totterdell & Parkinson, 1999). They consisted of 1) Did something else: relaxing/enjoyable, listing six examples, 2) Did something else: energetic/active, followed by six examples, 3) Got support from others, followed by six examples, 4) Thought about something else, followed by six examples, 5) Tried to solve things, with six examples, 6) Looked at things differently, with six examples, 7) Avoided thinking about things, with six examples, and finally 8) Let my feelings out, with six examples.

Finally section five was intended to obtain information about the menstrual cycle and menstrual cycle related changes/symptoms. Menstrual cycle phase was recorded by setting out three segmented phases along a line. Participants were instructed to tick one of the three phases that represented where they were in their menstrual cycle. Options consisted of 1 = the menstrual phase (when bleeding occurs), 2 = the intermenstrual phase (after bleeding has finished, between your menstrual and premenstrual phase), and 3 = pre-menstrual phase (a week or so before

bleeding recommences). It was felt this should be kept as simple as possible to avoid confusion and to promote accuracy of response.

An 11-item symptom rating scale was devised to gain information on absence or presence of symptoms, and severity. Five of the items related to affective change (irritability, tension, mood change, anxiety, depression) and the remaining six items covered somatic change (fluid retention, pain, fatigue, muscle tension, hot flushes, food cravings). The items were chosen on the basis of being among the most frequently reported symptoms in the literature on premenstrual syndrome. Responses were rated on a 4-point Likert scale (1 = never, to 4 = most of the time). This completed the questionnaire, at which point participants were thanked for their time (see appendix 2).

Procedure

For recruitment purposes an advert was placed on the first year psychology undergraduate board, inviting individuals to take part in a short questionnaire study concerning mood and feelings, which would take approximately 25 minutes. When sufficient numbers were recruited the study was conducted in the psychology department. Two adjacent rooms were selected for use. Participants were informed of the venue and time at which the study was scheduled to take place, again by placing the information on the notice board. Three assistants were required to carry out the study: one person standing between the two rooms to receive participants as they arrived, and two further people to occupy the rooms. On arrival female participants

were randomly assigned to the two rooms, the males automatically being assigned to the 'unaware' condition/room (Note – inclusion of males was partly to avoid specifying “women only” on adverts which might have partly undermined lack of awareness of study focus).

The questionnaire was set out in the two rooms, face down on several tables. Participants were seated then read a set of instructions stating the purpose of the study, and how the questionnaire was to be completed (see appendix 2). Group 1 consisted of all females (N = 33) who were instructed the study was about premenstrual syndrome, moods and emotions, and whether people regularly try and change their moods in some way. Group 2 consisted of a mix of male and female participants (N = 43, 14 males, 29 females), who were instructed the purpose of the study was about how people might try to control their moods and emotions during a typical working week. Participants were instructed to begin completing the questionnaire simultaneously. The process of completing the questionnaires took approximately twenty-five minutes, and was conducted in silence. On completion of the questionnaires all participants were thanked for their participation and allowed to leave.

Results

Data analysis was conducted using the SPSS package. Analysis of variance was conducted in a variety of combinations of independent factors and conditions, to establish whether there were any significant differences in reporting between the two groups (group 1 = aware condition, group 2 = unaware condition) on the measures

used, and also as a result of cycle phase. A between subjects analysis of variance found no significant differences on reporting for current negative affect for cycle by condition. There were no significant main effects and no significant interactions. A between subjects analysis of variance also found no significant reporting differences for current positive affect for cycle by condition. However a between subjects analysis of variance found a significant main effect of phase on negative affect 'yesterday', ($F(1, 57) = 6.529, p \leq 0.05$). Negative affect was reported to be higher during the intermenstrual phase for the aware group ($M = 2.18$) than for the unaware group ($M = 1.63$).

A one-way analysis of variance ignoring cycle phase was conducted separately for each regulation strategy by condition (1 = aware, 2 = unaware, 3 = males), revealing no significant reporting differences on seven out of the eight strategies. The only significant reporting difference was found for venting feelings by letting them out in some way (e.g. shouting, crying, letting off steam, breaking something and so on), ($F = 2, 73) = 4.07, p < 0.05$). A Student-Newman-Keuls test revealed the difference to lie between two conditions. The males (3) and the unaware group (2) together formed the unaware condition, and the aware group (1) were the all female aware condition. The aware condition ($M = 3.64$) reported to use regulation strategy 8 significantly more than the unaware condition ($M = 2.27$ for group 2, $M = 1.50$ for group 3).

Table Displaying Location of Mean Differences

Table 1.

* Indicates, from student-Newman-Keuls test, where the differences lies.

		Group 3	Group 2	Group 1
Mean	Condition			
1.5000	Group 3			
2.2759	Group 2			
3.6364	Group 1	*	*	

Thus the aware condition (group 1) reported to use strategy eight more than group 2 or 3, which together comprised the unaware condition.

Correlational Analyses

A Pearson correlation matrix was constructed, which revealed several significant relationships between variables. Negative mood regulation expectancy and mood labeling were positively associated ($r = .36, p < .01$). Negative mood regulation expectancy and mood monitoring were negatively associated ($r = -.28, p < .01$). Symptoms were found to be positively associated with mood monitoring ($r = .26, p <$

.05), negative affect yesterday ($r = .40, p < .01$), and negatively associated with negative mood regulation expectancy ($r = -.36, p < .01$).

Table 2.

Table Displaying Results from a Pearson Correlation Matrix

	MM Now	MM Yest	ML Now	ML Yest	Neg Affect Now	Neg Affect Yest	Pos Affect Now	Pos Affect Yest	Neg Mood Reg Expncy
Symptm	.2679 p= .035	.1936 p= .132	-.0472 p= .716	-.2278 p= .075	.1863 p= .146	.4004 p= .001	-.1820 p= .157	-.4514 p= .000	-.3620 p= .004
Reg Strat1	-.1798 p= .120	-.0725 p= .534	.1603 p= .167	.0296 p= .800	-.0219 p= .851	-.0986 p= .397	-.0362 p= .756	-.0815 p= .484	.1941 p= .093
Reg Strat2	-.0722 p= .536	-.1284 p= .269	.0088 p= .940	.0729 p= .531	.1760 p= .128	-.0405 p= .728	.1385 p= .233	.3522 p= .002	.1863 p= .107
Reg Strat3	.0072 p= .951	.1822 p= .115	.2846 p= .013	.1874 p= .105	-.1305 p= .261	.1654 p= .153	.0079 p= .946	-.0581 p= .618	.1410 p= .224
Reg Strat4	.0974 p= .403	.1035 p= .374	.1825 p= .115	.0654 p= .575	-.0238 p= .838	-.0442 p= .705	.2394 p= .037	.0964 p= .407	.3887 p= .001
Reg Strat5	.2471 p= .031	.2943 p= .010	.2298 p= .046	.0195 p= .867	-.0175 p= .881	.1522 p= .189	.3246 p= .004	.0407 p= .727	.1966 p= .089
Reg Strat6	.0979 p= .400	.1530 p= .187	.1846 p= .110	.0831 p= .475	.0599 p= .607	.0331 p= .777	.1985 p= .086	.1352 p= .244	.3873 p= .001
Reg Strat7	.0438 p= .707	.0271 p= .817	-.3038 p= .008	-.3186 p= .005	.2515 p= .028	.2207 p= .055	-.1677 p= .148	-.1360 p= .242	-.2662 p= .020
Reg Strat8	.1129 p= .332	.1002 p= .389	.1294 p= .265	.0103 p= .930	.0872 p= .477	.3647 p= .001	.0827 p= .477	-.1620 p= .162	.1214 p= .296
Neg Mood Reg Exp	-.2807 p= .014	-.0982 p= .399	.3673 p= .001	.2043 p= .077	-.2423 p= .035	-.1931 p= .095	.1712 p= .139	.1272 p= .274	

Discussion

Negative affect was found to be higher, although not significantly so, during the intermenstrual phase of the cycle, rather than the pre and menstrual phase. Strategy eight, which refers to venting feelings, was reported as being used more by participants in the aware condition, than those in the unaware condition (including both male and female participants). Finally negative mood regulation expectancy was positively associated with mood labeling and negatively associated with mood monitoring. Symptoms were positively associated with mood monitoring and negative affect, and negatively associated with negative mood regulation expectancy.

The present study was conducted to establish whether manipulation of participant awareness of the core study aim would influence reporting. It was hypothesized there would be a difference in reporting between the two conditions: an aware group and an unaware group. The aware group would report on the measures, particularly symptoms and negative affect, more in line with the premenstrual stereotype. However there were no main significant differences on reporting between the two groups on the measures in line with popular assumptions governing premenstrual syndrome, except for the use of venting as a mood regulation strategy. This strategy refers to venting feelings by letting them out in various modes of expression. Examples given for this strategy were shouted, screamed, let off steam, cried, started a fight/argument, broke something and got it out of my system. Results showed the aware group reported using this strategy more than the unaware group. This is interesting because often it is believed feelings should be controlled,

particularly at the level of expression (see chapter 5). It is suggested the result is due to the awareness of the core aim of the study. Participants in the aware condition reported letting their feelings out more in line with the premenstrual stereotype, the reason being twofold. In the first instance it is often believed women are more emotional as a result of their hormones, especially around the premenstrual phase of the menstrual cycle (Walker, 1997; Swann & Ussher, 1995; Bancroft, 1995; Ussher, 1992). Thus reporting was in line with the premenstrual stereotype. In the second instance, Ussher (1991, 1997) notes how women are not permitted to let out negative feelings such as anger. However she argues premenstrual syndrome does permit women to legitimately vent their feelings, particularly anger, with the explanation that they are being controlled by hormones. Thus it is suggested participants in the aware condition may have felt more able to report venting feelings because they believed the study was about premenstrual syndrome and mood.

In addition to participant awareness there were several significant associations evident between mood awareness (Swinkels & Giuliano, 1995), negative mood regulation expectancy (Catanzaro & Mearns, 1990), affect (Watson, Clarke, Tellegen, 1988), and symptoms reported. Negative mood regulation expectancy was found to be positively associated with mood labelling, and negatively associated with mood monitoring for the whole sample. This is consistent with assumptions that mood monitoring predicted less success at self-regulating mood/affect but mood labelling predicted a higher degree of success (Swinkels & Giuliano, 1995). Secondly symptom reporting was positively associated with mood monitoring, which is consistent with Swinkels & Giuliano's findings that a high degree of monitoring,

compared to low, predicted the experience of somatic symptoms. Symptom reporting was also positively associated with a higher degree of negative affect, which is understandable, and negatively associated with negative mood regulation expectancy (the higher the degree of symptoms, the lower the expectancy of regulating negative mood). These findings are significant in that they replicate findings by Swinkels & Giuliano (1995). They also justify further examination of mood awareness for the potential affects on emotional well-being.

Limitations

Despite collecting information on participant mood ‘yesterday’, the measure of mood/affect obtained was a static one-time retrospective measure, which attracts the associated problems already discussed (see chapter 1). Also the study failed to find any reporting differences on reported negative affect between the two conditions. This is surprising given that negative feelings are commonly associated with premenstrual syndrome (discussed in chapter 2). Of the 29 female participants in the aware condition, eight reported being in the premenstrual phase of the cycle at the time of the study. One of the reasons for failure to find any such differences may be because none of the participants in the aware condition were sufferers of premenstrual affective disturbance. The design of the study did not permit this information to be obtained. Participants may have also felt positive/happy at the time of reporting. However in the same instance the study was designed from the rationale that popular assumptions can influence symptom reporting, regardless of personal experience.

Summary

Results suggest that awareness of the study's aim resulted in reporting a higher degree of use of venting of feelings, thus partially confirming the hypothesis. Female participants in the aware condition reported venting their feelings more than either male or female participants in the unaware condition. It is believed this may be due to participants in the aware condition feeling more able to report the expression of their feelings because they were primed by the focus of the study; premenstrual syndrome and mood/emotions. Part of the premenstrual stereotype incorporates moody women (Walker, 1997), and women suppressing their feelings less (Ussher, 1997). Thus it is reasonable to suggest the influence of popular assumptions governing premenstrual syndrome enabled participants in the aware condition to report that they actually allowed more expression of feelings in order to regulate the way they feel.

Secondly, mood monitoring was found to be positively associated with symptom reporting and negatively associated with negative mood regulation expectancy. Mood labelling on the other hand was positively associated with negative mood regulation expectancy. Furthermore symptoms were positively associated with the reporting of negative affect, and negatively associated with negative mood regulation expectancy. This provides support for Swinkels & Giuliano's (1995) work, that the type of mood awareness displayed can have different affective consequences on overall emotional well-being. Such findings lend support to conduct further

research in to the style of mood awareness displayed in women who are known to suffer from premenstrual syndrome, particularly affective symptoms.

Chapter 8

Mood Awareness and Women's Experiences of Premenstrual Syndrome.

It was argued in chapters 4, 5 and 6 that factors apart from biology have a significant impact on subjective experience and outward expression of emotion. Chapter 7 then went on to test the hypothesis that popular beliefs surrounding premenstrual syndrome can have an impact on research. Results were particularly interesting, because although reporting in the aware condition failed to display a significant pattern for positive and negative affect in line with premenstrual syndrome, a significant difference in reporting was found for emotional expression. Now the focus shifts to self-diagnosed sufferers of premenstrual syndrome. The aims of this study were: firstly to establish whether there were any significant relationships between a number of variables that are known to be important for emotional well-being (highlighted in chapter 2), in a group of women suffering from premenstrual syndrome: and secondly, turning to subjective experience to gain a deeper understanding of what premenstrual syndrome means for this group of women. It is believed the epistemology of the present study should enable women to be able to express what premenstrual syndrome means for them, taking up recommendations by Ussher (1996), Swann (1997) and Walker (1997) to help overcome the current impasse in menstrual cycle research. The rationale for the study utilised a combined methodological approach (Tashakkori & Teddlie, 1998) to achieve the two core objectives. At first glance, the reader may feel that collecting both numeric and

written data is fairly standard practice. However for this study, the weighting given to the written data of subjective account was considered as valid as the numeric information.

An individual's awareness of his or her own mood has been found to have a significant bearing on emotional well-being (Swinkels & Giuliano, 1995). It is argued that self-awareness, in particular mood awareness, may be positively associated with the premenstrual phase of the menstrual cycle in women suffering from premenstrual syndrome. This is in part due to what is believed to constitute the main component of the syndrome, in the absence of a consensual definition, the timing factor (Asso, 1983; Bancroft, 1993, 1995). Researchers have focused on the premenstrual phase of the cycle as a cause of distress associated with menstrual cycle change because of the decline of hormones oestrogen and progesterone in the days leading up to the onset of menses (Rodin, 1992). Not only has this focus been dominant within the medical and academic research forum, but it has also formed the basis of popular held beliefs of the menstrual cycle in the public domain (Walker, 1997). The idea that women's moods are the result of their hormones during the association through cyclical timing is still evident (Walker, 1997). Therefore it is reasonable to suggest that women who suffer from premenstrual syndrome may be more prone to monitor the way they are feeling during this time in their cycle. Mood awareness was one of the characteristics assessed in the study presented in chapter 7. However the implications of mood awareness and menstrual cycle timing will now be discussed.

According to Swinkels & Giuliano (1995) mood awareness is comprised of two distinct dimensions; a monitoring tendency and a labeling tendency. Mood monitoring refers to the tendency to scrutinize or focus on one's mood state. In contrast mood labeling refers to the ability to identify and give a name to one's mood state. Swinkels & Giuliano (1995) found that high values on the two dimensions have different consequences for emotional well-being. High mood monitoring predisposes the individual to experience affective states more intensely, encounter more negative affect, report neurotic tendencies, have lower self-esteem, agree their moods are important in influencing their behaviour, yet report a low rate of success at regulating their moods. This is linked to Nolen-Hoeksema's (1991) findings that suggested ruminating on negative mood predisposes the individual to prolonged episodes of a depressed mood state. High mood labelers, in contrast to low mood labelers, report higher levels of self-esteem, experience more positive affect, report tendencies of extraversion, are less socially anxious or neurotic, express greater life satisfaction and report greater levels of success at self-regulating their moods.

The point of higher mood monitoring, compared to low, predicting the experience of more negative affect and less success in self-regulating negative mood is important because both are reported symptoms of premenstrual affective disturbance (Bancroft, 1995; Walker, 1997). Therefore it is hypothesized there will be a positive relationship between mood monitoring, negative affect and a lower expectancy to self-regulate negative mood and the premenstrual phase of the menstrual cycle. Also it is predicted that there will be a negative relationship between affect intensity and negative mood regulation expectancy. This is because high mood

monitoring is a form of paying constant attention to, or ruminating on one's mood, which will lead to prolonged negative affect. Swinkels & Giuliano (1995) found high monitoring, compared to low, was associated with a low expectancy to be able to self-regulate mood successfully. Indeed from the study reported in chapter 7, mood monitoring was positively correlated with symptom reporting and negatively associated with the expectancy that one can successfully regulate one's mood. Finally, because menstrual cycle distress is tied to the premenstrual phase specifically, I believe this may lead women to focus more on their moods and feelings around this time in anticipation of feeling less happy.

In addition to mood awareness, affect intensity has also been found to have significant consequences for emotional well-being (discussed in chapter 1). Affect intensity refers to the typical strength of an individual's affective responsiveness, and generalizes across both positive and negative emotions (Flett & Hewitt, 1995; Larsen & Diener, 1987). The degree of affect intensity has been found to influence an individual's ability to regulate their emotions (Larsen & Diener, 1987). Individuals found to be more highly emotionally intense (experience emotions more strongly) experience more frequent shifts in mood, report a greater frequency of somatic complaints, are at an increased risk of developing bipolar affective disorder, and are more likely to report neurotic symptoms (Larsen & Diener, 1978). The point of regulating emotions, experiencing more frequent shifts in mood and experiencing a higher frequency of somatic complaints are symptoms often reported by women suffering premenstrual syndrome. Therefore it is hypothesized that symptoms and negative affect will be higher during the premenstrual phase of the cycle. Also there

will be a negative relationship between affect intensity and negative mood regulation expectancy.

The second aspect of the present study concerns women's experience of premenstrual syndrome. Despite the large amount of research that has been conducted on the syndrome over the past seventy years, there remain many unanswered questions over definition, cause and treatment. As discussed in chapter 2, some researchers are now beginning to argue traditional research design has impeded furthering an understanding of the syndrome, principally on the basis of a preoccupation with generalizability only. Often conventional research methods still only rely on cause-effect principles, attempting to establish commonalities that can be generalized across large-scale populations. In the case of premenstrual syndrome, science has focused on generalizability through gender. A justification of biological functioning has been used to treat women as one homogenous group, which has led to the current impasse in menstrual cycle research. Bancroft (1995) argues future research has to take in to account that although the majority of women experience the menstrual cycle for the larger part of their lives, the way in which changes occur vary greatly from woman to woman. Bancroft (1995) particularly draws attention to the vulnerability of a woman to cyclical change, in that every woman experiences a unique set of life events and stressors. Thus the individual experiences the menstrual cycle from a unique position, and so often generalizability has been difficult to achieve, and therefore needs to be supplemented with additional means of inquiry.

Walker (1997) argues that the reason for why so many differences are found in menstrual cycle research is simply that women *are* so different. More often it

seems to be that experience of the menstrual cycle varies from woman to woman, cycle to cycle and across the lifespan (Walker, 1997). Walker (1997) calls for a paradigm shift in the way menstrual cycle research is conducted, with an emphasis towards words and meanings, rather than numbers and causes only. Thus women should be asked about their experience of menstrual cycle change, of lived experience and ways they manage the changes.

Swann (1997) argues that menstrual cycle experience is rather more complex than a mere biological independent variable or a socially constructed phenomenon. She defines it as an experiential interface resulting in a dynamic interplay of the two. Through a discourse analytic process she was able to gain some understanding of the rules and meanings which framed the lives and experiences of a clinical sample of women who had originally self-diagnosed premenstrual syndrome. Four main discourses were identified as being used discursively by these women to construct their version of premenstrual experience, namely feminine conflicts, mind-body dualism, the determining body, and the body regulating experience. She says that although these were only one group of women's accounts, they revealed how structure and social rules, particularly governing gender, are active in the way women experience their menstruating bodies.

Choi & McKeown (1997) also conducted research based on subjective experience. Their findings revealed how the premenstrual syndrome stereotype was used discursively by a sample of nine undergraduate women to construct their accounts of menstrual cycle change. The participants drew upon the stereotype frequently in their discourse, yet placed the self as separate to the premenstrual

syndrome woman. Although they believed that the 'pms woman' who had no control over her moods, cognitions and behavior because of her fluctuating hormone levels certainly existed, they described actual experience of their changes as 'not being like that'. Premenstrual syndrome was talked about as an extreme, with the participants having a much milder experience. These findings demonstrate how the premenstrual stereotype can influence an understanding of menstrual cycle change.

Swann & Ussher (1995) examined subjective accounts of women's experiences of premenstrual syndrome and found discourses of biology, femininity and bad behaviour, dualism and embodied meaning. They argued that rather than language only being derived from bodily experience, a splitting of a 'premenstrual' and 'normal' self illustrates how discourse may impose meaning upon bodily experience. Therefore many stressful life experiences which would be considered as traumatic in any context other than premenstrual syndrome, were instead positioning the body as the privileged source of distress. Such findings help to understand how these women were accounting for lived experience. Thus it is reasonable to suggest turning to subjective experience has begun to help further an understanding of a deeper sense of meaning of premenstrual syndrome. The present study has, therefore, also focused on subjective experience to establish what premenstrual syndrome means for this group of women.

Method

Participants

A total of 99 women participated in the study. All were members of the National Association for Premenstrual Syndrome (NAPS). This is a national organisation registered as a charity based in Kent and offers support and advice to women who seek help for premenstrual syndrome. Recruitment took part in two stages. NAPS publish a quarterly magazine that is distributed to all members. It covers topics of interest which are relevant to premenstrual syndrome, including treatment options and news of any developments in research. Firstly an article was written in the quarterly magazine, by myself, stating that the University of Leicester was planning to study some aspects of premenstrual syndrome. Then, some months later, included in the mailing of the following quarterly release of the magazine to members were one thousand questionnaire packages (included questionnaire, covering letter of explanation and a freepost return envelope to the University of Leicester). The questionnaire packages were placed in the magazine envelopes randomly by employees from NAPS until the supply was exhausted. NAPS had over five thousand members in total, thus the questionnaires reached approximately one fifth of the membership. The accompanying letter to the questionnaire explained that a study concerning some aspects of premenstrual syndrome was being conducted by the University of Leicester and invited the individual to take part. Confidentiality and anonymity were explained and reassurances given that any information supplied would be used for the purpose of the research only.

A total of 99 completed questionnaires were returned to the psychology department. Unfortunately, the freepost envelopes were dispatched from the psychology department in a separate box from the questionnaires and apparently became lost within the postal system, never reaching the NAPS headquarters. This resulted in the questionnaires being sent out without freepost return envelopes, which it is believed may have affected the response rate. The final response rate was just under 10%.

The average age of participants was 36 years, and ranged between 21-52 years. 60% of the participants were married, with the remainder being either single (20%), divorced (6%), living with partner (11%), or widowed (1%), allowing for missing cases. 25% of the sample reported being employed in a domestic/housewife unpaid capacity, 68% in some form of paid employment, and 4% were unemployed (3 missing cases). One third (33%) of the women were taking an oral contraceptive at the time of the study, but were not excluded as a result.

Of the total sample 47% were taking some form of medication which varied from evening primrose oil, ventolin inhalers for asthma, to beta blocking agents for a heart condition. Use of medication was not used as a criterion for exclusion from the study.

Design

The design of the study utilises a mixed method approach (Tashakkori & Teddlie, 1998). This involved the collection of both quantitative and qualitative data. The quantitative aspect of the questionnaire was designed to assess individual

difference characteristics of mood awareness, affect intensity, negative mood regulatory expectancy, and self-awareness. Order of presentation was as follows. Firstly, a short paragraph set out the aim of the questionnaire and instructions on how it should be completed. Demographic information was then requested. Next a short paragraph explained that although many premenstrual experiences are common for women, there are also aspects that can be unique to the individual. The participant was then invited to write freely about their experience of premenstrual syndrome in their own words (one third of A4 lined space provided). After this, information on menstrual cycle phase and premenstrual symptoms was requested. Swinkels & Giuliano's (1995) mood awareness measure followed, indicating the individual should think about the way they feel 'at that time'. Information concerning affect intensity was then requested, followed by a self-awareness measure. Information on negative mood regulation expectancies was gathered, succeeded by twenty questions relating to positive and negative feelings. Mood awareness was then assessed again at this point in the questionnaire, but with the instruction to think about how one was feeling 'yesterday'. Finally, there was a space provided at the end of the questionnaire which invited participants to make comments should they wish to do so. The questionnaire was nine pages long (see appendix 3).

Materials

Quantitative measures

Firstly, menstrual cycle phase was recorded by setting out three segmented phases along a line. Participants were instructed to tick one of the three phases that

represented where they were in their menstrual cycle. Options consisted of 1 = the menstrual phase (when bleeding occurs), 2 = the intermenstrual phase (after bleeding has finished, between your menstrual and premenstrual phase), and 3 = pre-menstrual phase (a week or so before bleeding recommences). It was felt this should be kept as simple as possible to avoid confusion and to promote accuracy of response.

An 11-item symptom rating scale was devised to gain information on absence or presence of symptoms, and severity. Five of the items related to affective change (irritability, tension, mood change, anxiety, depression) and the remaining six items covered somatic change (fluid retention, pain, fatigue, muscle tension, hot flushes, food cravings). The items were chosen on the basis of being among the most frequently reported symptoms in the literature on premenstrual syndrome. Responses were rated on a 4-point Likert scale (1 = never, to 4 = most of the time).

In order to measure the individual difference characteristic of mood awareness the scale developed and psychometrically validated by Swinkels & Giuliano (1995) was used. Swinkels & Giuliano have established the reliability and validity of the scale, which comprises of two distinct dimensions; mood monitoring and mood labelling. Within the present study each of the respective five items relating to the two dimensions were summed separately to obtain the rating on the individual dimensions, with four items being reverse scored prior to being summed (3 items relating to mood monitoring, and 1 item relating to mood labelling). The mood awareness scale was included after cycle phase and symptoms near the beginning of the questionnaire with the instruction of asking participants to complete the ten questions in relation to the way they were feeling 'at the time'. The mood awareness

scale was then also included at the end of the questionnaire with the instruction to think about the way they were thinking 'yesterday'. This was to gain some information of their awareness over time.

Affect intensity was measured using the 40-item affect intensity measure (Larsen, 1984). This scale was developed and validated by Larsen (1984) to measure the typical strength of emotions experienced by the individual. Test-retest reliabilities for this measure at one, two and three-month intervals were .80, .81, and .81 respectively. Also over a period of 2 years results yielded high retest reliability (.75, $p < .01$), (Larsen & Diener, 1987). Therefore the measure was selected on the basis of being valid and reliable.

Negative mood regulation expectancy was measured using the negative mood regulation scale (Catanzaro & Mearns, 1990). This taps the belief expectancy that some behaviour or cognition will alleviate a negative mood state. The scale consists of 30 items and was devised through a process of testing the psychometric properties, temporal stability, relationship with internal-external locus of control, and relationship with measures of depression, adjustment, and affect. The 30-item scale was found to have acceptable internal consistency, temporal stability, and discriminant validity from social desirability and locus of control (Catanzaro & Mearns, 1990). Therefore it was concluded this measure is valid and reliable for use.

To measure self-awareness the private self-consciousness ten-item component of Fenigstein, Scheier & Buss's (1975) 23-item private self-consciousness scale was used. The private self-consciousness scale consists of three factors: private self-consciousness, public self-consciousness, and social anxiety. The private self-

consciousness subscale was selected for use on the basis of Swinkels & Giuliano's (1995) claim that an individual can be high in private self-consciousness in general, but low in mood awareness. They argue that although mood awareness bears a likeness to private self-consciousness, the private self-consciousness component represents a global inner-state awareness, making it a multifaceted construct. The mood awareness construct, on the other hand, is self-awareness directed specifically towards one's mood/affect. Therefore the two constructs were included in the present study. Test-retest reliability of the scale was .79, establishing reasonable reliability.

In order to measure positive and negative affect the Positive and Negative Affect Scales (PANAS) (Watson, Clarke & Tellegen, 1988) were used. These are two ten-item mood scales which have been shown to demonstrate a high internal consistency, and good test-retest reliability (see Watson, Clarke & Tellegen, 1988). The scales are each comprised of ten words that describe different feelings and emotions. Ten words relate to positive affect: interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, active. Ten words represent negative feelings: distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery, afraid. The twenty words are placed in a mixed order with a small space next to each word. Participants were instructed to think about how they were feeling 'yesterday', and to respond by placing a number next to each word in the space provided. Response options given for participants to select from are 1 = very slightly or not at all, to 5 = extremely. Scoring the scales involved summing the ten items for positive affect to obtain an overall measure of positive affect, and the ten items for negative affect respectively.

Qualitative Information

After instructions and demographic information, the questionnaire was structured so participants were invited to write freely, in their own words, about first hand experience of premenstrual syndrome. It was felt that some place should allow women to make a more personal contribution to the research process for reasons previously outlined.

Procedure

As stated, contained within the package sent to NAPS members was a questionnaire accompanied by a letter inviting individuals to take part in a study aimed at gathering information about premenstrual syndrome. The instructions specified that participants would find the questionnaire contained several sections, each with a set of instructions. Participants were encouraged to complete the questionnaire in one attempt rather than filling in half of it on one day and filling in the remainder at another time. It was stipulated that there are no right or wrong answers. It was stated the questionnaire takes approximately twenty-five minutes to complete. At the beginning participants were required to write down the time, then at the end of the questionnaire the time was noted again. This was to establish the questionnaire had been completed in one attempt. At the end of the questionnaire participants were thanked for their time and instructed to return it via the post to the University of Leicester in the freepost envelope provided.

Results

Analyses of data were conducted in two parts, the quantitative analyses and qualitative interpretative process was carried out separately. Results will be presented separately for clarity.

Quantitative Analysis

Statistical analyses using SPSS were conducted for the quantitative data. A Pearson correlation matrix was constructed entering the following variables: negative affect, positive affect, mood awareness ‘generally’ and mood awareness ‘yesterday’ (monitoring and labelling), negative mood regulatory expectancy, self-awareness, symptoms, and affect intensity. A one-way ANOVA was conducted to establish whether there were any differences arising from cycle phase. No such differences were found on any of the dependent variables.

Pearson’s correlation revealed there to be some significant positive relationships between several variables. Mood monitoring ‘yesterday’ was found to be positively associated with affect intensity ($r = .264, p < .01$) self-awareness ($r = .267, p < .01$) negative affect ($r = .566, p < .01$), and negative mood regulation expectancy ($r = .276, p < .01$). Mood monitoring ‘yesterday’ was also positively correlated with mood monitoring ‘generally’ ($r = .595, p < .01$) and mood labelling ‘yesterday’ ($r = .576, p < .01$), but not mood labelling ‘generally’. Mood monitoring ‘now’ was positively associated with self-awareness ($r = .519, p < .01$), affect intensity ($r = .309, p < .01$) symptoms ($r = .229, p < .05$) negative mood regulation expectancy ($r = .252, p < .01$), and negative affect ($r = .299, p < .01$). Mood labelling

'yesterday' was positively associated with affect intensity ($r = .267, p < .01$), self-awareness ($r = .267, p < .01$), and negative affect ($r = .290, p < .01$). Mood labelling 'yesterday' was also positively correlated with mood labelling 'generally' ($r = .395, p < .01$) mood monitoring 'yesterday' ($r = .576, p < .01$), and mood monitoring 'generally' ($r = .475, p < .01$). Finally mood labelling 'generally' was positively correlated with affect intensity ($r = .213, p < .05$) and negative mood regulation expectancy ($r = .274, p < .01$). Self-awareness was positively associated with affect intensity ($r = .304, p < .01$) symptoms ($r = .261, p < .01$), and negative affect ($r = .216, p < .01$). Apart from self-awareness symptoms were only significantly positively associated with mood monitoring 'generally' ($r = .229, p < .05$). Apart from mood monitoring 'generally', mood labelling 'generally', and mood monitoring 'yesterday', negative mood regulation expectancy was also positively associated with affect intensity ($r = .336, p < .01$).

Table 3.

Table Displaying Results From Pearson Correlation Matrix

	Sympt	MM Gen	MM Yest	ML Gen	ML Yest	Affect Intens	Self Aware	Neg Mood Reg Exp	Pos Affect	Neg Affect
Sympt	**	**	**		**	**				**
MM Gen	.2290 p= .024	**	**			**	**	**	**	**
MM Yest	.0272 p= .790	.5855 p= .000	**			**	**	**	**	**
ML Gen	.1081 p= .289	.3078 p= .002	.0873 p= .393	**	**	**	**	**	**	**
ML Yest	.0483 p= .636	.4747 p= .000	.5765 p= .000	.3946 p= .000	**	**	**	**	**	**
Affect Intens	.0080 p= .389	.3093 p= .002	.2640 p= .009	.2135 p= .034	.2672 p= .008	**	**	**	**	**
Self Aware	.2608 p= .009	.5192 p= .000	.3473 p= .000	.1505 p= .137	.2675 p= .007	.3043 p= .002	**	**	**	**
Neg Mood Reg E	.0647 p= .527	.2523 p= .012	.2758 p= .006	.2739 p= .006	.1682 p= .096	.3365 p= .001	.1621 p= .109	**	**	**
Pos Affect	-.0211 p= .839	-.0542 p= .602	-.2013 p= .050	.0473 p= .647	.0073 p= .944	.1677 p= .103	.0905 p= .380	-.1149 p= .265	**	**
Neg Affect	.1022 p= .322	.2987 p= .003	.5662 p= .000	.0276 p= .788	.2902 p= .004	.1344 p= .189	.2161 p= .034	.1830 p= .073	-.3651 p= .000	**
Intrm	-.0724 p= .486	-.0495 p= .659	-.1794 p= .082	-.1297 p= .208	-.0187 p= .856	-.1254 p= .224	-.0889 p= .389	.0342 p= .741	.0919 p= .381	-.2211 p= .032
Preme	-.0212 p= .838	-.0337 p= .746	.1323 p= .201	-.1510 p= .142	.0774 p= .453	-.0119 p= .909	-.0394 p= .703	-.1314 p= .202	-.0063 p= .952	.1145 p= .272
Menst	.1149 p= .268	.0975 p= .347	.0593 p= .568	.0241 p= .816	-.0701 p= .497	.1653 p= .106	.1547 p= .132	.1161 p= .260	-.1044 p= .319	.1547 p= .215

Summary

A positive association between mood awareness (monitoring and labelling) and several other variables were evident. The higher the degree of mood monitoring ‘generally’ and ‘yesterday’, the higher the degree of affect intensity, self-awareness, negative mood regulation expectancy and negative affect. Mood monitoring ‘generally’ and ‘yesterday’ were also positively associated. In addition the higher the

degree of mood monitoring 'generally' was associated with a higher degree of symptoms reported.

Mood labelling 'generally' and 'yesterday' were found to be positively associated. Also the higher the degree of mood labelling 'generally' and 'yesterday', the higher the degree of affect intensity and negative mood regulation expectancy. In addition a higher degree of mood labelling 'yesterday' was associated with a higher degree of self-awareness and negative affect. The higher the degree of self-awareness, the more affect intensity, negative affect and symptoms were reported. Also a higher degree of symptoms were associated with a higher degree of mood monitoring 'generally'. Negative mood regulation expectancy was found to be positively associated with affect intensity. Finally, cycle phase was not found to be significantly associated with any of the measures, nor were there any differences in reporting on the measures as a result of cycle phase. This was also the case when assessed for high and low mood monitoring separately. Also positive affect was not found to be associated with any of the measures.

Qualitative Data Analysis

The qualitative data took the form of written accounts of personal experience of premenstrual syndrome. For analysis, a discourse analytic interpretative approach was used based on Parker's (1992, 1999) ideas of the political nature of language in terms of favoured positions, and the dual purpose of linguistic meaning. Discourse analysis is concerned with the nature of meaning. In particular patterns of meaning which organise the various symbolic systems that these participants inhabit were

identified. Firstly this involved reading and re-reading the transcripts many times in order to identify the various types of discourses that were being used by participants to construct their versions of premenstrual syndrome. Secondly analyses involved interpreting meanings of lived experience within the discourses by locating the positions they occupied and the functions they performed.

Ninety-two of the ninety-nine returned questionnaires contained some form of written account of premenstrual syndrome. Accounts ranged from a few lines to more detailed, descriptive discussion which had been continued on separate sheets of paper. Mostly the accounts were handwritten, five being typed. The discourses contained some valuable information which otherwise would not have been evident, which is also a further justification for enabling participants to include written accounts. This shall be presented briefly. 14 participants voluntarily included their full names, addresses, and telephone numbers for contact to be of further assistance to the researchers. 49 participants used 'time' as a framework for their account. The time for menstrual cycle distress to occur ranged from 3 to 14 days prior to the onset of menses, with 3 participants stating they suffered menstrual cycle distress from anything up to 26 out of a 28-day cycle. Only one participant mentioned that distress occurred after menses (7 days after). 20 Participants were in the menstrual phase of the menstrual cycle, 39 in the intermenstrual phase, and 37 in the premenstrual phase at the time of the present study. Seven participants mentioned obsessive compulsive disorder, in that they had previously been diagnosed as sufferers and prescribed medication, although they were not taking the medication at the time of the present study. Also 18 of the 92 participants were taking prescribed medication for

depression at the time of the present study. Other symptoms of interest which were mentioned in the written accounts that would otherwise have not been recorded were suicidal thoughts and attempted suicide, panic attacks, paranoia, and self-harming. Participant 50 included a typed list of symptoms she experienced, which numbered 52 in total. They included 'spaced out feelings of unreality', 'throbbing and spasm of the solar plexus', 'tingling/numbing of the right hand', 'restless legs in bed at night', 'burning sensation in the brain', and 'suicidal depression and crying'.

Discourses

Several core discourses were identified through reading and re-reading the participants' written accounts of premenstrual syndrome. A biological discourse was often used in conjunction with discourses of self-other to explain premenstrual syndrome. Also discourses of femininity were often utilised, as well as emotion discourses of anger and negative lability of emotion. Discourses of control featured throughout the majority of accounts, many participants constructing the self as an entity that was not under conscious, voluntary control because of premenstrual syndrome. These discourses were used by participants to describe their experience and understanding of premenstrual syndrome. Finally a fragmentation of lived experience from emotions was identified as part of the underlying discursive structure of accounts, which are taken as evidence for the continued impact of positivist ideology on mental structure, and therefore lived experience.

Represented within and through these discourses were accounts of painful life event experiences, which often meant one account contained a multitude of diverse

and fragmented pieces of information ranging from symptoms to divorce and personal loss. The space provided seemed to allow many of the participants a sense of freedom to express their personal experiences. Examining and interpreting deeper meaning from the discourses used to construct these accounts has highlighted some of the issues and ideologies that are most salient in the lives of this group of women who believe they suffer menstrual cycle distress. Extracts from the discourses shall now be presented for illustrative purposes.

Biological Discourse

Biological discourses featured frequently throughout many of the accounts of premenstrual experience. This was not surprising given that biological explanations have always presided as the legitimate authority of knowledge over women's lives due in respect of reproductive capacity and the menstrual cycle. The cause of menstrual cycle distress was often located in hormones, and the female biology cited as an unwanted restriction. Participant 68, who was a 34-year-old unemployed, single woman, wrote,

“I am very unhappy to have female biology and look forward to the freedom of menopause. My body makes me feel clumsy, shaky, weak and sick daily.”

Use of the term ‘to have’ implies an entity that is separate or apart from the self, and yet it is also acknowledged as being part of the self. Also ‘my body makes me feel’ positions the body as the privileged determining aspect of lived experience in this

account. The female body is constructed as a prison by the use of 'freedom' which implies a need for liberation from the body. The menstrual cycle is implied to be the overriding cause of distress by citing the menopause as the potential liberator. Also 'daily' implies that the whole menstrual cycle for this participant is a problem. Thus the female body, as a direct result of biological functioning, is represented as a negative aspect of the self. Interestingly many participants mentioned the menopause, seeing it as a solution to their distress. Participant 43 says, "I'm quite looking forward to the menopause to find the real me". Often biological explanations and solutions are portrayed as being able to solve or 'cure' problems, the public therefore having certain expectations of the medical profession and its allegiance to biology. Looking toward this biological event as providing a solution ties in with such predominant beliefs.

Biological discourses were always used negatively by participants and were often used to frame an account. Participant 72, a 28 year-old, divorced woman working as a sales assistant, wrote,

"I began my menstrual cycle at the age of 10.5 years.....I physically and emotionally changed. Along with this I became aware of emotions I'd never experienced before. My moods could swing instantly from joy to rages, tears to total depression, years of pigeonholed explanations. Teenage years of torment. I am now 28 and still screaming for a solution".

(..... material omitted)

Here the event of menarche is directly associated with complete, sudden and dramatic life change. The beginning of the menstrual cycle is traced as the source of negative lived experience in this account. A complete change is signalled by use of ‘physically and emotionally’, which implies a change in both the emotional and physical aspect of the self, and is then accompanied by dialogue on emotional experience. Biology is positioned as being directly responsible for changing the way the individual experiences the emotional self. No other explanations are sought or acknowledged for a partial/alternative role despite adolescence being a time of much challenge to self and identity for reasons other than purely the biological. Affective lived experience is portrayed as extreme for the individual. Also by use of the phrase ‘still screaming for a solution’ implies emotions are still experienced in an aversive manner. Screaming is particularly powerful because it suggests pain. Therefore biology is located as a cause of sudden and dramatic change which remains painful to the individual.

Discourses of self-other were particularly salient in many of the accounts. Prior to this extract from participant 48’s account, she had been describing her premenstrual symptoms that are affective in nature. She wrote,

“Sometimes it feels like a demon creeping up on me and taking the real me away, leaving a horrible ugly monster”.

In this account the individual constructs an image of the self as comprising two parts: the real self and an unrecognisable false ‘other’ self. This is implied by use of ‘taking the real me away’. Premenstrual distress is constructed as a manifestation that steals

upon the individual, taking her over. Use of the word 'creeping' implies it is deceptive, having the ability to dupe the individual in to losing herself. This performs the function of absolving the individual of responsibility for this negative, undesirable 'other' self. Thus the self is experienced as two different parts. Within this account the individual constructs herself as good and bad, classifying the negative undesirable aspect as a 'demon'. Use of 'demon' serves to dehumanise this aspect of the self, which provides the function of distancing the real self from this demonic premenstrual self. This is interpreted as evidence of pressure to be a 'good' woman in a conventional sense through gender stereotypes. The 'bad' aspect of self in this account is explained away through premenstrual syndrome manifesting as a demon and therefore making the individual this way. The individual can legitimately admit and acknowledge the negative, angry aspect of her lived emotional self through premenstrual syndrome.

There is further evidence of the predominance of this self-other discourse. Participant 67, a 30 year old, married civil servant wrote,

"It's hard to answer questions like this as I feel that I have 2 personalities. I am a different person altogether when I am suffering symptoms than when I'm not".

Here the individual constructs an account of two selves, the premenstrual 'other' self and the non-premenstrual self. It is implied that premenstrual symptoms change the person into a completely different character that does not resemble the

a-symptomatic, normal self. The nature of this 'other' self changes to such an extent, causing the individual difficulty in answering the questionnaire.

Implicit in the meaning of the account it is implied the individual has to consciously think about whom she is in order to answer the questions. There are a number of reasons for this, one interpretation being the dual nature of language as proposed by Parker (1992). It is implied that the individual is actively using language here to manage the way she constructs the self. This implies there is pressure to construct an acceptable self, yet the way in which the individual wants to answer the questions may not match up to this. Within this account there is an implied need to actively manage the way the self is constructed. The two personalities perform the function of separating undesirable experience from the normal or usual self, and legitimately explain away the negative premenstrual self. Again this account implies a splitting of the self.

Other discourses of self-other talked of a rational versus irrational self, participant 43 saying, "when in the pms phase, my beliefs become much more negative and more irrational". The presence of premenstrual syndrome is representative of irrationality. Participant 64 says, "the two weeks after my period I am sane", insinuating a sane versus insane or mad 'other' self. It seems that socially undesirable aspects of self, such as irrationality and appearing mad, were explained through premenstrual experience.

Much premenstrual experience was written about in relation to expectation of the female role, particularly for its disruptive capacity. Discourses of femininity featured throughout many accounts. Participant 82 was a married woman who defines

herself as a full-time wife and mother. She had been talking of the way in which premenstrual syndrome affects her, and of the relief when 'it' dissipates. She wrote,

"it's a relief. I'm calm throughout the following two weeks. I have lots of patience with my two toddlers and then.....I will wake up one morning and know instantly 'it' is back again. And then I have to fight with myself to stop yelling at my husband. I will feel on edge and the least little thing will set me off. I long to be aloneif only I could scream it out of my system I would feel better. I think things like "why am I living here like this? And I plan to divorce him and me and the children will live somewhere away from it all".

(Participant's own underlining/punctuation.)

This account of premenstrual distress is constructed out of the way it affects the individual's ability to perform her roles. This was fairly common across accounts in the present study. Rather than listing a group of symptoms which amount to what the individual feels constitute premenstrual syndrome, she instead talks of the way it affects her daily functioning. Relief is associated with being calm and having patience with the children. 'Having lots of patience' represents a characteristic that constitutes being a good mother. Being calm and patient is positioned as desirable, particularly in relation to mothering. However sudden and dramatic change follows in the dialogue, the reason for this being attributed to 'it'. Premenstrual syndrome is held responsible for what is inferred to be loss of the sense of calm and patience,

which functions to place responsibility with the disorder rather than the individual. Thus premenstrual experience for the individual manifests as a loss of desirable characteristics which are required for mothering and nurturing.

Premenstrual syndrome is referred to as 'it', some form of nondescript entity. This is interpreted as evidence for the way the individual finds it difficult to quantify or express through words in definitional terms what premenstrual syndrome is. This is consistent with the complexity of the debate surrounding the disorder. Further experience of what premenstrual syndrome means to the individual is represented through self-conflict, implied by use of the phrase "I have to fight myself to stop yelling at my husband". Premenstrual syndrome, or 'it', makes the individual yell at her husband. Again this absolves the individual from being held responsible for the undesirable behaviour of negative expression towards her husband in her role as a wife.

In addition it is also implied within this account that repression of expressing feelings is an issue, evidence being located in use of the phrase 'if only I could scream it out of my system I would feel better'. What follows in the dialogue is further evidence of negative thoughts and feelings towards the individual's role as a wife. The dialogue contains a representation of intention or desire to absolve herself of this role somehow. Again this is within the context of an account of what constitutes premenstrual syndrome for this individual, which positions such thoughts and words as being attributable to a disorder rather than the individual. Premenstrual syndrome seems to be performing the function of allowing the individual to express

negative feelings and experience of her role without holding her accountable for such disclosures.

Participant 94 was a 38-year-old mother of two children, living with her partner. She described her premenstrual symptoms and wrote,

“I find that I become very angry for no rational reason with my two small children on occasions which results in me shouting at them – but in this respect I do not seem to differ from most of my friends who are mothers”.

Anger is positioned as a premenstrual symptom. This impacts upon the way the individual behaves towards her children. It is implied shouting at the children is not desirable, and a result of premenstrual syndrome. Use of ‘I find I become very angry for no rational reason’ suggests anger requires clarification or justification in some way. In this context anger is also associated with irrationality, and is justified through premenstrual syndrome to counter such negative associations. However there is contradiction within the account as the individual attempts to normalise the behaviour by suggesting the behaviour is similar to that of other women who are mothers. Shouting at children represents loss of control, and being a bad mother because a mother should always be able to cope. However it is also inferred that shouting at children is a normal part of mothering from time to time. The way the individual is permitted to express this more negative aspect of mothering is by locating the origin in the disorder.

Emotion discourses featured frequently in accounts. This was not surprising given that the most predominant reported symptoms of premenstrual syndrome are affective in nature. (Walker, 1997, Bancroft, 1995). Participants often reported anger, as well as losing control of emotions. Participant 92 was a 41-year-old woman living with her partner. Referring to her symptoms she wrote,

“ At their most severe I will resort to violence – even threatening my partner with a knife to his throat. The easiest description that I can use is that it is like being uncontrollably possessed – unable to control emotions or feelings or behaviour – it seems that it is my body but that was all. Overwhelming feelings to the point of depression to the point of considerations of suicide would drive me to my bed for fear of myself and lack of control with others”.

The individual constructs an account of the self as emotionally volatile. Reference to threatening the partner with a knife functions to define just how potentially dangerous the individual can become through premenstrual syndrome. Use of ‘uncontrollably possessed’ implies not only being out of control but also taken over, which is also suggested by the use of ‘overwhelming’. Again language is used discursively to separate and absolve the self of responsibility for such negative feelings and behaviour. This is a vivid account of potential life threatening danger to self and others, and is how this participant has chosen to describe premenstrual syndrome.

Anger was used to describe premenstrual syndrome in so many of the accounts, often being positioned as a symptom. This made it difficult to be selective

in presenting data. Participant 24, a 42 year old married school teacher referred to her premenstrual symptoms and wrote,

“I get very angry at weekends which is two weeks before my period starts.

This results in utter fury and despair”.

This account begins with the mention of anger. Time is used, which performs the function of positioning anger in the context of the premenstrual phase of the cycle or thereabouts. Anger is therefore attributed to the timing of cycle phase, which is consistent with perceptions of the onset of symptoms associated with premenstrual syndrome. Fury has associated meanings such as frenzy and rage, and despair has those such as misery and melancholy. The use of these words implies a high degree of intensity of emotion. She then wrote,

“I have other problems – my eldest son and my husband have a bad relationship which have made me very down so I am on antidepressants. My marriage is variable and my husband has absolutely no idea”.

The focus of the account abruptly switches to the social. Dialogue on the relationship between the eldest son and the husband is given as a reason for the individual experiencing prolonged negative feelings. The negative feelings have become prolonged as indicated by the mention of antidepressants. Use of the word ‘variable’ implies that this relationship is inconsistent and changeable. There is much

dissatisfaction between the individual and her husband. The statement 'my husband has absolutely no idea' is far-reaching and all encompassing. Yet these issues are positioned as separate from premenstrual anger and fury, by use of 'other problems'. However, when placed in the context of time, there is a link between prolonged periods of being at home and the onset of anger and despair. The participant is a schoolteacher and so is working during the week. Use of 'I get very angry at weekends' implies the individual is referring to being angry about something in connection with her socially lived pattern, but then use of 'which is two weeks before my period' functions to explain the anger as a premenstrual symptom.

It seems this account contains anger, despair and dissatisfaction with family relationships, particularly the individual's marriage, yet this is framed as an account of premenstrual experience. 'Other' problems that can legitimately cause frustration and depression for the individual, such as marital/family problems, are separated out from the premenstrual anger. Interestingly this participant has written at the close of one of the sections in the questionnaire that concerns moods and feelings, 'I think anger and fury would be more relevant than irritable and hostile in section 4'.

A final example of an emotion discourse highlights an emotion other than anger. The emotion in question does however share the common negative associations that accompany anger. Participant 73 was a 46 year old married woman. Her account of premenstrual syndrome was short but dramatic. She wrote,

"I am aware of my moods, but I am unable to control them, like my jealousy".

Lack of control provides the core focus of this statement. Also awareness of mood implies the individual is actively engaged in thinking about the way she is feeling, this interpretation being influenced by Swinkels & Giuliano's (1995) work. A particular emotion is referred to, yet also positioned as being separate to the rest of her feelings. This performs the function of drawing attention to this particular emotion. The word 'jealousy' attracts meanings such as resentful, possessiveness, insecurity, mistrust and enviousness. Stenner (1998) says jealousy is perceived as a negative undesirable emotion in Western society. However he argues it serves to maintain interpersonal social order when there is a perceived threat to an individual's relationship with a treasured or valued other. He particularly focuses on the guarding aspect of jealousy, such as when a man believes his wife may be having an affair so escorts her on all occasions to ensure nothing happens. Jealousy, Stenner says, provides the passion or motivation necessary to keep things in their place, and should be considered as a positive, legitimate force at work.

Control is an issue for moods, but jealousy is specifically referred to which implies this emotion is particularly problematic for the individual. Drawing on Stenner's (1998) ideas, this suggests some form of threat to the individual's interpersonal order is evident. Although jealousy is conceived of negatively, it may be a legitimate emotion for the self. In the account, lack of control of emotion, in particular jealousy, is offered as a representation of the individual's experience of premenstrual syndrome. This it is believed serves to legitimise the experience of this seemingly negative emotion. It is implied one should not legitimately experience emotion, as implied by use of 'like my jealousy' in relation to lack of control.

Seemingly it is desirable to conceal or control jealousy. However in the light of Stenner's (1998) suggestions, the account raises the question of what has brought about such feelings, and the question of legitimacy.

Accounts of what constitutes premenstrual syndrome were frequently constructed through stressful life events. Often participants began writing about issues of control, anger, and negative emotional experience, accompanied by a statement of meaning containing a specific event. Participant 81 was a 41 year old care worker, previously divorced but with a current partner. She was writing about her symptoms of irritability and negative emotion in general, and then wrote,

“Yesterday I was told by my fiancée he was seeing another woman and our relationship is now ended. I move to a new house next week with my children which was planned in January”.

This statement is striking in that although fairly short, is loaded with implicit meaning. It is a short yet dramatic proclamation because of the potential for the impact of major life change, as well as profound emotional readjustment. Betrayal can be extremely difficult to come to terms with, particularly being enlightened as to the infidelity of one's partner. This relationship must be one of great value, implied by the position of the man as her fiancée. 'Fiancée' implies long term planning. Becoming engaged precedes marriage in both a social and Christian sense. To become engaged indicates marriage will follow. Marriage is therefore a symbol of ultimate social and Christian commitment between two people in a relationship in

Western society. Thus implications of an end to this planned union are far reaching. The strength of meaning within the statement ‘...and the relationship is now ended’, performs the function of emphasising just how dramatic this event is to the individual. The decision to marry is usually taken with great care and thinking, yet has suddenly been cancelled out by the other party or ‘ended’. ‘Ended’ implies dramatic, final. The account goes on to refer to an event which was planned some time ago as part of the relationship, namely moving to a new house. It is implied this will continue, but now is somehow incomplete or out of its original context. Again moving can be a stressful life event, and will now be further complicated by emotional readjustment.

Participant 45 was a 31-year-old, divorced sales consultant. She gave a long and detailed account of her symptoms and experience of premenstrual syndrome. On the third sheet of paper she wrote,

“I have been through a divorce and am currently separating from a 4 year long relationship. I have suffered with clinical depression/pmt since my teens and have lost many years and a loving husband and now partner due I’m sure to my violent mood swings.....I was referred by my latest doctor to the hospital but counselling is non-existent and resulted only in being encouraged to take Prozac or HRT – at 31 with no children”.

The individual has been through the experience of a divorce, which is known to be a highly stressful life event. She is currently separating from a long-term relationship,

which again draws upon personal coping resources and demands much emotional readjustment. The account then focuses on negative affect as a symptom. However the reason or origin of such negativity is unclear and left open to interpretation by use of ‘suffered with clinical depression/pmt’. All that remains certain is the individual experiences prolonged negative emotions. The cause of the negative emotions is questioned. Clinical depression is now also a possibility. Violent mood swings are a problem, which is why the individual has been referred for a hospital consultation. Use of ‘by my latest doctor’ implies a change of doctor on at least one occasion. The outcome of the referral is not favourable to the individual who expresses disappointment at being advised to take Prozac, a currently available prescribed antidepressant, or prescribed hormone treatment. This is particularly important and indicates significant implicit meanings. Given dominant aetiological theories of premenstrual syndrome are biomedical (Walker, 1997), it is reasonable to assume the solution to treating or curing the disorder will be medical, in the form of drugs or surgery. However the individual rejects such measures advocated by medical practitioners, despite seeking help and answers from them. Such a statement performs the function of questioning the validity of the ability of medical treatments, in this case drugs, to solve the individual’s distress. All this is positioned between the statement concerning socially lived experience (divorce and separation) and the implied desire for counselling.

Participant 52 was a 35-year-old divorced woman and trained nurse. In her account of premenstrual syndrome she wrote,

“I don’t think that I suffered from pms until I reached about 30 years of age. From this time onwards my life also became more stressful with a divorce, new partner, new job etc and so it is difficult to tell what symptoms are related to what. Some months are okay – this is usually when things are going reasonably well”.

This account clearly links the onset of premenstrual syndrome to socially lived experience, specifying change and life events that are known to be challenging. Also it is clearly implied when ‘things’ are progressing well, the symptoms are not evident.

One long, descriptive account underpins many of the findings presented in this study. It draws together much of the interpretation in a vivid, yet sincere manner. The first part of this account will be presented to end the discourse analytic interpretative process, inviting the reader to make interpretations by placing these within the context of the findings. Participant 97 was a 32-year-old single woman. She wrote,

“My pms started when I was 14. This coincided with several great upheavals in my life: (1) adolescence (2) leaving my country of birth (3) cultural re-adjustment (4) dealing with financial and adult matters prematurely. I have recently found out that the repression of my emotions in order to ‘look’ strong to the outside world has been the sole reason for my pms. It was valid to kick up a fuss by having a pms but not if I was not mentally okay. In the meanwhile over the many years my body had re-adjusted itself to this

miserable state to which it had gotten addicted to and the pattern had kept repeating for many years. Conventional medicine had added insult to injury in the form of quick fix cures”.

This account contains much reflection and insight. The individual traces the origin of her pms back to adolescence, implying recognition of the difficulties associated with this time of development. Also connections are made between life event stressors and distress, rather than such factors being separated out and disassociated. External events are accepted as being able to impact on the emotional, internal environment, which in this account enables the individual to recognise and understand her experience of pms. Also the question of conventional medicine having no answers other than ‘quick fix cures’ is in keeping with this realisation that stressful life events and difficulties, within this account, cannot be resolved easily through conventional reductionist methods. Rather, the answer has been located within and through acknowledgement of the culmination of lived experience for this individual. This account implies that pms is providing a form of outlet for the individual’s other problems.

Discussion

The present study was conducted to establish two principal aims. The first being whether there were any significant relationships between mood awareness (labelling and monitoring), self-awareness, affect intensity, negative mood regulation expectancy, symptoms, cycle phase, and affect in a group of women suffering from

premenstrual syndrome. It was hypothesised that reporting would be affected by cycle phase in the following ways: the premenstrual phase would be positively associated with negative affect, symptoms, mood monitoring, self-awareness, and lower negative mood regulation expectancy. It was also hypothesised that there would be a positive relationship between mood monitoring generally, self-awareness, affect intensity, and negative affect, but a negative relationship with negative mood regulation expectancy. Mood labelling would be positively associated with self-awareness, higher negative mood regulation expectancy and lower affect intensity. Finally, that affect intensity and symptoms would be positively associated.

There was no evidence to support the first part of the hypothesis: no differences in reporting as a result of the phase of the cycle were evident. There were no significant associations found between cycle phase and self-awareness, negative affect, symptoms, mood monitoring or negative mood regulation expectancy. This lack of findings on cycle phase is particularly interesting because it goes against all the popular assumptions and beliefs concerning the premenstrual phase of the cycle in particular. Lack of evidence on consistency of symptoms has seen the medical profession, instead, define the disorder through timing of onset of distress. Also participants were a group of self-diagnosed sufferers of premenstrual syndrome, and so it would be reasonable to assume an association with phase. However when considering these results in conjunction with the subjective accounts, they do make for interesting reading, which will be discussed shortly.

There was evidence to support the second part of the hypothesis which concerns mood awareness. Firstly mood monitoring was found to be positively

associated with self-awareness. The higher the degree of mood monitoring, the higher the degree of self-awareness. Although Swinkels & Giuliano (1995) suggested self-awareness and mood awareness are two distinct constructs, it would seem they do tap very similar aspects of inner state awareness. The positive association between the two constructs provides support for this assertion and would suggest the two constructs are more similar than originally believed, which is in contrast to Swinkels & Giuliano's (1995) argument. This would need further specific investigation, which is beyond the remit of the present study.

A mood awareness measure was recorded for generality of use, referred to as 'generally', and for the previous day, referred to as 'yesterday'. The reason for this was to assess mood over time. A positive association was found between mood monitoring 'generally' and 'yesterday', which indicates stability over time. There was also a positive association between mood labelling 'generally' and mood labelling 'yesterday', again indicating stability over time. Mood monitoring 'yesterday' and mood labelling 'yesterday' were also found to be positively correlated, which indicates the more monitoring exhibited by the sample, the more labelling was also indicated. Also mood monitoring 'generally' and mood labelling 'now' were positively associated. This is in line with Swinkels & Giuliano's (1995) assertion that monitoring and labelling are orthogonal.

As hypothesised there was a positive relationship between variations on mood monitoring (generally and yesterday) and affect intensity, negative affect and symptoms. However the hypothesised association between monitoring and negative mood regulation expectancy was not in the direction expected. Rather than being a

negative association it was in a positive direction, which indicates that increased monitoring was associated with a higher expectancy of negative mood regulation, rather than a lower expectancy. Swinkels & Giuliano (1995) found monitoring predicts low success at regulating mood, and so it was predicted that a higher monitoring tendency would be correlated with a lower negative mood regulation expectancy. However the results did not support this prediction: instead the more monitoring displayed, the higher the degree of expectancy to regulate negative mood.

The association between monitoring, affect intensity, and negative affect was consistent with Swinkels & Giuliano's (1995) findings that high monitors, in comparison to low monitors, tend to experience their emotions more intensely and encounter more negative affect. The association between symptoms and monitoring suggests the more aware one becomes of one's moods and inner state, the more sensitive to somatic and emotional changes one becomes, which may partially explain the results for this sample.

It was hypothesised that mood labelling would be positively correlated with self-awareness, negative mood regulation expectancy, and negatively associated with affect intensity. Evidence to support the prediction for self-awareness was forthcoming. General self-directed attention was associated with mood labelling. Also labelling was positively associated with a higher negative mood regulation expectancy, consistent with Swinkels & Giuliano's (1995) findings that high labelling, in comparison to low labelling, predicted a higher degree of success at self-regulation of mood/affect. Finally the negative association between labelling and affect intensity was not found. Instead the association was in positive direction. This

suggests that increasing emotional intensity does not affect the ability to be able to identify and label the mood/emotion, which is important for successful regulation outcome.

Symptoms were found to be positively associated with mood monitoring and self-awareness, but not cycle phase. This is interesting as it suggests self monitoring of mood/affect is associated with symptom severity. When attention is directed inward, this may serve to heighten perception of inner change and discomfort, which predisposes one to be more sensitive to emotional and somatic changes.

There was found to be a positive association between affect intensity and negative mood regulation expectancy. Larsen & Diener (1987) found individuals who are highly emotionally intense are more prone to experience somatic complaints, experience more frequent mood shifts, and yet report lower self-control over their emotional behaviour. There was no significant association between affect intensity and symptoms. However the association which was found to be significant, namely affect intensity and negative mood regulation expectancy, was in the opposite direction to that which would have been expected based on Larsen & Diener's (1987) findings. Higher affect intensity was associated with increasing negative mood regulation expectancy, meaning the expectancy to be able to regulate negative mood increased with affect intensity, rather than decreased.

In summary, several significant findings are evident. Cycle phase was not found to be associated with any of the measures, and did not affect the way participants responded. This is surprising given that premenstrual syndrome is partially conceptualised through a timing factor, acknowledged in the literature

(Walker, 1997; Asso, 1983) as well as by participants in their subjective accounts, which formed the second component of the present study. One reason for this could be that the static measure used was not sensitive enough to capture such associations. Mood monitoring was associated with increasing reporting of symptoms, affect intensity and negative affect, but was not associated with a low expectancy to self-regulate negative mood. These findings suggest phase of cycle is a less significant factor when it comes to experiencing negative affect as part of menstrual cycle change. Rather the style associated with self-directed attention, in particular mood monitoring, predisposes to the experience of more negative affect and perception of somatic and emotional changes (symptoms) associated with menstrual cycle change. This is consistent with findings from the previous study (chapter 7) which also found mood monitoring to be positively associated with more reported negative affect and symptoms.

The second aspect of the study concerned the examination of personal accounts of experience of premenstrual syndrome. Based upon recommendations from research on premenstrual syndrome (Bancroft, 1993, 1995; Swann, 1997; Ussher, 1996; Walker, 1997) it was felt necessary to make provision for subjectivity to be considered within the structure of the present study by providing a space for participants to write freely about their experiences, and to assess such information in parallel with the quantitative information. Although it can be argued that rating scales are subjective, they are a highly structured means of gathering information and so the space for writing was important. Several key discourses were utilised by participants to construct their versions of premenstrual syndrome: biological, self-other divide,

control, femininity, emotion and anger, and fragmentation of lived experience. Not surprisingly a biological discourse was frequently used as it represents the dominant discourse for the way women's bodies are talked about and referred to. A biological discourse served the function of privileging the body as the determining aspect of lived experience, which was also found to be the case in Swann's (1996) study. Also the menstrual cycle was traced as the source of the beginning of negative experience for many of these women. This is consistent with Laws' (1990) findings from her study on adolescent perceptions of menstruation. Menarche was perceived as a decisive negative event for girls, something to be ashamed and afraid of, even in boys and girls who had never experienced such an event (Laws, 1990).

A self-other divide was particularly salient in many of the accounts, manifesting in a variety of different ways from rational/emotional through to good woman/bad demonic premenstrual woman. This is consistent with findings by Swann & Ussher (1995) that the discursive category of premenstrual syndrome performed the function of allowing the individual to separate negative aspects of the self from one's 'normal' self. Ussher (1989, 1991) talked of a splitting of the female self. She argued that women can experience a splitting of the self through being placed in a double-bind, Madonna-whore dichotomy by patriarchal society. A woman is supposed to be good, pure and nurturing, yet also a sexual being which incorporates lustful, opposing aspects to the Madonna characteristics. Ussher (1991) goes on to argue conventional society still does not permit women to express the bad or negative aspects of their feelings, particularly anger, within this dichotomy. In addition to a splitting of the self being accounted for by Ussher's (1991) Madonna-whore

dichotomy, Burkitt's (1999) work provides a useful understanding for the findings of the present study. Burkitt (1999) argued women often express being alienated from their bodily experiences because medicalization has fragmented women's bodies in separate parts, particularly the process of menstruation, childbirth and menopause. Rather than seeing menstruation as a lived bodily experience that is part of the self as a whole person, women have a detached relation to it. Indeed this was found to be the case for much of the time.

Following on from the point of self-other, anger was particularly evident in the accounts. Again referring to Ussher's (1991, 1996) work, she argued that the notion of premenstrual syndrome is the only socially legitimate way that women are permitted to express anger. Brody (2000), when talking about the socialization of gender differences in emotional expression, highlighted how adult women anticipate more negative social consequences for expressing anger than men do. She also said that parents emphasise the control of emotional expression for their sons, whilst emphasising the control of aggression for their daughters. Therefore to express anger as a woman goes against the social norms governing femininity. Ussher (1991) argued that attributing the expression of anger to a biological abnormality (premenstrual syndrome) serves to make such lived experience more acceptable to women themselves and the public domain.

Contained within the construction of accounts was evidence of both language being used discursively by participants, as well as for the implications of pre-given meanings, referred to by Parker (1992) as the dual nature of language. An extract from participant 67's account illustrated this point. Parker (1998) argued language

often actively captures or traps the individual through pre-given, multiple meanings. Yet the user can also be more actively involved in the construction of accounts of the self from time to time by using language discursively, more actively selecting particular words or phrases to assist them in the way they chose to construct an account/response. Within the present study this was taken as evidence for the way these women were having to actively manage the construction of accounts of their emotional selves in relation to what they perceived would be socially acceptable or legitimate.

Feminine discourses were frequently used by participants, which is consistent with findings from studies conducted by Swann (1996) and Swann & Ussher (1996). Rather than participants merely listing the types of symptoms they had experienced, accounts of what premenstrual syndrome represented were constructed through roles and responsibilities, especially motherhood and marriage. This is in line with Ussher's (1991) assertion that often women feel they should not express negative feelings for fear of being perceived as unable to cope with their responsibilities. Women are the carers and nurturers of the family unit. Good wives and mothers cope, are altruistic and uncomplaining (Ussher, 1991). Ussher (1996) argued that premenstrual syndrome can provide a legitimate means of expressing negative feelings for women. Discourses of premenstrual syndrome and disordered biology are the only available discourses for women to use when talking about experience of distress and life dissatisfaction, particularly emotional distress (Ussher, 1996). Also Swann (1996) suggested that women are placed in an unrealistic position by social expectation of the 'perfect mother' as being controlled, happy, and always able to

cope. Anger and shouting are not considered to be desirable ways of behaving towards one's children, yet they are a normal part of lived experience. The account used to illustrate the point of femininity through mothering contained meanings which suggest that shouting and being short tempered around one's children are part of the normal experience of mothering.

In addition to accounts being comprised of roles constructed out of femininity, participants also referred to many stressful life events when writing about what premenstrual syndrome meant for them. This is consistent with Parry's (1994) findings that up to 75% of women with premenstrual syndrome have other problems, and that premenstrual syndrome usually does not exist in isolation. Also, Asso (1988) argued that menstrual cycle disorders should be investigated with continued counselling support to establish whether the menstrual cycle distress is the central problem, or possibly an exacerbating factor. Asso (1988) further stated that the menstrual cycle provides a physiological backdrop to socially lived experience, which can be clearly affected by social events. Sometimes when an individual's personal coping resources become stretched, menstrual cycle change may be "the straw that breaks the camels back" (Asso, 1988).

A predominant theme that emerged from the majority of accounts, including those which have been used to illustrate meanings evident in discourses, is the separation of emotions from life events. This is taken as evidence for van Dijk's (1999) discourse-cognition-society triangle. He argued that ideologies characterise the mental dimensions of society, and so form the basis of mental structures. The way accounts were discursively constructed reflects the conventional scientific view that

is still dominated by positivism. Emotions were positioned as separate to lived experience for much of the time. This upholds traditional scientific beliefs of separating emotions into cause or effect categories, rather than seeing emotional experience as an ongoing process which can be influenced by our socially lived experiences as they unfold. This, it is argued, may predispose to failure to make connections between menstrual cycle distress and challenging life events, particularly for the way menstrual cycle distress can be exacerbated. Also negative emotions and mood change are understandably positioned as unwanted and problematic. However there was no acknowledgement in the accounts of negative feelings and moods as part of normal ongoing experience. Bancroft (1993, 1995) highlighted how mood fluctuations and negative feelings are part of normal everyday existence. Therefore striving to always feel happy and positive can be unrealistic.

Summary

The present study utilised a combined methodological framework to achieve two main objectives. Firstly to establish whether there were any significant relationships between a number of variables known to be important for emotional well-being, in a sample of women suffering from premenstrual syndrome. Secondly to establish a deeper understanding of what premenstrual syndrome means for these women, providing an opportunity for subjective experience to be heard and valued. In particular mood monitoring was found to be positively associated with negative affect and a higher degree of reported affect intensity and symptom severity. Such results imply the style of focusing on mood/affect is associated with a higher degree of

menstrual cycle symptoms, rather than cycle phase, which was not found to be significant. This meant rejecting the hypothesis that cycle phase would be an important factor on the way participants reported on the other variables, particularly mood monitoring and symptom severity. Yet from the second component of the study, the qualitative data revealed 49 participants believed timing to be an important factor for symptoms. There are two possible explanations for this discrepancy. One speculative explanation for this discrepancy may be that participants reported on the measures as they felt at the time, yet reproduced through language dominant beliefs about the premenstrual phase of the cycle in relation to symptom onset and severity. This is significant given that thirty nine out of the total number of participants reported being in the premenstrual phase of the cycle at time of completing the questionnaire. Secondly different participants had claimed to experience symptoms at very different parts of the menstrual cycle which were not necessarily in the premenstrual phase, and so the static measure used for the study was not sensitive enough. This would indicate that restricting menstrual cycle related problems to a narrowly defined period, namely the premenstrual phase, is not the most appropriate way of defining menstrual cycle related emotional distress. Nevertheless, such a discrepancy is clearly an important finding, highlighting the frequent mismatch between popular beliefs governing the premenstrual phase of the cycle and actual experience.

The second component of the study found several core discourses were used discursively by participants to construct their version or account of premenstrual syndrome. Biological discourses featured prominently, consistent with dominant

medical and popular held beliefs connected with the female biology as problematic and in need of a cure. A self-other divide was also utilised by many participants, which it is believed performed the function of enabling expression of negative elements in lived experience without having to occupy a position of direct responsibility, and tied in with discourses of femininity. Loss of control was frequently seen as a direct result of premenstrual syndrome, the disorder often constructed as taking over the individual like a demon or other personality unknown to the individual. Accounts revealed many stressful life events that placed high demands on personal coping resources. Finally it was observed that accounts were constructed in such a way as to separate out life events from emotional responses. Emotions were positioned as separate to life events for much of the time, reflecting dominant positivist ideology.

Future Research

A major criticism of the present study is the absence of a matched control group for comparison on the measures used. It would be useful to establish whether women who suffer with premenstrual syndrome are more prone to use a mood monitoring style, and whether they experience affect more intensely than women who do not report to suffer from menstrual cycle related affective disturbance. This would be especially important for the link between a ruminative response style and prolonged experience of negative affect (Nolen-Hoeksema, 1991). On comparison between studies in this thesis, reporting of mood monitoring by participants from the

study in the previous chapter was similar ($M = 4.2$, $SD = .9$) than by participants in the present study ($M = 4.02$, $SD = 3.8$).

The symptom rating scale used contained no positive changes, which meant participants were prompted to think about menstrual cycle change in a negative frame of reference. Future research should take account of Nichols (1995) recommendations regarding the incorporation of positive changes in scales used to assess symptoms/changes. Also despite recording a ‘generally’ and ‘yesterday’ measure for mood awareness, measuring affect (using the PANAS) was still a static one-time measure, attracting the disadvantages outlined in chapters one and three. The scale used to assess private self-consciousness (Fenigstein, Scheier & Buss, 1975) was selected on the basis of maintaining consistency, as it was used by Swinkels & Giuliano (1995). However Burnkrant & Page (1984) advocate several modifications to this scale, and so future research should take these recommendations in to consideration.

Some of the participants were taking an oral contraceptive at the time of the present study, which it could be argued may affect the outcome. With regard to oral contraceptive use and known effects on mood, research findings on the effects of oral contraceptive use on mood, depression and premenstrual syndrome are mixed. The evidence on use of oral contraceptive use and mood suggests the majority of women taking an oral contraceptive experience no change in mood as a result (Glick & Bennett, 1982). Also although there are popular assumptions that oral contraceptive use may improve premenstrual symptoms because of the regulatory function, again there is no conclusive evidence to support such an assumption, the outcome being

dependent upon the presence of a concurrent psychiatric illness (Glick & Bennett, 1982). Therefore oral contraceptive use was not used as exclusion criteria for participation in the present study. Also other forms of medication were being taken at the time of the study by some participants, which could be argued may affect results. There is no conclusive evidence to suggest any one form of medication affects the manifestation and progress of premenstrual syndrome. Therefore use of medication was not used as exclusion criteria.

It could be argued the accounts were not representative of a cross section of the menstruating female population, and so the findings of this study can not be generalised. Also, in addition to participants being a self-selected sample, they were all members of a self-help organisation and so would have more to say about their experiences of the disorder. However the philosophy of the present study is not underpinned by the rule of generalisation in a rigid sense, and also does not seek to judge any one particular group of women's account of subjective experience as less valid than any other. Rather it is recommended that more research should be undertaken which allows more women to be able to share their subjective experiences of premenstrual syndrome in order to further understanding, thus supporting calls from Swann & Ussher (1995), Ussher (1996) and Walker (1997). The main conclusion drawn from the present study is that mood monitoring was positively associated with negative affect and symptoms, but also stressful life event experiences as well as dominant perceptions associated with menstrual cycle change are important factors in the way women experience their menstruating bodies.

Chapter 9

Mood Monitoring And The Menstrual Cycle

The present chapter will examine findings from a study which tracked mood and affect in a group of women over the period of one complete calendar month. This was undertaken for two purposes. Firstly, to be able to study emotion as a naturally occurring process over time, a process approach (otherwise referred to as an intensive time-sampling procedure) was required for reasons outlined in chapter 1 and chapter 3. Secondly, it was necessary to further examine positive and negative affect in relation to the timing of the menstrual cycle because of the discrepancy found in data from the combined methodological study reported in the previous chapter. In particular 50% of participants in the combined methodological study had stated that timing was an important factor in their menstrual cycle distress. Yet none of the three cyclical phases were found to be associated with increased symptom reporting or negative affect. Also the study which manipulated participant awareness (chapter 7) failed to find any differences on reporting for negative affect, which was surprising given popular assumptions. In addition results from this study found mood monitoring was positively associated with symptom reporting, and in the combined methodological study mood monitoring was positively associated with the reporting of negative affect. From these results it would seem that mood monitoring was emerging as a significant factor in the way participants reported on their affect and symptoms, rather than cycle phase. Also results from the study which had manipulated participant awareness (reported in chapter 7) had found cycle phase not to be a

significant factor for reported negative affect as part of menstrual cycle change. Rather the style associated with self-directed attention, namely mood monitoring, was thought to predispose to the experience of more reported negative emotion and perception of somatic and emotional changes associated with cyclical change. A more thorough investigation of emotion, symptoms, and mood awareness was therefore required. However to be able to investigate these factors more thoroughly, particularly in regard to cyclical phase, an approach was required which could incorporate the use of time across the menstrual cycle. An intensive time-sampling procedure was deemed to be the most appropriate way of achieving such aims.

A number of factors are believed to have an effect on the way an individual experiences emotional states. In the present study I will focus particularly on mood awareness and affect intensity. Given that the most commonly reported symptoms experienced by women presenting for medical help with menstrual cycle problems concerns emotion (Bancroft, 1995), the nature of emotion in relation to the menstrual cycle should be given further consideration. More specifically in relation to affect, mood and affect awareness have been found to influence both the nature of an emotional experience (positive and negative), and the duration of the emotional experience, and so have implications for overall well-being (Swinkels & Giuliano, 1995). Also the individual difference characteristic affect intensity, which refers to the degree of strength of an emotional experience, is believed to influence the nature of the experience of emotional states (Flett et al., 1988; Flett et al., 1995; Fujita et al., 1991; Larsen, 1986; Larsen et al., 1987). In particular women have been found to be more emotionally intense than men (Fujita et al. 1991). The present study therefore was

also interested in establishing whether affect and mood awareness, and affect intensity have an impact upon the nature of emotion, in a group of women reporting premenstrual emotional symptoms. In order to achieve the main objectives of the present study, time was operationalized as a psychological variable. This is because it is my belief that women's awareness of their mood and emotional state may be enhanced around the time of the premenstrual phase of the cycle, as negative mood is commonly explained by cycle phase. Therefore an understanding of emotion and mood awareness combined with the impact of the cyclic variation of time provided a framework for the present study.

Further justification in support for conducting the intensive time-sampling study is gained from the issue of symptom reporting by women, in particular negative emotion, anxiety, and mood changes (Bancroft, 1993; Walker, 1997). Indeed the focus of interest on women's emotional instability and the normally occurring cyclical rhythm of the menstrual cycle has been further strengthened by the inclusion of the Late Luteal Phase Dysphoric Disorder (LLPDD) in the revised edition of the Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994). Disturbance in emotion and mood resulting from women's cyclicity, therefore, remains a prominent research focus.

Accuracy of emotion reports over the course of the menstrual cycle

Retrospective reporting of mood change premenstrually is often not consistent with prospective reporting in the same samples (McFarlane et al., 1988; Abplanalp, 1983). Motherwell et al. (1994) carried out a longitudinal prospective study to establish evidence of mood fluctuations in the premenstrual phase of women's menstrual cycles, as well as other menstrual, day of the week, and lunar

fluctuations. There was no evidence found to support the hypothesis of a classic premenstrual mood down phase. Rather there were more cyclical changes associated with day of week, lunar phase, and postmenstrual phase.

McFarlane et al. (1988) referred to the 'classic menstrual mood pattern' as the belief that pleasant emotion in the ovulatory phase of the menstrual cycle is followed by a negative emotion in the premenstrum when the ovarian hormone levels drop. However they also point out that fifteen years of research have provided little supportive evidence for this pattern. Furthermore, McFarlane et al. (1988) found that fluctuations in women's moods due to the menstrual cycle were less than fluctuations due to day of the week effects. Also recollection of menstrual mood changes differed from concurrently reported changes; women recalled more pleasant moods in the follicular phase and more unpleasant moods in the premenstrual and menstrual phases than they reported concurrently. Therefore the intensive time-sampling procedure used for the present study eliminates many of the problems encountered by use of static on-time measures, and instead tracks mood and affect over time against the backdrop of lived experience.

Affect Intensity

Swinkels & Giuliano (1995) reported that individuals high in mood monitoring also displayed a tendency to experience emotion more intensely, compared to low monitors. Affect intensity has been found to be a stable individual difference characteristic, which refers to the typical strength of an individual's emotional responsiveness (Larsen & Diener, 1987). Diener et al. (1985) have found that some individuals experience emotion with greater intensity

than others, and that such differences are apparent for both positive and negative affect. Affect intensity has also been found to have a number of consequences for overall wellbeing. Persons high in affect intensity, compared to lows, have been found to experience more frequent mood shifts, to report a greater frequency of somatic complaints, to be more at risk of bipolar depression/mood disorder, and to be more likely to report neurotic symptoms (Larsen, 1987). Also women have been found to be more emotionally intense than men (Fujita et al., 1991). Therefore affect intensity was also considered within the framework of the present study because one of the commonly reported symptoms of premenstrual emotional distress is the lability of mood. If a woman experiences her emotions and moods as more intense, then any change in her mood will be experienced as more pronounced.

Emotion/Mood Awareness and the Menstrual Cycle

Mood awareness is a key factor in determining the course of emotional experience, as discussed previously. Also popular beliefs surrounding the premenstrual phase and negative mood may enhance awareness at particular times during the menstrual cycle. For some women, this may mean constantly monitoring their emotional state. Monitoring one's mood and emotions may predispose to a ruminative cognitive style (Nolen-Hoeksema et al. 1993), which can prolong the experience of negative emotion. Therefore it is possible that some women may monitor their emotions more at given points in their menstrual cycle, particularly the premenstrual phase, predisposing them to experience more negative emotion. It is important to look at the role of mood monitoring and affect intensity for the way they may moderate the effects of the menstrual cycle. If a

woman believes the premenstrual phase of her menstrual cycle causes her to feel negative or depressed, she may tend to monitor her feelings more around this time of her cycle, which may prolong the experience of any negative feelings. Also if a woman experiences her emotions with a greater degree of intensity, then any change in her feelings around the premenstrual phase will be experienced as more pronounced.

Emotion and Mood Over Time

Rather than treating emotion as a one-time outcome measure, the study assesses its variations over time. The resulting data are processed using a pooled time-series regression technique (eg. West & Hepworth, 1991). It is believed such a technique has the potential to address some of the issues already outlined, and gain a more ecologically valid assessment of emotion and mood as it unfolds over time. This is because cyclicity has been identified as a factor in mood research, with daily, weekly and monthly time frames having a variety of effects on the individual (Gallant et al., 1991; Mansfield et al., 1989; Totterdell et al., 1995).

Bancroft (1995) is noted for his critical appraisal of menstrual cycle research. He is especially critical of the way in which the application of conventional mathematical research methods has little clinical value, because of an inability to accommodate the cyclical patterns experienced by women. Bancroft (1995) calls for a methodological and theoretical reconceptualization of the operationalization of research into premenstrual syndrome. By adopting a process approach (Larsen, 1989), the cyclical nature of premenstrual syndrome, particularly in relation to emotion and mood, can be tracked over time. Totterdell & Parkinson (1999) utilised a process approach to investigate the use and

effectiveness of particular kinds of mood regulation strategies for improving mood in a group of teachers over a two-week period. This study utilised a diary technique which meant participants were equipped with pocket computers to record the appropriate measures/data at regular intervals throughout each day. Overall this method proved to be a sensitive method for recording emotion and mood as it unfolded naturally over time, in relation to such factors as work and hassles that shape and become part of the emotion experience (Parkinson & Totterdell, 1998; Totterdell & Folkard, 1992).

The present study was conducted to gain an understanding of the characteristics of emotion in a group of women who believed they suffered from premenstrual syndrome. It is hypothesised that both mood awareness and affect intensity will have an impact on the emotion (positive or negative) reported by the women during the premenstrual phase of the menstrual cycle. Those women exhibiting a high mood monitoring tendency are predicted to experience more negative emotion, particularly during the premenstrual phase of the cycle, than those women low in mood monitoring. Finally, affect intensity as an individual difference characteristic, and the mood monitoring dimension, as found previously by Swinkels & Giuliano (1995), would be positively correlated.

Method

Participants

The participants were 22 women, aged between 17 and 48 years ($M = 35.1$). Consideration was given to the sample size in relation to the length of the study, the frequency of measurement, number of measures and the time it takes to

complete the measures. An intensive time sampling procedure places high demands upon both the researcher and the participants (Tennen et al., 1991). To prevent sample attrition it was decided that such a number of participants could be given the necessary high degree of support, ensuring a higher response rate. The question of the quality of the data was an important consideration. One of the key reasons for using a process approach was more a consideration of tracking a small number of women over a period of time to establish affect and events as they unfold.

The participants were recruited from two sites on a university campus to take part in a mood study. The criteria for participation were that individuals had to be women who believed they suffered some degree of premenstrual syndrome and that they were pre-menopausal.

Three participants were taking an oral contraceptive, with the remaining 19 participants using other forms of contraception. Oral contraceptive use was not used as grounds for exclusion from the study. Reasons for this were outlined previously (chapter 8, see Glick & Bennett, 1982).

Occupationally participants ranged from university lecturer (10), nurse (1), secretary (5), PhD student (1), trainee accountant (1), youth worker (1), school teacher (1), designer in the fashion industry (1) and research assistant (1). All 22 participants successfully completed the study, which ran over a total of 31 consecutive days.

Procedure

As Tennen et al. (1991) point out, an intensive time sampling procedure makes large demands upon both the researcher and participants. Participant

support was therefore an important consideration when planning the investigation. Participants were paid £80 on completion of the investigation for the commitment of their time, which took place over one complete calendar month (March 1998). Prior to the investigation (several days before) participants were given a one-hour training session on the use of the pocket computer. This involved running through the procedure to turn the computer on, enter personal identification number, respond to the programme, and turning the computer off once the programme had been completed. Participants were also encouraged to try out the procedure prior to the investigation. For this purpose there was a facility within the programme that asked whether the user was testing. The user had to respond 'yes', enabling the programme to run without triggering the date, time and memory for the commencement of the investigation. This facility allowed the participant to practice using and running through the programme before the investigation commenced. Part of the one-hour instruction session involved the participant observing myself using the computer, then running through the programme several times whilst being observed. To trigger the computer for the commencement of the investigation, participants had to respond 'no' to the computer when asked if testing. All participants were instructed to do this on the 1st March, and were telephoned to ensure that they were complying with this request.

There was a facility for being able to exit the programme once running, by removing the battery from the computer and allowing a one-minute time lapse before the battery was replaced. Removal of the battery did not interrupt the memory, date and time however, so that no data would be lost. Removal of the battery also enabled access to programming of the alarm, so that if participants

wished to turn the alarm off for a period of time, for example if they were going to a meeting, they could do so. All operating instructions were documented on A4 paper so participants had written instructions to refer to (appendix 4.2). Finally, participants were given a mobile telephone number for use between the times of 8am and 10pm for the duration of the study. They were instructed to telephone the researcher immediately if they had any problems with the pocket computer. Each participant was also telephoned twice a week to provide encouragement and support, and check for any problems that may have arisen.

Instrument

Materials used for the intensive time sampling procedure were developed and validated by Peter Totterdell (1996). They took the form of a variety of software programmes for use with a pocket computer. (For use of alternative instruments see Totterdell, 1996). The main criteria he used were as follows; the instrument had to be portable, inexpensive, signal the participant to respond without the intervention of the investigator, record the time at which the participant responds, accurately record elapsed time, have sufficient display size to allow presentation of the scales and questions, have sufficient memory for programmes and data storage, and allow downloading of data to PC for subsequent analysis. Totterdell (1996) developed and validated a suite of programmes for the pocket computer to satisfy these requirements, and the programmes have since been used in a number of field and laboratory studies.

The pocket computer used was a Psion Organiser II: Model LZ (which is advertised as an electronic personal organiser, costing approximately £135). It contains a built-in clock and calendar, used for setting alarms and time-sampling

events. The computer weighs 250g without batteries. Dimensions with the protective case closed are 142x78x29 mm. The LZ model has 64K ROM and 32K RAM, and has a four line by 20-character LCD screen. The keyboard is alphabetical and not QWERTY. Data can be transferred to a PC or Macintosh using a Comms link (approximate cost £60). A 128K flash datapack (approximate cost £70) was used for the programmes and a 128K flash datapack for the datafiles. Totterdell (1996) says the advantage here is in the separation of programmes from data, programmes and data are safe in the event of power failure, and the ability to use the MK III datapack copier. The MK datapack allows for programmes to be simultaneously copied from a master datapack to up to 8 datapacks.

Data recording design

A visual analogue scale format for self-reports was used with the pocket computer. Although an open-ended response format has the advantage of allowing participants to select events which have the most personal meanings, and describe events in their own language, they become difficult to categorise. The use of the visual analogue scale format overcomes this problem. Sandvik et al. (1993) examined the reliability of self-report measures of well being against those of non-self reports, which included informant reports. Results showed good convergent and discriminant validity. Self-report measures were found to correlate highly with the non-self report measures. The recordings were signal-contingent (Wheeler & Reiss, 1991), which means that events and feelings were recorded whenever prompted by an agreed signal; in this case an alarm. This enabled participants to report on their current experiences rather than relying on memory.

Rating scales

The pocket computers emitted auditory reminders (which could be switched off by participants if necessary) signalling two hourly intervals throughout the day (during night-time this was switched off). The computer automatically recorded the time and date at which participants responded. The participants were encouraged to keep as close to the timed signalled intervals as possible, and actual time of responding was automatically recorded. Completing the rating scales usually took 2-3 minutes. Figure 1 shows an example of a visual analogue rating scale.

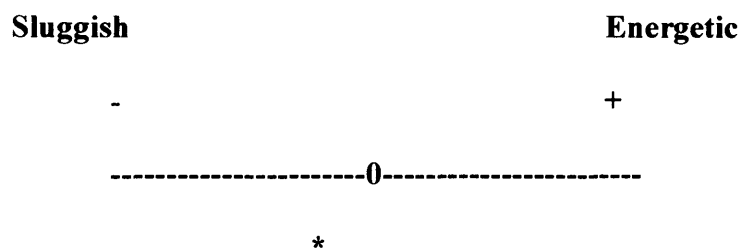


Figure 1. Presentation of bipolar rating scale

Participants were required to move the cursor (shown in figure 1 as an asterisk) up to the horizontal line using one press of the vertical arrow key on the pocket computer. Then they had to move the cursor to the position along the line that represented their responses using the horizontal arrow key, before finally pressing a key to indicate they are satisfied with the cursor's position. Date and time of completion, and column position of the cursor (1-20) were automatically

recorded.

Performance of Pocket Computer

Totterdell (1996) found that participants responded favourably to using the pocket computer, and there were only a few problems with the hardware and software. Overall the instrument was found to be highly reliable and valid (Parkinson & Totterdell, 1999). It enables the researcher to cue the participant to respond without being present, and collect data at all times of the day in all locations without direct intervention or excessive disruption. The key drawback is that the researcher has no control over the conditions under which the scales are completed. Also the pocket computer may interfere with the participant's daily life, thus having the potential to alter the constructs being measured. However this is a problem common to research generally for much of the time. Overall it proved to be a valuable research tool for use within this thesis.

Measures

Participants completed a number of questionnaires and took part in a semi structured interview prior to the commencement of the study. However only a subset of the questionnaire measures completed by the participants were used in the present study.

The participants were required to think about the previous 2 hours and then complete six bipolar rating scales of their mood. The adjectives at the ends of each scale were chosen from the UWIST mood adjective checklist (Matthews, Jones, & Chamberlain, 1990), and were two scales each for hedonic tone (sad-

happy and depressed-cheerful), tense arousal (calm-tense and relaxed-anxious), and energetic arousal (tired-alert and sluggish-energetic). The participants selected from one of nineteen possible positions along each visual-analogue scale to represent most accurately how they had been feeling during the previous 2 hours. One of the two scales from each dimension was presented in reverse direction and reverse scored.

A principal-components factor analysis of the residual scores (residuals from a regression model to eliminate between-person, serial dependency, day of week, time of day, and day of study effects – see analysis section) with varimax rotation and specifying a three-factor solution produced the expected pairing of scales (all factor loadings $> .85$). Therefore a consolidated score was calculated for each dimension by averaging the ratings from the two items. The consolidated scores have been labelled happiness ($\alpha = .82$) for hedonic tone, calmness ($\alpha = .82$) for (reverse of) tense arousal, and energy ($\alpha = .75$) for energetic arousal.

Mood Awareness

Participants responded to unipolar rating scales 2 hourly to indicate the percentage of time they had been aware of their mood.

Menstrual Cycle Phase

Participants were required to record the first day of menses on the pocket computer. The researchers were then able to calculate cycle phases for participants based upon the timing of the first day of the menstrual period. The cycle was broken down into three separate phases; the menstrual phase was represented as day 1-7; the intermenstrual phase was represented as day 7-21; the

premenstrual phase was represented as day 21-28.

Response compliance

The 22 participants completed a total of **3239** mood ratings during the study (excluding the practise day). This meant that a vast amount of data was generated, translating in to **372** data points per participant, totalling **8184** data points in the SPSS file. The participants had the potential of completing the mood ratings a maximum of eight times a day. Under this assumption the response rate represented at least a 53% response compliance, which is normal for this type of methodology (Totterdell, 1996; Totterdell & Parkinson, 1999).

Results

Use of statistics in the analysis of temporal data

Missing data are a common problem with intensive time sampling studies. Unfortunately the standard methods for dealing with missing data are not possible because they would reduce the data set a great deal. Therefore a technique that allows for missing data had to be used. Secondly there is a problem with non-independence, in that observations from each participant are not independent. Specifically there are three types of non-independence that had to be accounted for; trend, cycle, and serial dependency. Trend refers to regular change over time through factors such as response habituation. By cycle one is referring to a rhythm or repetition in the data. Finally serial dependency means that adjacent observations are more likely to be correlated than observations at greater intervals, also known as autocorrelation.

To overcome the problems just referred to the thesis draws upon the work of West & Hepworth (1991), Larsen (1987) and Totterdell (1996). A pooled time-series regression procedure with the use of dummy variables was employed which remove differences in the data set ascribed to differences between participants. The whole data set can then be analysed as though it were the time series of an aggregate person. Totterdell (1996) reviews the suitability of other techniques for use with temporal data., such as structural equation modelling and the Box-Jenkins autoregressive integrated moving average model. However he concludes that pooled time-series is the most suitable, and thus is the general technique used in this thesis.

In order to remove any trend, cycle, and serial dependency from the time-series dependency from the time-series, so meeting the assumption of independence between observations (West & Hepworth, 1991; Totterdell, 1996; Totterdell & Parkinson, 1999), the following control variables were created for entry into the regression models: dummy variables for N-1 days of the week to remove variance attributable to particular days of the week; a variable for the previous value (first-order lag) of the dependent variable to remove serial dependency in the time-series a variable for the number of observations (bin).

The analyses mainly involved entering independent variables into the regression models following entry of the control variables to test for relations with the dependent variables.

To establish whether menstrual cycle phase predicted affect (happiness, calmness, energy) a regression model was constructed using the affect variables as separate dependent variables, and dummy variables for each cycle phase as independent variables, after controlling for all the variables mentioned above.

Also similar analyses were conducted to establish whether there were any interactions and predictors based on the other individual difference characteristics of affect intensity and negative mood regulation expectancy. For affect intensity and negative mood regulation expectancy no significant effects were found.

Happiness

Regression analyses were conducted to determine whether menstrual phase influenced happiness, calmness and energy. In each case for the analyses the control variables were entered in block 1 and the first-order lag of the dependent variable in block 2. It should be stated that for **all** regression analyses reported on in this chapter, the variance due to day of week and the first-order lag were always found to be significant. This is partially why it was necessary to control for these effects, but also because essentially one was interested in whether the variance on the dependent variable(s) were significant. Although the menstrual phase had no significant effect, both the intermenstrual phase and the premenstrual phase were reliable predictors of reported happiness, shown below.

Table 4.

Table Displaying Results of Happiness Predicted by Menstrual Cycle Phase

	Happiness Predicted by Phase
Intermenstrual Phase	Prior $R^2 = .50$, R^2 change = .001, $F(31, 2098) = 69.52$, $p < .01$
Premenstrual Phase	Prior $R^2 = .50$, R^2 change = .005, $F(31, 2098) = 69.19$, $p < .01$

To assess whether the effect of cycle phase interacted with mood monitoring, the cross product of each of the three dummy variables representing cycle phase with mood monitoring were entered into the regression equation in

separate analyses following the entry of the corresponding variables individually. Although the interaction term for mood monitoring with menstrual phase had no significant effect, both the interaction terms for mood monitoring with premenstrual phase and mood monitoring with intermenstrual phase did, show in table 5.

Table 5.

Table displaying Mood Monitoring as an Interaction with Cycle Phase for Predicting Happiness

	Mood Monitoring as an Interaction with Cycle Phase
Mood Monitoring X Premenstrual Phase	Prior $R^2 = .50$, R^2 change = .003, $F(31, 2098) = 70.01$, $p < .01$
Mood Monitoring X Intermenstrual Phase	Prior $R^2 = .51$, R^2 change = .005, $F(31, 2098) = 70.60$, $p < .01$

In order to interpret these significant interactions the effects of the premenstrual phase and the intermenstrual phase were assessed separately for higher and lower mood monitors as defined by a median split procedure. For high mood monitors, regression analyses established that both the premenstrual phase and intermenstrual phase significantly predicted happiness Regression analyses confirmed that the menstrual and intermenstrual phases were not significant predictors of happiness for participants displaying a low mood monitoring tendency, yet the premenstrual phase was. Results are shown in table 6.

Table 6.

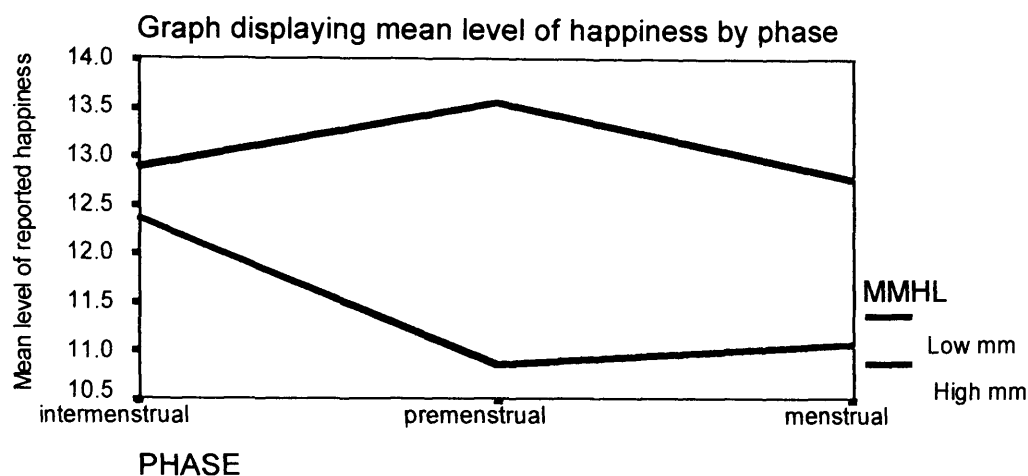
Table Displaying Happiness Predicted Separately for High and Low Mood

Monitors by Menstrual Cycle Phase

	Happiness Predicted for High Mood Monitors
Premenstrual Phase	Prior $R^2 = .33$, R^2 change = .006, $F(21, 1208) = 28.50$, $p < .01$
Intermenstrual Phase	Prior $R^2 = .33$, R^2 change = .01, $F(21, 1208) = 29.05$, $p < .01$
	Happiness Predicted for Low Mood Monitors
Premenstrual Phase	Prior $R^2 = .59$, R^2 change = .003, $F(19, 820) = 62.19$, $p < .01$

In order to establish the direction of the effects on reported happiness across cycle phase, aggregate means of happiness for each participant during each cycle phase were compared for high and low mood monitors. The graph (over page) displays the mean level of happiness for high and low mood monitors separately. High mood monitors experienced less happiness ($M = 11.46$) than low mood monitors ($M = 13.07$) although a t-test revealed these difference to not be significant.

Graph 1.



Energy

Regression analyses were conducted to establish whether any of the three cycle phases predicted energy. Again the control variables were entered in block 1, the first-order lag of the independent variable in block 2. The menstrual phase did not predict energy, but the intermenstrual phase and the premenstrual phase did. Results are shown in table 7.

Table 7.

Table Displaying Energy as Predicted by Menstrual Cycle Phase

	Energy Predicted by Cycle Phase
Premenstrual Phase	Prior $R^2 = .55$, $R^2 = .001$, $F(31, 2098) = 83.53$, $p < .01$
Intermenstrual Phase	Prior $R^2 = .55$, $R^2 \text{ change} = .002$, $F(31, 2098) = 83.85$, $p < .01$

To assess whether the effect of cycle phase interacted with mood monitoring, the cross product of each of the three dummy variables representing cycle phase with mood monitoring were entered into the regression equation in separate analyses following entry of the corresponding variables individually. The

interaction between mood monitoring and the menstrual phase of the cycle was not a significant predictor of energy. However the interactions between the premenstrual phase and mood monitoring and intermenstrual phase and mood monitoring were, thus providing a justification for conducting analyses separately on participants displaying high and low mood monitoring respectively.

Table 8.

Table Displaying Mood Monitoring as an Interaction with Menstrual Cycle

Phase for Predicting Energy

	Energy Predicted by Mood Monitoring as an Interaction with Cycle Phase
Mood Monitoring X Premenstrual Phase	Prior $R^2 = .55$, R^2 change = .00, $F(31, 2098) = 83.91$, $p < .01$
Mood Monitoring X Intermenstrual Phase	Prior $R^2 = .55$, R^2 change = .005, $F(31, 2098) = p < .01$

Regression analyses was conducted for high and low mood monitors separately and established that the menstrual phase of the cycle did not predict energy for high mood monitors. However the premenstrual phase and intermenstrual phase did. Results for low mood monitors established that intermenstrual, menstrual and premenstrual phases of the cycle did not predict energy on the low mood monitoring dimension. Table 9 below displays the significant results.

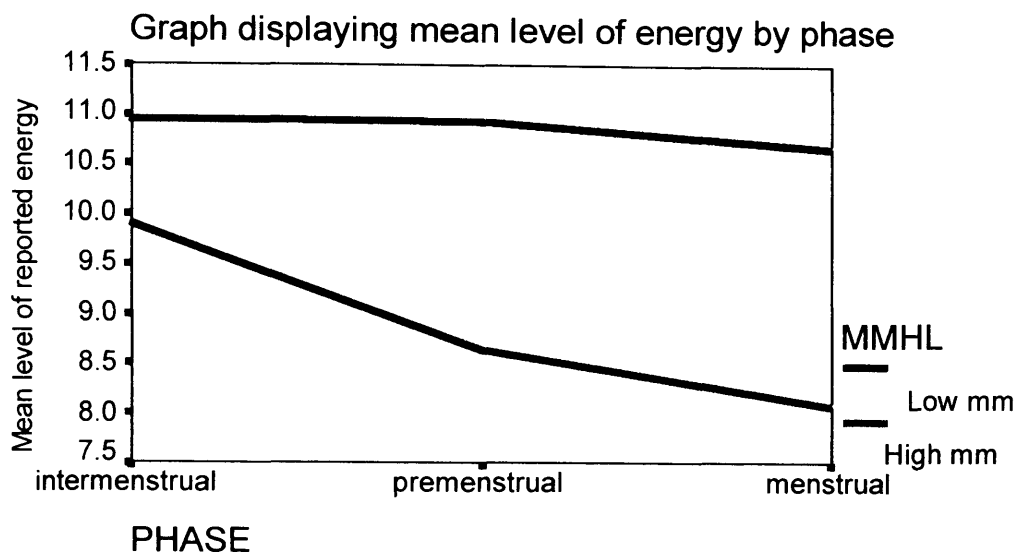
Table 9.

Table Displaying Energy Predicted by Menstrual Cycle Phase for High and Low Mood Monitors Separately

Energy Predicted for High Mood Monitors	
Premenstrual Phase	Prior $R^2 = .44$, R^2 change = .005, $F(21, 1208) = 45.64$, $p < .01$
Intermenstrual Phase	Prior $R^2 = .44$, R^2 change = .009, $F(21, 1208) = 46.41$, $p < .01$
Low Mood Monitors	Not significant

In order to establish the direction of effects of reported energy, aggregated means were compared for levels of energy between cycle phase, for high and low mood monitors. Participants displaying a high mood monitoring tendency experienced less energy ($M = 8.91$) than the low mood monitors ($M = 10.85$), although a t-test revealed the difference not to be significant. For high monitors the intermenstrual phase witnessed the highest average of energy ($M = 9.91$), decreasing in the premenstrual phase ($M = 8.64$), to the lowest menstrually ($M = 8.08$). For Low mood monitors energy was highest in the intermenstrual phase ($M = 10.95$), remaining fairly constant (premenstrual, $M = 10.94$, and menstrual $M = 10.66$), as displayed in the graph presented below.

Graph 2.



Calmness

Regression analyses were conducted to establish whether calmness was predicted by cycle phase. The control variables were entered in block 1, the first-order lag of the independent variable in block 2 (phase of cycle, entered in separate analyses), and the dependent variable in block 3 (calmness). **None** of these phases significantly predicted calmness.

In order to assess whether the effect of cycle phase interacted with mood monitoring, the corresponding product of each of the three dummy variables representing cycle phase were entered into the regression equation in separate analyses following entry of the corresponding variable individually. The interaction between mood monitoring and the menstrual phase was not a predictor of calmness. However the interaction between mood monitoring and the premenstrual phase and the interaction between mood monitoring and the intermenstrual phase did predicted calmness, as shown in table 10.

Table 10.

**Table Displaying Calmness Predicted by the Interaction Between Mood
Monitoring and Menstrual cycle Phase**

	Calmness Predicted by Mood Monitoring as an Interaction with Cycle Phase
Mood Monitoring X Premenstrual	Prior $R^2 = .47$, R^2 change = .001, $F(31, 2098) = 60.90$, $p < .01$
Mood Monitoring X Intermenstrual	Prior $R^2 = .47$, R^2 change = .001, $F(31, 2098) = 60.97$, $p < .01$

In summary, the menstrual phase of the cycle, as an interaction with mood monitoring for the whole sample, did not predict calmness. Although the menstrual phase of the cycle, as an interaction with mood monitoring, did not predict calmness, the intermenstrual and premenstrual phases did. Therefore analyses for the high and low mood monitoring dimensions was conducted separately.

Regression analyses confirmed that the menstrual and intermenstrual phases of the cycle did not predict calmness for the high mood monitors. However the premenstrual phase did. Regression analyses also established that the menstrual and intermenstrual phases of the cycle did not predict calmness for low mood monitors. However, again, the premenstrual phase did, as shown in table

11.

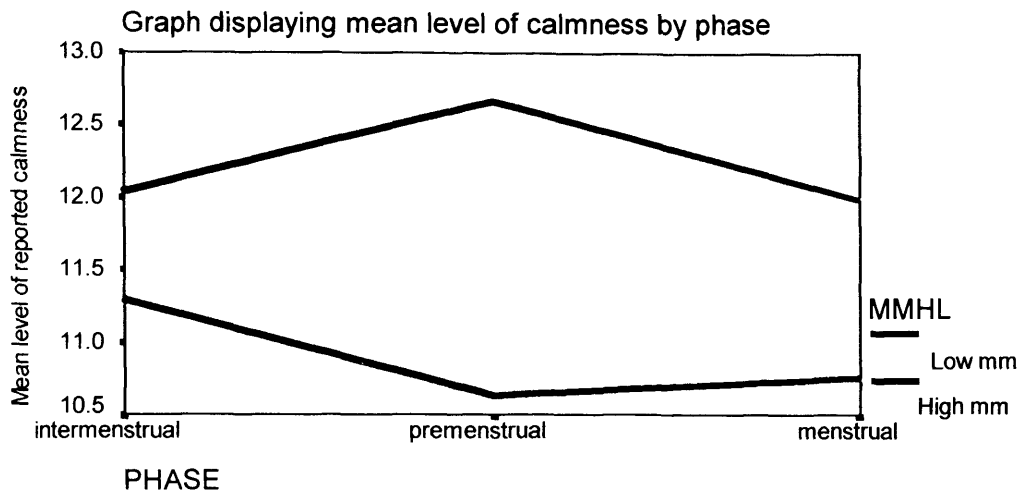
Table 11.

**Table Displaying Calmness Predicted by Menstrual Cycle Phase for High
and Low Mood Monitors Separately**

	Calmness for High Mood Monitors
Premenstrual Phase	Prior $R^2 = .31$, R^2 change = .002, $F(21, 1208) = 26.94$, $p < .01$
	Calmness for Low Mood Monitors
Premenstrual Phase	Prior $R^2 = .62$, R^2 change = .003, $F(19, 880) = 76.83$, $p < .01$

To assess the direction of the effects of phase on calmness aggregated means were compared for levels of calmness between cycle phase, for high and low mood monitoring. Participants displaying a high monitoring tendency reported less calmness ($M = 10.91$) than those displaying the low monitoring tendency ($M = 12.23$), a t-test revealed this difference to be significant ($t = 2.69$, $p < .05$). For high mood monitors the intermenstrual phase witnessed the highest average level of calmness ($M = 11.30$), decreasing in the premenstrual phase ($M = 10.63$), with a slight increase in the menstrual phase ($M = 10.75$). Low mood monitors on the other hand reported the highest level of calmness in the premenstrual phase ($M = 12.66$), slightly less in the intermenstrual phase ($M = 12.03$), the lowest level being in the menstrual phase ($M = 11.99$). These results are displayed in graph 3.

Graph 3.



To summarise happiness and energy were significantly increased in the intermenstrual phase but significantly decreased in the premenstrual phase. However these effects were moderated by mood monitoring, such that they were only apparent for high, but not low mood monitors. For calmness, phase had no main effect, but the premenstrual phase interacted with mood monitoring, with high mood monitors reporting less calmness, but low mood monitors reporting greater calmness during this phase.

Mood Labelling

Regression analyses were conducted utilising interaction variables between mood labelling and cycle phases with all three affect variables (happiness, energy, calmness). There were no significant effects.

Correlational Analyses

A series of Pearson r correlations were conducted with the affect variables, cycle phases, mood monitoring and labelling and affect intensity. There were several significant positive and negative results. See table for summary:

**Table of Pearson Correlations between Mood
Awareness, Mood Monitoring, Affect Intensity, and the
Mood Variables.**

Table 12.

	Affect Intensity	Mood Monitoring	Mood Labelling
Affect Intensity	** p < .001	.6790 p < .001	.2870 p < .001
Mood Monitoring	.6790 p < .001	** p < .001	.1518 p < .001
Mood Labelling	.2870 p < .001	.1518 p < .001	**
Happiness	-.730 p < .001	-.1312 p < .001	.1036 p < .001
Calmness	-.0920 p < .001	-.0689 p < .001	.0951 p < .001
Energy	-.1245 p < .001	-.1377 p < .001	.0499 p < .001

There was found to be a positive relationship between affect intensity and mood monitoring. Also mood labelling and affect intensity were positively related.

There was a significant negative relationship between affect intensity and the affect variables. Thus the higher participants scored on affect intensity, the less happiness, calmness and energy they reported experiencing. Mood monitoring was found to have a negative relationship with all three affect variables. Thus the higher participants scored on mood monitoring, the less happiness, calmness, and energy they reported experiencing.

Mood labelling was found to be positively correlated with affect intensity, and positively associated with the affect variables. Thus the higher participants scored on mood labelling, the greater the presence of happiness, calmness and energy they reported experiencing.

Discussion

This study was conducted to investigate affect and mood over one complete calendar month in a group of self-diagnosed sufferers of affective premenstrual symptoms. With the use of an intensive time-sampling approach differences were found in reported affect across cycle phase. The nature of affect experienced was predicted by cycle phase, and the style of mood awareness. The style of mood awareness was found to have different affective consequences. As hypothesised, cycle phase did have a predictive consequence on affect for those women exhibiting a high mood monitoring tendency, but not for low mood monitors (except that calmness was higher during the premenstrual phase for low monitors). There was no predictive effect for cycle phase depending on the mood labelling dimension. Also, as hypothesised, there was a positive relationship between mood awareness and affect intensity. In addition, day of week was always found to account for a high degree of variance on reported affect, in line with findings by McFarlane et al (1988), although this was not the essential focus of the present study.

Emotion and Mood Awareness

Differences in reported positive and negative affect were found to be dependent upon the type of mood awareness displayed. There were no significant

findings based upon the mood labelling dimension for cycle phase or affect.

However, high mood monitors reported less happiness, calmness and energy, whereas low mood monitors reported smaller or no differences. This lends support to the concept of mood monitoring being potentially adaptive or detrimental (Kirschenbaum, 1987; Swinkels & Giuliano, 1995). The findings provide evidence to support Swinkels & Giuliano's (1995) assertion that high mood monitoring predisposes the individual to experience more negative affect, which can be detrimental to overall emotional well-being.

The present findings suggest there is an effect of cycle phase upon affect. The level of positive affect decreased consistently across the three phases. However the premenstrual phase was not always found to be the point in time when participants experienced the lowest, or most negative, level of affect. For high monitors the intermenstrual phase of the cycle predicted energy and calmness, but not happiness. Of all the phases separately, the intermenstrual phase of the cycle witnessed the greatest amount of happiness, energy and calmness. The premenstrual phase of the cycle predicted energy, calmness and happiness. However the amount of these decreased (mean comparisons) compared to the intermenstrual phase. Finally the menstrual phase did not predict energy or calmness, but did predict happiness. The amount of all three affect variables was lowest, or more negative, during this phase of the cycle. The amount of calmness, energy and happiness was highest during the intermenstrual phase. The premenstrual phase witnessed a decline, but it was during the menstrual phase that affect was lowest (most negative), which does not support the common assumption that affect is lowest, or most negative, premenstrually.

There was a positive association between affect intensity and mood

labelling, this also being the case for mood monitoring. The findings of the present study are consistent with those of Swinkels and Giuliano (1995), who found a positive relationship between mood monitoring and affect intensity. However the present study also found a significant positive relationship between mood labelling and affect intensity. Although monitoring and labelling are two separate dimensions, they are orthogonal (Swinkels and Giuliano, 1995).

Such a relationship between affect intensity and monitoring has implications for premenstrual syndrome. A higher degree of affect intensity has been linked to an increased risk of bipolar depression and frequent mood shifts (Larsen, 1987). If a woman experiences her emotions more intensely, then any changes in mood and affect would also be experienced more strongly. Mood changes are one of the affective symptoms often reported with premenstrual syndrome, and so when combined with an increased tendency to monitor one's mood, this could predispose the individual to perceive their emotions as strong and unstable for some of the time.

Emotion

Participants displaying a high mood monitoring tendency reported less energy, calmness and happiness than participants low on mood monitoring. This is a significant finding, and supports Swinkels and Giuliano's (1995) claim that high monitors experience more negative emotion. In particular high monitors reported less happiness overall than low monitors. Across cycle phase high monitors reported the least happiness during the premenstrual phase, whereas the low monitors reported fewer differences, and experienced most happiness during the premenstrual phase. One possible explanation is that women who believe they

suffer from premenstrual affective symptoms may anticipate that they are going to feel negative around the premenstrual time. The tendency to monitor one's mood leads to a continued and prolonged self-focusing on one's mood and feelings, and so anticipation combined with monitoring one's feelings and mood may lead to less happiness. The process of monitoring moderates the experience of reported affect, combined with anticipation of 'premenstrual mood', leading to less happiness. For low monitors who are less aware of their moods there is an opposite effect, and so they are happier during the premenstrual phase.

Limitations

The main limitations to this study are that the demands of participating may have influenced the phenomena being studied. Participation would most certainly have made the women more aware of their moods. Also, because the duration of the study ran over a complete four weeks in a group of women with premenstrual syndrome, this again may have influenced reporting. Popular assumptions associate the premenstrual phase of the cycle with negative mood, which again may have influenced the monitoring and reporting of mood by some of these women. By having to think about their feelings for the previous two hours, this may have caused some of the women to monitor their moods more than they usually do, and so have an effect on reported affect.

Summary

This study has identified how variations on the mood monitoring dimension (high and low) of mood awareness can have different affective consequences in women suffering with premenstrual syndrome. Women

displaying a high monitoring tendency, compared to lows, were consistently less happy, energetic and calm. Also affect intensity was found to be positively associated with a higher degree of reported mood monitoring. It would seem that a degree of self-regulatory failure may be evident for these women, due to their tendency to experience emotion and emotional change more intensely, and monitor and ruminate more about their feelings. Alternatively, when feeling down it may be that the individual has a tendency to monitor the way they are feeling more than at times when feeling happy.

As a result of these findings it was necessary to focus more specifically on the mood monitoring dimension to examine the impact of high monitoring, compared to low, on the ability to self regulate emotions and mood. Also it would be useful to establish what kinds of self-regulatory strategies these women were initiating when displaying a high monitoring tendency, as well as during the premenstrual phase of the cycle. Therefore further analyses were conducted on the data to meet these objectives, which will be reported in chapter 10.

Chapter 10

Mood Monitoring and Mood Regulation

From the diary study reported in chapter 9, mood monitoring was found to have significant implications for the experience of affect. Participants who scored high on the mood monitoring dimension, compared to lows, reported less energy, calmness and happiness. Mood labelling was not a significant predictor of emotion, nor did it significantly interact with cycle phase. This chapter will, therefore, focus more specifically on mood monitoring, rather than mood labelling, to examine the impact of monitoring on mood regulation strategies used by this same group of women. Firstly mood regulation, types of regulation strategies and ways of responding to depressed mood shall be considered for implications on successful mood regulation. In particular ruminative responding will be examined. Finally a set of hypotheses will be proposed which focus on mood monitoring with respect to mood regulation.

As discussed in chapter 1, this thesis holds with the view that for much of the time individuals are actively engaged in regulating the way they are feeling. Parkinson et al. (1996) have argued that emotion does not simply run its own course in respect to external and internal events outside our control. Rather people make evaluative judgments about their moods, which often results in conscious attempts to change the way they are feeling. Indeed chapters 4, 5, and 6 provided evidence in

respect to this. Therefore an individual who appraises their mood to be negative may deliberately engage in some form of activity they think might help alleviate those feelings. Parkinson and colleagues (1996) referred to such activity as conscious mood regulation. This is where an individual deliberately initiates some form of activity (physical or mental) for the specific purpose of changing the way they feel. Parkinson et al. (1996) point out that an individual may not always wish to change their mood, but rather may want to maintain a positive mood. However the present chapter is specifically concerned with changing negative or depressed mood. Also, regarding mood regulation, Parkinson et al. (1996) acknowledge that regulation occurs on both a conscious and unconscious level, although such boundaries are less clear. This chapter is concerned with conscious mood regulation by a group of women who reported on the extent to which they had used specific regulation strategies during the previous two hours, over the period of one calendar month.

Thayer, Newman & McClain (1994) argued that because mood is a central element of human activity, mood management is basic to many of our common daily activities. They reviewed studies which had been conducted to establish what types of activities people engaged in when feeling depressed, and found a wide range including distractions, relaxation, and tension reducing activities. From their own research they also found that strategies judged to be the most effective were those which involved 'active mood management' (e.g. listening to music), but strategies that involved 'avoidance' were not considered to be effective. Of further relevance to the present chapter are Thayer, Newman & McClain's (1994) findings on gender. Men and women were found to use different types of regulation strategies for

changing bad moods. Out of a total of six regulation strategy categories, men were more likely to use 'pleasurable activities/distraction' or 'direct tension reduction' using alcohol and drugs. Women, on the other hand, were more likely to use 'passive mood management' and 'social support'. Thayer, Newman & McClain (1994) concluded that men were using more successful 'active' strategies, whilst women used less active means to change their negative moods. They argued that women tended to focus their attention on negative mood and think about the way they were feeling rather than attempt to actively engage in regulation or divert attention using diversion strategies. In particular Thayer, Newman & McClain (1994) found women tended to seek out social support more than men did. Talking to someone about the way they were feeling fixed attention on mood, and so these women continued to engage in emotional activity.

In order to be able to engage in successful mood regulation, it is accepted that a certain amount of self-awareness is vital for an individual to be able to register and monitor how they are feeling, and thus decide whether there is a problem with negative mood and to select an appropriate regulation strategy. However, as discussed in chapter 1, self-awareness can be potentially adaptive or detrimental (Kirschenbaum, 1987). Although Thayer, Newman & McClain (1994) only used a one-time questionnaire method, their work highlighted that women are more likely to use an emotion focused response style than men are. Nolen-Hoeksema, Morrow & Friedrickson (1993) examined outcome differences in responding to depressed mood, specifically looking at ruminative responding versus distracting responding. Ruminating about one's negative mood, Nolen-Hoeksema (1991) argued is a

response style that involves the individual continually self-focusing on the way they are feeling. Ruminative responses were defined as thoughts and behaviours that focus the depressed individual's attention on his or her symptoms and possible causes and consequences of those feelings (Nolen-Hoeksema, 1991). Nolen-Hoeksema (1991) argued that women are more prone to use this style of self-focusing, and that it can partially help to explain why twice as many women than men are reported to suffer from depression (Nolen-Hoeksema, 1987). Indeed Nolen-Hoeksema, Morrow & Friedrickson's (1993) study found that ruminative responding to depressed mood served to prolong the experience of the mood. In contrast, individuals who engaged in distracting responding (thoughts and behaviours which take the individual's mind off his or her symptoms of depressed mood and divert attention to pleasant or neutral events) were more likely to engage later in active problem solving to overcome problems that might have led to their depression. Also they found that women were more likely to engage in ruminating about their depressed moods than men, and to be depressed for longer periods of time.

Overall Nolen-Hoeksema, Marrow & Friedrickson (1993) concluded there to be a strong link between ruminating and longer periods of depressed mood, and that women are more likely to engage in this self-focusing style of responding to depressed mood.

Such findings are important for this thesis, particularly in relation to the mood monitoring dimension of mood awareness and the results discussed in the previous chapter. Swinkels & Giuliano (1995) found high mood monitoring, compared to low, was associated with negative mood and ruminative responding. Results from the

diary study (chapter 9) found high monitors, compared to lows, reported less happiness, energy and calmness. Therefore it is important to establish how these women (high monitors) responded to negative mood.

Given that people often engage in active mood regulation, or attempt to control the way they are feeling, Totterdell & Parkinson (1999) investigated whether people could improve their mood more successfully by increasing their use of certain regulation strategies. They were particularly concerned with upward mood regulation by means of controlled affect regulation. A sample of 30 trainee teachers used pocket computers to complete ratings of their mood and their use of mood regulation strategies every two hours during the day for two weeks during a school placement. The regulation strategies used for the study were divided into two main categories with two subgroups; engagement (cognitive, and behavioural), and diversion (cognitive and behavioural) strategies. Engagement strategies focused attention and effort directly on the negative feelings/mood, and were divided into subgroups of strategies involving rationalisation, reappraisal, social support and venting. Diversion strategies, on the other hand, directed attention away from the negative feelings/mood, and were divided into subgroups of strategies involving pleasant or relaxing distraction activities, active or constructive activities, cognitive distraction and avoidance.

Overall, diversion strategies were found to be used more than engagement strategies. Both engagement and diversion strategies were associated with increases in cheerfulness and calmness, but only engagement strategies were associated with increases in energy. The most effective strategies in relation to associated

improvements in mood were behavioural diversion activities and cognitive reappraisal. Totterdell & Parkinson (1999) explained these findings in terms of the best success at getting out of a bad mood, for these participants, was when they did something distracting or when they changed the meaning of their mood or situation.

It seems that some ways of responding to negative mood can help alleviate or change an individual's feelings in an upward direction. Actively engaging in mood management, such as listening to music or engaging in a pleasant activity to take one's mind off the mood can be a successful way of responding to negative mood (Thayer, Newman & McClain, 1994). Strategies that divert attention away from negative feelings were found to be effective by Totterdell & Parkinson (1999) and Nolen-Hoeksema et al. (1993). Although a degree of self-awareness is necessary initially, a continuing focus on negative feelings/mood can actually maintain the experience of that mood for a longer period of time, thus making it more difficult to be able to regulate negative feelings in an upward direction. In contrast to cognitive and behavioural diversion strategies as a way of responding to negative mood, a ruminative style may focus the individual's attention on the symptoms and possible causes in a contemplative fashion, and so prolong the experience of the mood. Women have been found to be more prone to respond in this manner to negative mood (Nolen-Hoeksema, Morrow & Friedrickson, 1993).

These findings are relevant to this thesis in the light of findings on the mood monitoring dimension of mood awareness, particularly as high monitors reported less success at mood regulation (Swinkels & Giuliano, 1995). Chapter 9 discussed results from the diary study conducted as part of the research for this thesis which found

high monitoring, compared to low, to be associated with less reported happiness, energy and calmness. Therefore further analyses were required to establish how those scoring higher on mood monitoring responded to negative mood.

Based on the material presented and on results from chapter 9, it is hypothesised that high monitors, compared to lows, will engage in mood regulation **more** in order to regulate their mood in an upward direction. This is because high monitors are more likely to notice changes in their mood due to continued attention, and also from the results noted in chapter 9 that high monitors were less happy, energetic and calm overall and so would have a greater need to change their mood. However the prediction is also that high monitors, compared to lows, will report **less** success at mood regulation.

Furthermore, of the four mood regulation categories it is hypothesised that high mood monitors will engage in cognitive engagement more than any of the other three categories because of the similarity between ruminating and deliberately directing attention toward one's moods and possible causes. Finally it is hypothesised that the premenstrual phase of the menstrual cycle will predict a higher degree of mood regulation by high mood monitors than the other two phases, and in particular the use of cognitive diversion strategies. This is because although women generally tend to use ruminative responding more (Nolen-Hoeksema, 1991), it is argued that these female participants will be driven by the belief that their negative mood during this time in their cycle is due to biological factors over which they have little or no control. Therefore they will attempt to divert attention away from their moods.

Method

Participants

Participants consisted of the same 22 women referred to in the previous chapter, which introduced and discussed results relating to emotion from the psion study (see page 204).

Procedure

In addition to completing six bipolar ratings of their mood, mood awareness, and menstrual cycle phase, participants were also provided with written examples of four categories of engagement strategies and four categories of diversion strategies (see appendix 4.3). During the 40 minute training session on how to use the pocket computer, participants were instructed on the meanings and use of the regulation strategies, and how these translated on to the visual analogue scale. To record responses on use of the strategies, participants responded by placing the cursor in the appropriate place along the line (outlined in the method section of chapter 9).

In addition to the two-item scales for three dimensions of concurrent affect (happiness, energy, calmness), participants also reported to what extent they had used four different kinds of affect-regulation strategy (cognitive diversion, behavioural diversion, cognitive engagement, and behavioural engagement) over the previous two hours. The regulation strategies were selected from Totterdell & Parkinson's (1999) study referred to in the introduction of this chapter. They selected regulation strategies for use based on clarification of regulation strategies on a hierarchical

cluster analysis of conceptual distinctions participants made among 162 affect-regulation strategies in a card-sort task. High level distinctions were made between cognitive and behavioural categories, and between engagement and diversion strategies (see table below).

Table Displaying Mood Regulation Strategies

Table 13.

	Cognitive	Behavioural
Diversion	Avoided thinking about things Think about something else	Do something else: energetic/active Do something else: relax/enjoyable
Engagement	Look at things differently Think things through	Get support from others Let feelings out

For the pocket psion eight scales were derived from the four engagement (two cognitive and two behavioural) and four distraction (two cognitive and two behavioural strategies): rationalisation (thought things through), reappraisal (looked at things differently), social support (got support from others), venting (let my feelings out), pleasant or relaxing activities (did something relaxing/enjoyable), active or energetic activities (did something energetic/active), cognitive distraction (thought about something else), cognitive avoidance (avoided thinking about things).

Participants were given a copy of the written examples to refer to. In addition two further mood-regulation scales requested the participants rate how much they had generally tried to improve their mood, and how successful they had been in improving their mood during the previous two hours.

Participants also used unipolar rating scales every two hours to rate the percentage of time they had been aware of their mood as well as rating to what extent unpleasant events had happened during the previous two hours. Participants were also required to enter a numerical code what their main activity had been during the previous two hours: work, domestic, or other leisure activities. This code was used to produce a dummy variable for leisure activities (leisure = 1, work activities = 0).

Results

Overview of analysis

The same regression model was used as explained in the previous chapter (page 212 see also West & Hepworth, 1991).

A pooled time series method was utilised for the regression analyses. To establish whether regulation strategies predicted affect (happiness, calmness, energy) a regression model was constructed, using the affect variables as separate dependent variables, and dummy variables for each strategy as independent variables. Although the analyses for this chapter concentrated specifically on the mood monitoring dimension of mood awareness (high and low monitoring being determined by use of a median split mode procedure), similar analyses were conducted to establish whether

there were any interactions and predictors based on mood labelling for strategies.

None were found to be significant for mood labelling.

Mood Monitoring and Strategy Use

Aggregated means for each participant score on the four categories of strategy revealed that high mood monitors reported using more of all four kinds of strategies than low monitors did. Behavioural diversion was reported to be used most by both high and low monitors. Also both high and low monitors used cognitive engagement the least (see table below). These differences in use of strategies for high and low monitoring were found to be significant (cognitive engagement, $t = -12.36$, $p < .01$, cognitive diversion, $t = -13.57$, $p < .01$, behavioural engagement, $t = -7.55$, $p < .01$, and behavioural diversion, $t = -12.45$, $p < .01$).

Table of Aggregated Mean Scores for Strategy Use

Table 14.

	High mood monitors	Low mood monitors
Behavioural Diversion	3.90	2.47
Cognitive Diversion	3.55	2.08
Behavioural Engagement	3.26	2.41
Cognitive Engagement	3.03	1.80

Strategies and Affect

Regression analyses were conducted to determine whether any of the mood regulation strategies predicted affect. In each case for the analyses the control variables were entered in block 1, the first-order lag of the dependent variable in block 2.

For the whole sample cognitive engagement did not predict happiness. However cognitive diversion, behavioural engagement and behavioural diversion did. Calmness was predicted by all four kinds of strategies: cognitive engagement, cognitive diversion, behavioural engagement and behavioural diversion. Also energy was predicted by all four kinds of regulation strategies: cognitive engagement, cognitive diversion, behavioural engagement and behavioural diversion. These results are shown in table 15.

Table 15.

Emotion Predicted by Use of Regulation Strategies

Happiness predicted by strategy use	
Cognitive diversion	Prior $R^2 = .51$, R^2 change = .02, $F(31, 2081) = 69.91$, $p < .01$
Behavioural engagement	Prior $R^2 = .54$, R^2 change = .03, $F(31, 2081) = 79.11$, $p < .01$
Calmness predicted by strategy use	
Cognitive engagement	Prior $R^2 = .47$, R^2 change = .001, $F(31, 2081) = 60.81$, $p < .01$
Cognitive diversion	Prior $R^2 = .47$, R^2 change = .006, $F(31, 2081) = 61.90$, $p < .01$
Behavioural engagement	Prior $R^2 = .47$, R^2 change = .005, $F(31, 2081) = 61.80$, $p < .01$
Behavioural diversion	Prior $R^2 = .51$, R^2 change = .04, $F(31, 2081) = 71.88$, $p < .01$
Energy predicted by strategy use	
Cognitive engagement	Prior $R^2 = .55$, R^2 change = .001, $F(31, 2081) = 84.23$, $p < .01$
Cognitive diversion	Prior $R^2 = .55$, R^2 change = .01, $F(31, 2081) = 84.08$, $p < .01$
Behavioural engagement	Prior $R^2 = .55$, R^2 change = .002, $F(31, 2081) = 84.71$, $p < .01$
Behavioural diversion	Prior $R^2 = .56$, R^2 change = .01, $F(31, 2081) = 87.28$, $p < .01$

To assess whether the effect of strategy use interacted with mood monitoring, the cross product of each of the four dummy variables representing strategy with mood monitoring were entered in to the regression equation in separate analyses following the entry of the corresponding variables individually. The interaction term for cognitive engagement with mood monitoring had a significant effect for cognitive engagement. The interaction term for cognitive diversion with mood monitoring had a significant effect for cognitive diversion. Also the interaction term for behavioural engagement with mood monitoring and behavioural diversion with mood monitoring were significant for behavioural engagement and behavioural diversion. These results are shown in table 16 below.

Table 16.

Table Displaying Interactions between Mood Regulation Strategies and Mood Monitoring

Cognitive Strategies	
Cognitive engagement X mood monitoring	Prior R ² = .96, R ² change = .65, F (30, 1971) = 1615.03, p < .01
Cognitive diversion X mood monitoring	Prior R ² = .96, R ² change = .63, F (30, 1971) = 1973, p < .01
Behavioural Strategies	
Behavioural engagement X mood monitoring	Prior R ² = .95, R ² change = .78, F (30, 1971) = 1388, p < .01
Behavioural diversion X mood monitoring	Prior R ² = .94, R ² change = .70, F (30, 1971) = 1174.27, p < .01

In order to interpret these significant findings, the effects of strategies on affect were assessed separately for high and low monitors as defined by a median split mode procedure. For high mood monitors regression analyses established cognitive engagement strategies did not predict happiness. However cognitive diversion did, as did behavioural engagement and behavioural diversion. For low

mood monitors the only strategy group found to predict happiness was behavioural diversion. These results are shown in table 17.

Table 17.

Table Displaying Happiness Predicted by Strategy Use for High and Low Mood Monitors Separately

Happiness predicted for high mood monitors	
Cognitive diversion	Prior $R^2 = .33$, R^2 change = .003, $F(21, 1195) = 28.39$, $p < .01$
Behavioural engagement	Prior $R^2 = .39$, R^2 change = .01, $F(21, 1195) = 29.78$, $p < .01$
Behavioural diversion	Prior $R^2 = .34$, R^2 change = .01, $F(21, 1195) = 37.36$, $p < .01$
Happiness predicted for low mood monitors	
Behavioural diversion	Prior $R^2 = .36$, R^2 change = .006, $F(16, 1191) = 21.36$, $p < .01$

For high mood monitors regression analyses revealed that all four strategy groups predicted calmness: cognitive engagement, cognitive diversion, behavioural engagement and behavioural diversion. However for low monitors only behavioural diversion predicted calmness, as shown in table 18 below.

Table 18.

Table Displaying Calmness Predicted by Strategy Use for High and Low Mood Monitors Separately

Calmness predicted for high mood monitors	
Cognitive engagement	Prior $R^2 = .33$, R^2 change = .004, $F(21, 1195) = 27.13$, $p < .01$
Cognitive diversion	Prior $R^2 = .34$, R^2 change = .02, $F(21, 1195) = 28.20$, $p < .01$
Behavioural engagement	Prior $R^2 = .34$, R^2 change = .02, $F(21, 1195) = 28.56$, $p < .01$
Behavioural diversion	Prior $R^2 = .40$, R^2 change = .08, $F(21, 1195) = 38.25$, $p < .01$
Calmness predicted for low mood monitors	
Behavioural diversion	Prior $R^2 = .63$, R^2 change = .00, $F(19, 876) = 77.82$, $p < .01$

For high mood monitors both cognitive engagement and cognitive diversion did not predict energy, but behavioural engagement and behavioural diversion did. For low monitors, cognitive engagement predicted energy, yet cognitive diversion did not. Also behavioural diversion predicted energy, yet behavioural engagement did not. See table 19 below.

Table 19.

Table displaying Energy Predicted by Strategy Use for High and Low Mood

Monitors Separately

Energy predicted for high mood monitors	
Behavioural engagement	Prior $R^2 = .44$, R^2 change = .04, $F(21, 1195) = 46.40$, $p < .01$
Behavioural diversion	Prior $R^2 = .46$, R^2 change = .01, $F(21, 1195) = 48.72$, $p < .01$
Energy predicted for low mood monitors	
Cognitive engagement	Prior $R^2 = .64$, R^2 change = .001, $F(19, 876) = 83.24$, $p < .01$
Behavioural diversion	Prior $R^2 = .64$, R^2 change = .003, $F(19, 876) = 83.99$, $p < .01$

Phases and Strategies

To establish whether menstrual cycle phase predicted use of strategy for the whole sample, a regression model was constructed using the strategy variables as separate dependent variables, and dummy variables for each of the cycle phases as independent variables. There were no significant effects of any phase on any reported strategy.

To assess whether the effect of cycle phase interacted with mood monitoring, the cross product of each of the three dummy variables representing phase of cycle with mood monitoring were entered in to the regression equation separately following

the entry of the corresponding variables separately. The interaction terms for intermenstrual phase with mood monitoring was not found to have a significant effect for cognitive engagement, cognitive diversion, behavioural engagement or behavioural diversion. The interaction term for menstrual phase with mood monitoring was not found to have a significant effect for cognitive engagement, cognitive diversion, behavioural engagement or behavioural diversion. However the interaction term for the premenstrual phase with mood monitoring had a significant effect for behavioural engagement and cognitive diversion but not for behavioural diversion or cognitive engagement. See table 20 below.

Table 20.

Table Displaying results of Interactions Between the Premenstrual Phase of the Menstrual Cycle and Mood Monitoring for Predicting Mood regulation Strategies

Behavioural engagement	
Premenstrual phase X mood monitoring	Prior $R^2 = .27$, R^2 change = .001, $F(31, 2081) = 25.17$, $p < .01$
Cognitive diversion	
Premenstrual phase X mood monitoring	Prior $R^2 = .33$, R^2 change = .001, $F(31, 2081) = 33.16$, $p < .01$

Aggregated means indicated use of cognitive diversion was similar in the premenstrual ($M = 3.72$) and menstrual phase ($M = 3.76$), and slightly less in the intermenstrual phase ($M = 3.2$) for the whole sample.

In order to interpret the significant findings on the premenstrual phase and mood monitoring, the effects of phase on strategy use were assessed separately for high and low mood monitors. For high mood monitors the premenstrual phase predicted use of cognitive diversion, but not for the remaining three strategy groups.

For low mood monitors the premenstrual phase only predicted use of behavioural diversion, but none of the other three strategy groups (behavioural engagement, cognitive engagement, cognitive diversion). Again after affect was controlled for the premenstrual phase still predicted use of behavioural diversion. See table below for results.

Table 21.

Table Displaying Effects of Phase on Strategy Use for High and Low Mood Monitors Separately

	Premenstrual Phase For High Mood Monitors
Cognitive diversion	Prior $R^2 = .32$, R^2 change = .002, $F(21, 1195) = 26.96$, $p < .01$
	Other Two Phases Not Significant
Controlling For Affect	
Happiness	Prior $R^2 = .32$, R^2 change = .003, $F(22, 1194) = 25.93$, $p < .01$
Calmness	Prior $R^2 = .32$, R^2 change = .003, $F(22, 1194) = 26.65$, $p < .01$
Energy	Prior $R^2 = .32$, R^2 change = .003, $F(22, 1194) = 25.92$, $p < .01$
	Premenstrual Phase For Low Mood Monitors
Behavioural Diversion	Prior $R^2 = .16$, R^2 change = .004, $F(19, 876) = 9.30$, $p < .01$
Controlling For Affect	
Happiness	Prior $R^2 = .16$, R^2 change = .006, $F(19, 876) = 9.43$, $p < .01$
Calmness	Prior $R^2 = .17$, R^2 change = .005, $F(19, 876) = 9.90$, $p < .01$
Energy	Prior $R^2 = .16$, R^2 change = .006, $F(19, 876) = 9.01$, $p < .01$

Successful Regulation

Aggregate mean scores on success at improving mood for both high and low mood monitoring revealed that high monitors ($M = 3.9$) reported greater success at improving mood than low monitors ($M = 2.6$). A t-test for equality of means revealed these differences to be significant ($t = -2.37$, $p < .05$). Mean comparisons also revealed that behavioural diversion was reported to improve mood the most ($M = 3.2$) followed by cognitive diversion ($M = 2.9$), behavioural engagement ($M = 2.8$) and cognitive engagement ($M = 2.4$).

To establish whether reported use of strategy predicted success at mood regulation for the whole sample, a regression model was constructed using the success/improve variable as a separate dependent variable, and dummy variables for each strategy as independent variables separately. All four mood regulation strategies predicted success at upward mood regulation, results are displayed in table 22 below.

Table 22.

Table Displaying Strategy Use Predicting Success at Upward Mood Regulation

	Successful Mood Regulation
Cognitive engagement	Prior $R^2 = .30$, R^2 change = .03, $F(31, 2081) = 29.76$, $p < .01$
Cognitive diversion	Prior $R^2 = .31$, R^2 change = .04, $F(31, 2081) = 31.36$, $p < .01$
Behavioural engagement	Prior $R^2 = .34$, R^2 change = .07, $F(31, 2081) = 35.75$, $p < .01$
Behavioural diversion	Prior $R^2 = .42$, R^2 change = .15, $F(31, 2081) = 48.01$, $p < .01$

To assess whether strategy use interacted with mood monitoring in predicting success at mood regulation, the cross product of each of the four dummy variables representing strategies with mood monitoring were entered in to the regression equation in separate analyses following the entry of the corresponding variables individually. The interaction term for cognitive engagement with mood monitoring had a significant effect, as did behavioural diversion with mood monitoring, and behavioural engagement with mood monitoring. Also the interaction term for cognitive diversion with mood monitoring was significant. See table 23 below.

Table 23.

Table Displaying Interaction Variables for Strategy Use Interacting With Mood Monitoring

Cognitive engagement X mood monitoring	Prior $R^2 = .28$, R^2 change = .02, $F(30, 1971) = 26.55$, $p < .01$
Behavioural diversion X mood monitoring	Prior $R^2 = .39$, R^2 change = .12, $F(30, 1971) = 42.06$, $P < .01$
Cognitive diversion X mood monitoring	Prior $R^2 = .30$, R^2 change = .04, $F(30, 1971) = 28.40$, $p < .01$
Behavioural engagement X mood monitoring	Prior $R^2 = .31$, R^2 change = .05, $F(30, 1971) = 30.25$, $p < .01$

In order to interpret these significant findings the effects of strategy use on reported success at improving mood were assessed separately for high and low mood monitors. For high mood monitors cognitive diversion predicted success at improving mood. Even after affect was controlled for cognitive diversion still predicted success. Cognitive engagement also predicted success. Again after affect was controlled for, cognitive engagement still predicted success at mood regulation. Behavioural diversion was found to predict success at regulating mood, which remained so even after affect was controlled for. Finally behavioural engagement predicted success at mood regulation. Affect was again controlled for, and still found behavioural engagement to be a successful predictor. See table 24 for results.

Table 24.

Table Displaying Results of Successful Mood Regulation Predicted for High Mood Monitors

	Successful Mood Regulation for High Mood Monitors
Cognitive Diversion	Prior R² = .32, R² square = .03, F (21, 1195) = 27.67, p < .01
Controlling For Affect	
Happiness	Prior R ² = .98, R ² change = .65, F (21, 1084) = 3649.54, p < .01
Calmness	Prior R ² = .98, R ² change = .65, F (21, 1084) = 3649.95, p < .01
Energy	Prior R ² = .98, R ² change = .65, F (21, 1084) = 3655.08, p < .01
Cognitive Engagement	Prior R² = .31, R² change = .01, F (21, 1195) = 25.79, p < .01
Controlling For Affect	
Happiness	Prior R ² = .35, R ² change = .02, F (21, 1084) = 28.79, p < .01
Calmness	Prior R ² = .35, R ² change = .02, F (21, 1084) = 28.06, p < .01
Energy	Prior R ² = .32, R ² change = .01, F (21, 1084) = 25.09, p < .01
Behavioural Diversion	Prior R² = .38, R² change = .09, F (21, 1195) = 36.33, p < .01
Controlling For Affect	
Happiness	Prior R ² = .35, R ² change = .02, F (21, 1084) = 28.74, p < .01
Calmness	Prior R ² = .35, R ² change = .02, F (21, 1084) = 28.06, p < .01
Energy	Prior R ² = .32, R ² change = .01, F (21, 1081) = 25.09, p < .01
Behavioural Engagement	Prior R² = .35, R² change = .06, F (21, 1195) = 31.84, p < .01
Controlling For Affect	
Happiness	Prior R ² = .40, R ² change = .06, F (21, 1084) = 34.64, p < .01
Calmness	Prior R ² = .39, R ² change = .06, F (21, 1084) = 33.86, p < .01
Energy	Prior R ² = .39, R ² change = .08, F (21, 1084) = 34.17, p < .01

For low mood monitors each of the four strategy groups also predicted success at mood regulation. Affect was again controlled for and the results remained significant, which are presented in table 25.

Table 25.

Table Displaying results of Successful Mood Regulation Predicted for Low Mood Monitors

	Successful Mood Regulation for Low Mood Monitors
Cognitive Diversion	Prior $R^2 = .29$, R^2 change = .10, $F(19, 876) = 19.54$, $p < .01$
Controlling For Affect	
Happiness	Prior $R^2 = .32$, R^2 change = .09, $F(20, 875) = 21.02$, $p < .01$
Calmness	Prior $R^2 = .30$, R^2 change = .09, $F(20, 875) = 19.38$, $p < .01$
Energy	Prior $R^2 = .29$, R^2 change = .09, $F(20, 875) = 8.33$, $p < .01$
Cognitive Engagement	Prior $R^2 = .32$, R^2 change = .13, $F(19, 876) = 22.35$, $p < .01$
Controlling For Affect	
Happiness	Prior $R^2 = .37$, R^2 change = .14, $F(20, 875) = 26.04$, $p < .01$
Calmness	Prior $R^2 = .36$, R^2 change = .14, $F(20, 875) = 25.22$, $p < .01$
Energy	Prior $R^2 = .34$, R^2 change = .14, $F(20, 875) = 23.01$, $p < .01$
Behavioural Diversion	Prior $R^2 = .50$, R^2 change = .30, $F(19, 876) = 46.10$, $p < .01$
Controlling For Affect	
Happiness	Prior $R^2 = .51$, R^2 change = .28, $F(20, 875) = 46.09$, $p < .01$
Calmness	Prior $R^2 = .49$, R^2 change = .28, $F(20, 875) = 42.88$, $p < .01$
Energy	Prior $R^2 = .49$, R^2 change = .29, $F(20, 875) = 42.72$, $p < .01$
Behavioural Engagement	Prior $R^2 = .30$, R^2 change = .10, $F(19, 876) = 19.89$, $p < .01$
Controlling For Affect	
Happiness	Prior $R^2 = .32$, R^2 change = .09, $F(20, 875) = 21.04$, $p < .01$
Calmness	Prior $R^2 = .31$, R^2 change = .09, $F(20, 875) = 19.84$, $p < .01$
Energy	Prior $R^2 = .29$, R^2 change = .09, $F(20, 875) = 18.18$, $p < .01$

Discussion

The present chapter was concerned with additional examination of data from the diary study reported in chapter nine. It became necessary to focus on the mood monitoring dimension of mood awareness because findings had indicated that this style of mood awareness predicted affect/mood (happiness, calmness, energy). In particular participants high on the mood monitoring dimension were less happy, energetic and calm. When these results were considered in conjunction with Swinkels & Giuliano's (1995) premise that mood monitoring is associated with a lower degree

of reported success at active mood regulation, it was hypothesised that participants scoring higher on mood monitoring, compared to lows, would report to have engaged in mood regulation **more**, yet report a **lower** degree of success at attempted mood regulation. Furthermore, of the four regulation categories, it was hypothesised that high mood monitors would report engaging in cognitive engagement more than cognitive diversion, behavioural engagement or diversion because of the similarity to ruminative responding. Finally it was hypothesised that the premenstrual phase of the menstrual cycle would predict use of cognitive diversion strategies by high mood monitors, because of the belief that negative mood around the premenstrual phase of the cycle is due to biological changes over which there is little or no control.

Firstly analyses revealed that those participants scoring higher on mood monitoring reported using more of all four kinds of strategies than those lower on monitoring. Therefore high monitors engaged in active mood regulation **more** than the low monitors, which supports the hypothesis. However high mood monitors also reported a **greater** degree of success at upward mood regulation than low monitors. Even after affect was controlled for this was still the case, which suggests that the improvement in mood was due to the regulation strategy being used. This finding was not in the predicted direction and is in contrast to findings by Swinkels & Giuliano (1995). One explanation could be that because high monitors are constantly focusing on their mood, they are able to collect more affective information. This affords more immediate feedback on whether a particular mood regulation attempt is proving to be successful or not, and so enables them to change the particular regulation strategy in use at that time if necessary. This would also partially explain why high monitors

were found to engage more in all four kinds of mood regulation strategies than low monitors. Adding to this explanation, it is suggested that high monitors are likely to engage in active mood regulation more because they are feeling more negative than low monitors, and so have a more urgent need to do so from the point of their internal well-being.

In considering use of particular mood regulation strategies it was hypothesised that high mood monitors would report using cognitive engagement more than the other three category groups. This is because cognitive engagement strategies such as ‘evaluated why things aren’t going well’, and ‘thought about why I’m in a bad mood’ represent some form of continued emotional engagement in the way one is feeling. Ruminative responding to depressed mood was defined as thoughts and behaviours that focus a depressed individual’s attention on his/her symptoms and possible causes and consequences (Nolen-Hoeksema, 1991), which bears a similarity to cognitive engagement. High monitoring has been found to be associated with ruminative responding (Swinkels & Giuliano, 1995) and so it was hypothesised that high monitors would use cognitive engagement more than cognitive diversion, behavioural engagement or diversion. However analyses did not confirm this. Rather it was found that high monitors reported using **behavioural diversion** most, followed by cognitive diversion, and behavioural engagement. Cognitive engagement was reported to have been used the **least**, and so this part of the hypothesis was also not supported. This is an interesting finding and ties in with high monitors reporting a greater degree of success at mood regulation, because behavioural diversion was found to be the most

effective of the four strategy categories in the present study as well as the study by Parkinson and Totterdell (1999).

Of additional interest from the analyses was use of strategies for predicting affect. For high mood monitors cognitive diversion, behavioural diversion and behavioural engagement predicted happiness. All four strategy categories predicted calmness. Finally cognitive strategies did not predict energy, but both behavioural diversion and behavioural engagement predicted energy. For low mood monitors only behavioural diversion predicted happiness and calmness, and both behavioural diversion and cognitive engagement predicted energy. Therefore it can generally be stated that use of strategies predicted affect for high mood monitors. For low mood monitors it seemed that only behavioural strategies (diversion and engagement) predicted affect. Behavioural diversion was used most by both high and low monitors, and so would seem to be the most preferred group of strategies. This is consistent with findings by Totterdell & Parkinson (1999) who found that diversion strategies were used more than engagement strategies. Also behavioural diversion was reported to achieve the greatest degree of success at changing mood.

The final part of the hypothesis predicted that the premenstrual phase of the cycle would predict use of active mood regulation by those reporting higher on the mood monitoring dimension, compared to lows. Analyses revealed that the intermenstrual and menstrual phase of the cycle did not predict use of any of the four regulation strategy groups for both high and low monitors. However the premenstrual phase of the cycle predicted use of cognitive diversion by high monitors, and behavioural diversion by low monitors, which supports the hypothesis. Even after

affect was controlled for this was still the case. Thus it can be stated that the effect of cycle phase and high mood monitoring was accountable for the use of cognitive diversion rather than mood itself. Of particular interest is that neither of the other two cycle phases predicted use of mood regulation. It was the premenstrual phase only which predicted mood regulation and suggests that the effect of cycle phase is an important factor in menstrual cycle experience for these women, but not in the way it has previously been assumed. The effect of phase is more complex than a causal relationship between timing and emotion. Rather the monitoring style used combined with the premenstrual phase are important factors in the way these women have experienced and interacted with their mood in terms of mood regulation.

During the premenstrual phase both high and low monitors made use of diversion strategies to actively regulate mood in an upward direction. High monitors used cognitive diversion, and low monitors used behavioural diversion, which both divert attention away from the negative feelings being experienced. These results provide support for the contention that high monitors were acting from the premise that to attempt to actively engage in the way they were feeling would be useless, because negative feelings were due to biological factors. Instead they actively attempted to divert attention away from their feelings by 'not thinking about them'.

Summary

Apart from the prediction that high monitors would be less successful at deliberate mood regulation and use cognitive engagement the most, the hypotheses proposed within the present chapter were supported. High mood monitors were found

to engage in active mood regulation more than low monitors, yet also reported to experience greater success at mood regulation. Also high monitors used cognitive diversion more than any of the other three strategy groups, but used cognitive engagement the least when attempting to upwardly regulate negative mood. Diversion strategies were used by both high and low mood monitors and were reported to be the most successful regulation strategies by high and low monitors, which lends support to the argument that diverting attention away from depressed mood can be a better predictor for successfully regulating depressed mood in an upward direction (Nolen-Hoeksema, 1991; Nolen-Hoeksema, Morrow & Friedrickson, 1993).

Finally, of the three phases of the menstrual cycle, it was the premenstrual phase which predicted use of deliberate mood regulation in various forms of cognitive diversion by high monitors. It seems that although high mood monitoring, compared to low, predicted less happiness, calmness and energy (chapter 9), attending more closely to mood may have facilitated immediate and accurate feedback of whether a particular regulation strategy was effective or not. This may have enabled participants to adjust the way they were responding to their negative mood more immediately and more accurately. This meant high monitors used all of the regulation strategies more often, and by trying to use the most effective strategy also experienced more success at active mood regulation.

Limitations

The present analyses examined the success of deliberate affect regulation strategies to promote positive mood across the menstrual cycle. However it needs to

be acknowledged that self-regulation of mood to optimal levels will depend on a wide variety of activities that could not be captured due to limitations of the scales used on the pocket computer. Also mood is often required to match up with a situation or event, and so reasons other than menstrual cycle phase may have been more important for some of the time for these women when attempting to self-regulate their mood. Also the participants were not a homogeneous group of women, and so they did not face a broadly similar range of situations. Therefore there could have been a number of other predictors which were important in initiating active mood regulation and selection of particular kinds of strategies which were not made apparent by use of the pocket computer.

Cognitive and behavioural diversion strategies were found to be used the most by participants scoring higher on mood monitoring. This was interpreted as evidence that such strategies were more effective at regulating mood by diverting attention away from an emotional focus. However these participants may have been trying to divert attention away from the way they were feeling purposely because they were aware that participation in the study had caused them to be more self-focused on their feelings than they usually are.

Overall the further analyses conducted and presented within this chapter have supplemented the understanding of the mood awareness and mood regulation which occurred in this group of women who believed they suffer some form of premenstrual affective disturbance. These findings will be discussed in relation to the results from the previous studies conducted as part of the research for this thesis in the following and final chapter.

Chapter 11

Discussion and Conclusion

This thesis set out to establish a deeper understanding of emotional control and premenstrual syndrome. From the broader picture of what is known about premenstrual syndrome, emotional lability and negative feelings have been found to be the most commonly reported symptoms for which women seek help (Bancroft, 1995; Walker, 1997). This formed part of the argument that the research should concentrate on the emotional aspect of the syndrome, particularly with regard to the control of negative feelings. Consequently it became necessary not only to understand the origins and development of premenstrual syndrome, but also to consider such knowledge in parallel with the way emotion has been defined and researched during the last hundred years, because premenstrual syndrome is a entity of this century (Richardson, 1995).

Summary of Main Argument

From reviewing the literature in chapters 1 and 2 on emotion and premenstrual syndrome, it was argued that scientific knowledge has to be assessed against social and cultural belief systems. Firstly this is because both emotion and premenstrual syndrome have strong, and at times synonymous, associations with the female gender. Following the work of Ussher (1989, 1991), Swann (1995, 1997), Swann & Ussher (1995) and Walker (1997) it was argued in chapter 2 that

premenstrual syndrome is a gendered illness, and so issues of power and inequality automatically become salient and require acknowledgment. Secondly the way in which knowledge has been produced in regard to premenstrual syndrome required consideration because it is now becoming increasingly accepted by some (e.g. Harré, 1996, 1999; Smith, Harré, & Van Langenhove, 1995) that scientific inquiry cannot accomplish absolute objectivity and produce fixed truths or facts. This was particularly important because it is often *assumed* in the lay and academic/medical communities (e.g. Dalton & Holton, 1994) that the link between hormonal fluctuations and negative mood (Rodin, 1992) exists as a taken-for-granted fact. However chapter 2 argued that there is little evidence for such an assumption. To support this argument attention was drawn to the lack of a consensual definition to account for what constitutes premenstrual syndrome, and the absence of any agreed form of treatment to effect a ‘cure’.

From the literature several other issues became apparent which also informed the research process for this thesis. In particular much of the previous research conducted on emotion and premenstrual syndrome based on positivist principles which set out to isolate variables, and so establish a causal link between certain factors. However it is argued this has served to fragment the way women’s emotional discomfort has been conceptualized, and consequently reported by women themselves. Often this form of inquiry encouraged women to report on emotional ‘symptoms’ as an isolated entity rather than in relation to their lives and everyday experiences. It is argued this approach to researching affective symptoms leads to limited knowledge and understanding of premenstrual emotional distress. Also it was

argued in chapter 2 that use of retrospective questionnaires as a research tool not only limited the kinds of information that could be acquired, but also often taps popular assumptions and cultural beliefs rather than personal experience (e.g. Clarke & Ruble, 1978; Parlee, 1974). Therefore the research for this thesis, although using some traditional methods of inquiry, has also attempted to look at premenstrual emotional distress in different ways which has included subjective accounts.

A further emerging issue linked to fragmentation was one of **time** itself, which featured as an underlying theme throughout the thesis. Time, and indeed lived experience, it was argued is a fluid process that is never arrested (Larsen, 1984, 1989). In addition to this, a timing factor is produced naturally by the menstrual cycle as an endless rhythm throughout much of a woman's life (Walker, 1997). Outlined in chapter 2 was a brief presentation of a 28 day menstrual cycle beginning with the menstrual phase, represented from approximately day 1 to 5, though the follicular, ovulatory, and luteal phases, to the premenstrual phase, represented as around approximately day 24 to 28. In particular it was argued that research agendas have been preoccupied with the premenstrual phase of the cycle, attempting to construct causal links between endocrinological changes during this phase and women's emotional behavior (Warner & Walker, 1992). The very name of the syndrome is derived from this particular phase. It was therefore argued that timing would be a salient factor in the lives of women who believed they suffered from premenstrual syndrome, and should be taken into account within the research process. Cycle phase was used throughout much of the research, and formed the basis of the rationale for the diary study to enable emotional experience to be tracked over time. A process

approach to conducting research on emotion took into consideration that emotion is fluid, unfolding naturally over time, and changing in accordance with context and social experiences in addition to biological factors. The diary study also recorded when participants had begun menstruating so the premenstrual phase could be identified during analysis. This was especially useful to examine **variation** in affect over time after analyses from the combined methodological study (reported in chapter 8) had found conflicting results between the quantitative and qualitative data on the relevant importance of the timing and stage/phase of the menstrual cycle for participants.

A final issue raised by the literature, particularly from recommendations for future research on premenstrual syndrome by Swann (1995, 1996), Swann & Ussher (1997) and Walker (1997) as well as within the theoretical debate addressing the epistemology of scientific inquiry, was **subjectivity**. It was argued that in order to gain a deeper understanding of premenstrual syndrome and emotional premenstrual discomfort, women should be given a 'voice' in the research process. With lack of a clear definition of premenstrual syndrome, those women who believe they suffer from the illness should be given an opportunity to define what it means for them and their experiences of it. Also not only was it argued that language used to construct personal accounts reflects social reality (Potter & Wetherell, 1987), but also the deeper ideological forces that are in operation within society could be identified and explored (van Dijk, 1998). In particular the dominant ideologies of control, gender and rationality exerted a powerful influence over the way participants believed they should experience emotions. These were discussed respectively in chapters 4, 5 and

6. Secondly examination of subjective accounts enabled extraction of richness and a sense of meaning contained within the data concerning what premenstrual syndrome meant to a group of women who believed they suffered from it (chapter 8). Such meanings, and the contrast between meanings from earlier accounts in the qualitative interview study on emotional experience and accounts of premenstrual syndrome in the combined methodological study yielded interesting findings, and shall be discussed later in this chapter.

To accommodate the underlying issues discussed a paradigm shift was necessary. This had implications at both the theoretical and practical level for this thesis. On the theoretical level a critical realist perspective (Yardley, 1997) was adopted, which performed two functions. Firstly it allowed for the critical evaluation of the meanings attached to women's emotional and premenstrual experiences to be examined, acknowledging how meanings and knowledge are not necessarily fixed and concrete. Secondly the material reality of biological functioning, such as cyclical variation and what constitutes emotional experience reported 'at the time' by participants could be acknowledged. In practical terms it meant that a dialogic, hermeneutic approach could be utilized in conjunction with more conventional ways of measuring reported emotional experiences. Overall the main objective of the thesis was to gain a deeper understanding of the issues in question, in addition to establishing the existence of relationships between certain factors known to be important in the way negative emotion is controlled and regulated (e.g. mood awareness).

Findings and Explanations

To understand more clearly what is involved in emotional discomfort as part of the experience of problematic (premenstrual) emotions, it was argued that firstly one had to determine what people consider are normal and acceptable experiences of emotion. Also beliefs concerning ways in which emotion should be expressed and regulated were important to ascertain. Furthermore, by referring to Parrott's (1995) work, it was argued that 'being emotional' as part of everyday lived experience was worthy of study in its own right.

A qualitative interview study was undertaken to meet these objectives, which utilized a counselling style approach to empower participants (Bhavnani, 1990; King, 1996). It was a large detailed study, generating a wealth of rich, meaningful data. Results were set out across three chapters. Chapter 4 provided evidence that emotion is subject to rigorous social control, despite arguments that we now live in a less restrained climate, which supported Lupton's (1998) argument. Emotional experiences were found to be complex, and were determined by the place participants occupied within the social order. It was argued that emotions provided a way of locating participants in the social world, and so were essential and functional. This also meant participants had to actively work at their inner feelings as well as outer expressions of emotion for much of the time, consistent with Hochschild's (1983, 1990) work on feeling rules. This often caused participants to experience emotional dissonance in that they were re-working the gap created between social norms and the private self. Participants viewed emotion as dysfunctional, which is in contrast to the academic view, and was in line with Parrott's (1995) findings. Thus emotion was

subject to tight control, being governed by strict social norms and social rules that were underpinned by various key dominant ideologies.

Chapter 5 examined the relationship between the gender ideologies of masculinity and femininity and the way they impacted on emotional experience. Evidence that gender stereotypes remain dominant and powerful shapers of emotional experience was provided, which it is argued strengthens the need to acknowledge the way gender ideology, although non-material, impacts directly on perceptions and behavior. Male emotion characteristics, represented as being ‘unemotional and well controlled’, were positioned as favoured in both male and female participant accounts, which is consistent with Golombok & Fivush’s (1994) argument. It is argued such findings provide evidence that women still occupy a disadvantaged position within society. There was further evidence of this in accounts as men were at times presented as being ‘unemotional’ whereas women were deemed the more emotional sex, women always being associated with outward emotional expression. This is consistent with Lutz’s (1996, 1998) argument. At the same time though, suppression of emotional expression occupied the favoured position in *both* male and female participant accounts. Also meanings representing woman/femininity were at times synonymous with what it meant to be emotionally expressive (e.g. Mike’s account, chapter 5). It is therefore argued that women are associated with being emotionally expressive, which sets them against the favored position within society which is to be as outwardly unemotional as possible. Thus women are being placed in a double bind, which is consistent with Ussher’s (1989, 1991) argument on women’s emotional status. Overall evidence was provided in chapter 5 that private emotional

experiences had to be actively managed and regulated against dominant emotion norms, supporting the argument within the thesis that the emotional self is not arrested or contained.

In chapter 6 the dominant ideology of rationality versus emotion was explored. Evidence was presented which demonstrated how emotion and rational thought continue to be portrayed as separate and opposite, rather than interactive and continuous. It was argued that in Western culture this dominant ideology, with origins in Ancient Greek, mediaeval and Euro-American thought, places rationality and reason as separate to emotion and also as superior (Barbalet, 1998). Evidence was presented, demonstrating how rationality occupied the favoured position in participant accounts for much of the time. Emotion and moods were often referred to as 'subjective' and 'irrational', with participants striving for a desire to somehow rationalize and objectify private singular experiences. This, it was argued, created tension in lived experience for participants by placing them in danger of seeing the emotional aspects of their selves as irrational and unfounded. This fits with Lutz (1996) and Barbalet's (1999) argument that Western culture still continues to view emotion with caution and suspicion, and by associating emotion with irrationality immediately serves to devalue experience. However it was argued that emotion is not separate to rational thought processes, but rather there is a large component of thought and meaning in all emotional reactions, drawing on the work of Averill (1995), Lazarus & Lazarus (1994), Ellsworth (1995) and others. Lazarus & Lazarus (1995) argued that all emotional reactions have their own implacable logic. It is the external observer who may not understand it, rather than the emotional response

appearing outwardly ‘irrational’. It was further argued that as emotions are products of personal meanings and interactions, one has to value and attempt to understand subjective experience in order to understand the nature of emotions. Indeed there was evidence of implacable knowledge in participant accounts (e.g. Fred’s account, chapter 6). It was argued that once participants valued their feelings and placed them in context with life events, emotions did make sense at the subjective level.

Overall findings presented from the qualitative interview study found evidence that emotion is still associated with negative beliefs such as being out of control and irrational. Emotion is perceived of as dysfunctional rather than functional or valuable in the lay community (Parrott, 1995; Van-leeson et al. 1999). To be perceived as emotionally controlled is paramount if an individual is to be acceptable to the wider social order. Being emotionally expressive implies lack of control and order, and a sense of being out of touch with rational thought and so appearing irrational.

Being associated with emotion is a disadvantage. For women this is especially problematic because feminine ideology positions women as the emotional sex. Women and emotion characteristics are still at times synonymous, which is consistent with the findings of Lutz (1996) and Lupton (1998). However at the same time women are placed in a double-bind because they have to work hard at maintaining the more public male ‘unemotional’ characteristics. On the one hand women are responsible for the emotional welfare of the family (e.g. Jenny’s account in chapter 5), yet have to maintain absolute emotional control in the workplace (e.g. Alice’s account in chapter 5). This it is argued represents a tension in the emotional lives of

many women who are consequently subject to tighter emotional controls than men because of their association with the same organizing characteristics which define emotion.

Next a study (reported in chapter 7) was conducted to test the premise that cultural beliefs concerning premenstrual syndrome are still powerful shapers of reported experience, irrespective of actual experience. It was necessary to establish whether this is an issue for research in the way that it had been previously (e.g. Aubuchon & Calhoun, 1985; Koeske & Koeske, 1975). Also the qualitative interview study had found evidence that ideology and social norms have a powerful impact on emotional lived experience. Therefore cultural belief systems governing premenstrual syndrome required consideration. Although the study failed to find any significant reporting differences between the two groups based on affect, symptoms or cycle phase, there was a very specific limited effect. The aware group reported using more ‘venting’ strategies, which means outwardly expressing emotion. This is a significant result when considered against the findings from the qualitative interview study that had highlighted how the striving for emotional control and active suppression of feelings was essential. It is argued the belief that the study was concerned with premenstrual syndrome enabled participants in the aware condition to admit they did outwardly express emotion more than participants who believed the study was concerned with mood and feelings over a typical working week. Although Western culture demands emotional suppression, Ussher (1989, 1991, 1992b) and Ussher & Swann (1995) have argued women’s disordered biology, namely premenstrual syndrome in the twentieth century, provides a legitimate means of expressing certain

emotions. These results support this argument, which leads on to findings of the combined methodological study reported in chapter 8.

With the combined methodological study (chapter 8) the focus of the research within the thesis purposefully shifted to self-diagnosed sufferers of premenstrual syndrome. It was carried out to fulfill two principal aims; firstly to establish whether there were any significant relationships between a number of variables known to be important in emotional experience (e.g. mood awareness, affect intensity as discussed in chapter 1). This was because although the study manipulating participant awareness (chapter 7) was conducted for the main aim of establishing reporting differences, there were also some significant associations found on the emotion measures used. The expectancy of successfully regulating negative mood (Catanzaro & Mearns, 1990) was positively associated with the mood labeling dimension of mood awareness (Swinkels & Giuliano, 1995) and negatively associated with the mood monitoring dimension. Also symptom reporting was positively associated with negative affect and negative mood regulation expectancy. Therefore it was felt necessary to investigate mood awareness, symptoms and negative mood regulation expectancy further in a sample of known sufferers of premenstrual syndrome. Secondly, for reasons already outlined, there was a need to examine and explore subjective experiences of premenstrual syndrome to gain a deeper understanding of the syndrome and premenstrual emotional discomfort.

Turning attention to the written accounts first, several core discourses were used to describe what premenstrual syndrome meant for this group of women sufferers. It was most interesting because the majority of participants did not set out a

list of symptoms which they suffered from. Instead they wrote about problematic life events and emotional lived experiences, which it is argued reflects the lack of any clear definition. The majority of participants defined the syndrome through describing lived experiences. Unsurprisingly biological discourses were used frequently to explain the origins of discomfort and distress, often referring to menarche as the point in participant's lives when problems began to occur. This, it was argued, privileged the body as the main attributional source of distress in the lives of these participants, and was consistent with Swann's (1996), Ussher's (1996), and Law's (1990) findings. Also feminine discourses were evident, participants often describing premenstrual syndrome as preventing them from being the kind of mothers and wives they wanted to be (or thought they should be).

A self-other divide was evident. This divide manifested itself throughout accounts in a variety of ways from being rational/emotional through to good woman /bad demonic angry premenstrual woman. It is argued that fragmentation of experience provided a key function, by enabling participants to distance themselves from negative aspects of the way they were outwardly expressing emotions and justifying inner feelings. This in turn absolved them of personal responsibility, so avoiding recriminations on a wider social level. These findings were consistent with Ussher's (1989, 1991, 1996) arguments on the splitting of the female self. Also Burkitt's (1999) work was referred to for helping explain this sense of a fragmented self. Burkitt (1999) has argued that women often have a detached relation to their bodily experiences because the medicalization of the female body has fragmented women's bodies into separate parts. Indeed it is argued that participants were

experiencing their emotional selves as fragmented for much of the time, having outlined life events and then positioning emotional experiences as separate to many life events.

Closely integrated with discourses of self-other were emotion discourses. These are of overriding importance for the thesis, because when assessed against the other findings so far discussed, they help further an understanding of the nature of emotional premenstrual experience for this group of participants, which was a core objective of this thesis. All of the emotion discourses were concerned with negative emotional experience, anger featuring predominantly. Accounts were constructed out of discourses of anger, which was often cast as having no legitimate cause or origin other than as being a premenstrual symptom. Participant 92's account was presented which examined how she had constructed her emotional self as potentially dangerous and violent towards her partner. Participant 24's account was also presented which constructed her as someone suffering with anger to the point of 'utter despair', using time to position this anger as a premenstrual symptom, yet also referring to a problematic family life and marriage. The anger was located as separate from the life events, yet the life events were constructed as being so major that the participant was taking antidepressant drugs as a result.

Differences between the written accounts in the combined methodological study and accounts from the qualitative study are important. The qualitative interview accounts were constructed out of the need to be emotionally controlled for the majority of time, even to the point of suppressing positive emotional responses. Participants felt uncomfortable when being emotionally expressive and highlighted

possible negative social consequences. However the accounts on premenstrual syndrome were quite different in that emotional expression was pervasive, in particular anger. It is argued that these differences in accounts provide evidence to support the argument that premenstrual syndrome was providing a form of outlet for the expression of emotion, particularly anger. Conventional emotion rules governing expression were able to be contravened in these accounts because the premenstrual syndrome was responsible rather than the individual. A demonic premenstrual 'other' would take over the real or 'normal' self, causing the anger or the depression. Thus it can be stated these findings support Ussher's (1991, 1992b) argument that attributing the expression of anger to a biological abnormality (premenstrual syndrome) serves to make such lived experience more acceptable to women themselves as well as the public domain. From an emotional perspective premenstrual syndrome absolved the individual of responsibility to strictly control emotion in the written accounts.

From the quantitative data of the combined methodological study some significant associations on the emotion variables assessed and mood awareness (Swinkels & Giuliano, 1995) were evident. Interestingly menstrual cycle phase (intermenstrual, premenstrual, menstrual) was **not** found to be significantly associated with any of the emotion variables or reported symptoms. Instead mood monitoring was found to be positively associated with reported negative affect, affect intensity and symptoms. However high mood monitoring was not associated with a low belief expectancy to self-regulate mood. Rather the association between these two measures was in a positive direction. Finally mood labeling was also positively associated with the belief expectancy to be able to self-regulate negative mood.

These results required further consideration on two counts. Firstly menstrual cycle phase was not found to be a consequential variable. No significant associations were found between the phases and any of the other emotion variables. Secondly there was a discrepancy between the quantitative and qualitative results in the combined methodological study (from the same sample). In open ended accounts, 50% of participants had either directly stated or referred to timing discursively as being an important factor in accounts of their experience of premenstrual syndrome. Yet no significant differences were evident between reporting of symptoms and affect across cycle phase. It was argued such a discrepancy could be attributed to dominant perceptions and beliefs concerning premenstrual syndrome, particularly the timing factor, being reproduced through language in the accounts, despite 'actual' experience. Therefore it became necessary to track affect and mood more precisely over time, to establish more clearly whether **timing** really is an important factor in menstrual cycle emotional experience.

The second consideration raised from this combined method study was that mood awareness seemed to be an important factor in emotional experience because several significant associations had been found between mood monitoring in particular and other affect variables. Similarly results from the study manipulating participant awareness (chapter 7) had found mood monitoring was positively associated with symptoms. It was also important to investigate this further because mood monitoring has implications for the potential to successfully self-regulate negative mood (Swinkels & Giuliano, 1995, discussed in chapter 1).

The diary study was conducted principally to address the issues outlined. Also it was argued that a process approach to researching mood and affect would provide the most appropriate way forward, enabling mood to be assessed more accurately as an ongoing interactive process incorporating **time**. Firstly differences in reported positive and negative affect were found to depend upon levels of mood monitoring (but not mood labelling). In particular high monitors compared to lows, reported less happiness, calmness and energy overall across the three cycle phases. It was argued these findings support Swinkels & Giuliano's (1995) argument that high monitoring predisposes the individual to experience more negative affect, and so have a detrimental effect on overall well-being. Secondly mood monitoring moderated the effect of cycle phase upon affect. For high mood monitors the intermenstrual and premenstrual phases predicted happiness and energy, and the premenstrual phase predicted calmness. For low mood monitors only the premenstrual phase predicted the happiness and calmness dimensions of emotion, but in a positive not negative direction.

Overall for the whole sample unpleasantness of reported emotion decreased consistently from the highest reported level in the intermenstrual phase, through the premenstrual phase to the menstrual phase. The level of the three emotion variables was at its most negative during the menstrual phase of the cycle. This was an interesting result because the common assumption is for reported affect to be at its lowest point during the premenstrual phase. However when high and low monitors were assessed separately, high monitors were least happy during the premenstrual phase of the cycle, yet low monitors reported being happiest. These results were

explained in terms of the high monitoring tendency predisposing participants to *anticipate* the onset of negative feelings during the premenstrual phase of the cycle, so resulting in less happiness. In contrast low monitors would have been less engaged with the way they were feeling and so less susceptible to prolonging the experience of negative affect.

Correlational analyses of the diary study data also revealed some significant relationships between the affect variables. Firstly mood monitoring was found to be negatively associated with the affect variables. The higher the reported degree of monitoring, the less happiness, calmness and energy were reported. Also monitoring was positively associated with affect intensity. Thus the higher the degree of monitoring, the stronger the degree of experienced affect. These findings were in line with Swinkels & Giuliano's (1995) results. Mood labeling on the other hand was only negatively associated with happiness, but positively associated with calmness and energy. It was argued these results provide partial support for the notion of self-directed attention being either adaptive or detrimental. Kirschenbaum (1987) proposed that self-monitoring was a necessary condition for generalized self-regulation to occur. However he also differentiated between positive and negative forms of self directed attention. Negative self-directed attention was defined as focusing on failure experiences, which according to Kirschenbaum (1987) predisposes to self-regulatory failure. On the other hand positive self-directed attention focuses on an individual's successful means of self-regulation. It is argued that the monitoring tendency of mood awareness (Swinkels & Giuliano, 1995) parallels the negative form of self-directed attention, whereas the labeling tendency is

representative of the positive form of self-directed attention. According to Swinkels & Giuliano (1995) labeling a mood means the individual more swiftly and accurately identifies it and consequently take steps to correctly self-regulate, or divert attention to other factors.

Summarizing results from the diary study, it was argued that mood monitoring was found to be important in the experience of affect for this group of participants. In particular high mood monitoring, compared to low, predicted less happiness, energy and calmness. Also cycle phase had a predictive effect for high and low mood monitoring, in particular the premenstrual phase. In contrast there were no main significant effects of mood labeling.

The main focus of the thesis is concerned with emotional control and premenstrual emotional experience. Due to the potential consequences of mood monitoring for mood regulatory failure (Swinkels & Giuliano, 1995), and therefore emotional control, it was argued that mood monitoring should be examined more specifically in relation to the way participants responded to negative mood. Therefore further analyses of the diary data were conducted (reported in chapter 10).

Mood regulation strategies assessed in the diary study were focused on specifically as part of the analyses. These consisted of four main strategy groups/categories, which had been identified by Parkinson & Totterdell (1999): cognitive diversion, behavioral diversion, cognitive engagement, and behavioral engagement. It was argued that because ruminative responding was associated with mood monitoring in Swinkels & Giuliano's (1995) work, cognitive engagement

would be the strategy group used most by high mood monitors. Both ruminating and cognitive engagement represent a form of continued emotional engagement through the similarity of focusing attention specifically on negative feelings and their causes. Ruminative responding was discussed by reference to Nolen-Hoeksema's (1991) work. It was argued this style of responding was particularly important to the thesis, as a similar response to cognitive engagement, because of the gender differences found in the way men and women have been found to respond to depressed mood (Nolen-Hoeksema, 1991; Nolen-Hoeksema, Morrow & Fredrickson, 1993; Thayer, Newman & McClain (1994). Women, it was argued, tend to respond more passively to negative mood than men, which has been found to be less effective at alleviating negative moods. The set of hypotheses proposed focused on mood monitoring in relation to conscious attempts at upward mood regulation.

Apart from the prediction that cognitive engagement would be the strategy group used most by high monitors, it was predicted that high monitors would engage in active mood regulation **less** than low monitors and report **less** success at mood regulation than low monitors. This was proposed on the grounds of the association between monitoring and ruminative responding, and the findings of monitors reporting less success at active mood regulation (Swinkels & Giuliano, 1995). However in terms of timing, it was hypothesized that the premenstrual phase of the menstrual cycle would predict use of cognitive diversion mood regulation strategies by high monitors. This was proposed on the grounds that although women use more ruminative responding in general (Nolen-Hoeksema, 1991), during the premenstrual phase of the menstrual cycle women sufferers would believe their negative mood was

due to biological factors over which they have little or no control and so would not ruminate. Rather they would use cognitive diversion in an attempt to take their minds off the way they were feeling.

Results from the analyses partially supported the hypotheses. Firstly high mood monitors were found to have engaged in active mood regulation **more** than low monitors, and also reported **greater** success at regulating negative mood. Indeed high monitors reported using more of all four kinds of strategies than the low monitors. Secondly high mood monitors reported using behavioral diversion most out of the four main strategy groups, rather than cognitive engagement. Even after prior mood was controlled for this was still the case for reported success and use of strategies. Thus it was argued that use of strategies and greater reported success by high monitors was due to the way they were monitoring their moods rather than trait negative affect. These results were in contrast to previous findings by Swinkels & Giuliano (1995) as well as the evidence that women tend to focus attention on negative feelings by various forms of continued emotional engagement (e.g. social support, found by Thayer, Newman & McClain, 1994). In contrast participants displaying a high monitoring tendency had reported deliberately diverting attention away from their feelings by actively engaging in activities which would take their mind off their feelings. Additionally behavioral diversion was reported to be the strategy group used overall by both high and low monitors, which is in line with findings by Parkinson and Totterdell (1999) that various forms of diversion strategies were the most preferred strategies used by trainee teachers.

Out of the three phases of the menstrual cycle, it was the premenstrual phase which predicted use of regulation strategies by high and low mood monitors. Specifically cognitive diversion strategies were predicted for use by high monitors, which supported the hypothesis. These results were still significant, even after controlling for mood, which indicates that strategy use could be attributed specifically to the premenstrual phase rather than the associated negative emotion. It is interesting that from the study manipulating participant awareness (chapter 7) participants in the aware condition had reported using more ‘venting’ which is a form of behavioral engagement. However behavioral engagement was not predicted for use across the menstrual cycle (all three phases) for the whole sample in the diary study, nor specifically for high and low monitors during the premenstrual.

Possible explanations for these results were offered. It was argued that high monitors’ (chapter 9) greater negative emotion meant that they had a stronger compulsion to actively attempt to change their mood. Also because these participants were monitoring their moods and feelings more than the low monitors, they were receiving more immediate feedback on whether a particular strategy was effective or not. This in turn would enable the individual to initiate use of a different strategy, which would explain why high monitors reported using more of all four different kinds of strategies. Thus, overall because high monitors were actively attempting to regulate their mood more than low monitors, they experienced a greater degree of relative success. Despite mood being controlled for on use of strategies and reported success at mood regulation, strategy use and reported success was still significant. Thus it was argued the results on strategy use and successful use of regulation could

be attributed the way participants were monitoring their moods rather than their feeling negative.

Conclusions Drawn

This thesis set out to establish a deeper understanding of emotional control and premenstrual emotional experience. Firstly the research has revealed that emotional experience is still subject to strict emotion rules for much of the time. For emotion to be accepted as *normal*, inner feelings and outward expression have to appear consistent with conventional rules that are located within the worldview held by Western society. Apart from biology, which is always acknowledged, dominant ideologies that together comprise this worldview were found to be equally influential on the way emotional experience is perceived and experienced. However it is argued that such emotion rules are not as clear cut at the individual level. The research revealed that private singular experience does not always comply with these preexisting rules, which serves to create tensions within everyday emotional experience. Such tensions have to be actively managed by the individual, which is often problematic because it demands a high degree of personal resources. This, it is argued, is why the lay community continues to define emotion as dysfunctional.

The second main conclusion that can be drawn from the research concerns premenstrual emotional experience. Being emotionally *out of control* is a predominant feature, with the underlying theme of negative emotions. Anger featured

as the dominant emotion, and caused problems at the personal level. However rather than listing emotional, or any other, symptoms as comprising premenstrual syndrome, women constructed premenstrual syndrome out of problematic life events and traumatic personal emotional experiences. It is argued this provides support for the argument that premenstrual syndrome is not purely a biological entity, and can only be accurately assessed when a more complete picture of a woman's current social situation and life experiences can be gained (Bancroft, 1995; Blake, 1995; Parry, 1994).

A further concluding point to be made about premenstrual emotional experience is that it is concerned with being emotionally expressive, in contrast to the normal or non-premenstrual experience of emotion. In particular the outward expression of anger is a key feature. When assessed against the emotion norms governing strict control, and the way in which women themselves *defined* premenstrual syndrome, it is argued the label provided by the disorder served a performative function. Premenstrual syndrome allowed the acknowledgment and expression of negative emotion. Although women are deemed the more emotional sex, anger is the one emotion which they are socialized to repress (Brody, 2000). It is argued the label of premenstrual syndrome enabled women to express negative emotion, and in particular anger (Ussher, 1991, 1992b, 1996). This argument is strengthened by the findings concerning gender ideology's continuing powerful influence over women (Van-Leeson et al. under review).

In addition the research found partial support for Swinkels & Giuliano's (1995) assertions concerning mood monitoring and mood labeling. Although three separate studies were conducted incorporating the mood awareness construct, affect intensity (Larsen & Diener, 1987), positive and negative affect (Watson, Clarke & Tellegen, 1990), and the negative mood regulation belief expectancy (Catanzaro & Mearns, 1990), they yielded varying results. In summary there was found to be a negative association between mood monitoring and mood, which meant a higher degree of reported monitoring was associated with more reported negative mood/affect. Mood labeling was positively associated with mood, meaning the higher degree of reported labeling, the higher the degree of reported positive mood/affect. Mood monitoring was also found to be positively associated with affect intensity (Larsen & Diener, 1987), which meant the higher the degree of reported monitoring, the stronger the intensity of reported mood/affect. However these associations were not found consistently across all three studies and so it is argued that mood monitoring is *likely* to be an associative factor in regard to negative affect and affect intensity.

Mood monitoring was found to be associated with a higher degree of symptom reporting consistently across two studies. It is therefore argued that if an individual is constantly paying more attention to the way they are feeling, they are more likely to be aware of somatic and psychological changes. This caused one to consider the role of timing in the menstrual cycle. It was argued that *time* would be an important factor for women who believe they suffer with premenstrual syndrome, as well as affecting reporting in research. However there were no significant

associations found between phase of cycle and affect intensity, or negative mood, yet at the same time participants stated that the premenstrual phase of the cycle was a salient factor. The diary study revealed that cycle phase did have an effect, in that high monitoring, compared to low, was associated with a decrease in positive mood to the lowest point in the month being the premenstrual phase. For the whole sample, though, the lowest point of actual reported mood occurred in the menstrual phase of the cycle, which was not in line with popular beliefs. Therefore it is argued that the effect of cycle phase on mood is not straightforward, and cannot be accounted for by associative/causal explanations. Rather the influence of timing is more complex. It is argued that mood monitoring interacts with the premenstrual phase to predict mood and so the mood monitoring dimension of mood awareness (Swinkels & Giuliano, 1995) is an important factor in premenstrual experience of mood.

The premenstrual phase is significant, being important on the way women who believe they suffer with premenstrual syndrome attempt to actively regulate their moods. The premenstrual phase predicted use of cognitive diversion by high mood monitors, and behavioral diversion by low monitors. Behavioral diversion was rated as being the most successful form of mood regulation by both high and low monitors. It seems that high monitors, although reporting a greater degree of success at mood regulation on all four strategy groups, are not making the maximum use of the most successful group of strategies during the premenstrual phase (namely behavioral diversion).

Implications

The findings of this thesis have implications on two levels. Firstly there are practical implications for women who are being investigated by the medical and/or psychological professions for premenstrual syndrome. In order to be able to provide women suffering from emotional and somatic discomfort with the help they need, it is necessary to establish the individual needs of the person, rather than base decisions and advice on unfounded generalizations. To achieve this it is argued that premenstrual syndrome should not be investigated from a biomedical perspective alone, but rather women should be given full counselling support as part of the process (e.g. Asso, 1988). Secondly there are implications for women in general, whether they believe themselves to suffer from premenstrual syndrome or not. There is a real danger that a woman's emotional integrity may be undermined by from time to time and be dismissed as an inconsequential, irrational reaction because of the assumptions surrounding the premenstrual phase of the cycle for its ability to *change* a woman's emotional disposition. Finally, some women may tend to monitor their feelings more if they believe they might be suffering from premenstrual syndrome, which in turn may leave them more susceptible to negative mood. This will also have implications for mood regulation, in that some women may actively use cognitive diversion during the premenstrual phase for reasons already discussed.

There are also theoretical implications for the way future research into premenstrual syndrome should be conducted. Firstly this applies to how one goes about defining what it is exactly that is being researched. It is no longer adequate to

set a research agenda based on the same previously held assumptions (chapter 2), nor go about conducting the research in the same way. Rather the researcher needs to attempt to go beyond the impasse in menstrual cycle research by reconceptualizing what constitutes the premenstrual syndrome itself, and rejecting the concept of homogeneity for women. Practically, the way in which one goes about conducting the research in methodological terms will then have to alter to meet these new challenges set by re-thinking premenstrual syndrome, which it is hoped will eventually lead to new ways of understanding women's premenstrual emotional discomfort.

Reflexivity: An Issue for Interpretation

Scientific inquiry has traditionally sought to eliminate the researcher from that which is being researched. However the evolving debate concerning the use of qualitative *approaches* as research tools, particularly in regard to epistemology, has directly acknowledged the position of the researcher in the research process. Instead of denying the presence of the researcher, a reflexive approach not only acknowledges honestly that a researcher *always* has some effect on participants or the phenomena being studied (e.g. Latour & Woolgar, 1979), but also that the researcher brings certain qualities to the research process. Smith (1996) argued this alternative position can be harnessed as a valuable part of the research itself. Henwood argues (2000) it can also help to support and validate the research process. As part of the research process for this thesis I have actively sought to reflect on my position in relation to participants when conducting the qualitative interviews and diary study,

for which I had a lot of participant contact. In addition to this, in terms of theoretical sensitivity, I have also considered my preexisting knowledge on premenstrual syndrome which helped shape the planning of this research, as well as continued reading and acquisition of new knowledge I brought to the research process when interpreting meanings from data.

Being reflexive required me to consider any ways in which I thought my own personal issues and beliefs may have interacted with the research, in terms of what participants said or wrote and how I interpreted meanings from data and language. In the first instance it had to be recognized that I am female, and so have my own set of experiences of a regular menstrual cycle and cyclical variation of hormones. Also I am subject to the same emotion rules and norms which female participants were and so have my own set of beliefs and experiences of how such rules are sometimes problematic for me personally. However I did not have any set ideas concerning what constitutes the premenstrual syndrome at the outset of this research and was genuinely guided by the literature. It very soon became apparent that despite medical science normally appearing so outwardly 'precise' when considering diagnostic criteria applied with caution to initial diagnoses, in the case of premenstrual syndrome this is not so. I have also worked as a Registered General Nurse previously and so have experienced the practical interface between the medical and nursing professions. Apart from influencing and shaping the research question, I believe my previous experience strengthened the way I was able to both understand the implications from the literature as well as interpret meanings and be able to apply theoretical ideas in more practical terms. Also I have witnessed, first hand, how often

a diagnostic label can be more salient to a health care professional than a person's account of their illness and discomfort, thus serving to dismiss subjective accounts.

Combined with knowledge from the literature on premenstrual syndrome and the current debate occurring within mainstream psychology, I firmly support the need to be more critical of the way research is conducted and for what purpose. The potential abuse of power in the relationship of patient/doctor is, I believe, paralleled by the researcher/researched relationship and so underscores this need. There is a fine line between an individual gaining help from the medical profession and being labeled with negative consequences. In the case of premenstrual syndrome many women may be given the label or attach it to themselves, but at the same time are not certain of procuring help. Therefore due to the ambiguity surrounding the disorder women should be allowed to express what premenstrual syndrome means for them, bearing in mind the disorder was defined by a male dominated medical profession, and framed within a historical context that has always linked female emotional discomfort to female biology. At the same time medical science has failed to acknowledge the disadvantaged position women occupy within society, emotionally and practically. It is hoped this will in turn further an understanding of the issue that overshadows the lives of many women: premenstrual syndrome.

Such beliefs have evolved through the research process itself, underscored by my personal experience of the medical profession and what it means to be a woman. At the same time it needs to be stated that I consider myself more fortunate than many women in that I do not perceive myself to suffer from premenstrual syndrome.

What I consider to be normal cyclical changes could be deemed ‘symptoms’ by another woman. Sometimes the fluid retention is uncomfortable, but never worthy of being given the status of a ‘syndrome’ with all the accompanying negative medical connotations of a disorder. This will have most certainly influenced the way I pursued the research question and interpreted meaning, particularly when focusing on social factors and traumatic life events. Had I considered myself to be a sufferer, the interpretation of meaning and conclusions drawn might have been different. An alternative perspective taken on the written accounts of premenstrual syndrome might have sought to establish the meanings in relation to the lack of evidence or treatments as confounding anger and emotional discomfort perhaps? However I choose to stay with the interpretations that have been presented.

Limitations

The main limitations of the research are that, firstly, there were no comparison groups used in the combined methodological study or the diary study. The research process would be strengthened by the ability to be able to compare both subjective accounts of what premenstrual syndrome means for people who do not perceive themselves to be sufferers, as well as comparisons on mood over time, affect intensity and mood awareness. Comparison of mood monitoring and regulation strategies used by non-sufferers would be particularly useful also. It would be helpful to establish whether non-sufferers differed in the way they monitor and self regulate mood. Secondly a more controlled use of regulation strategies with a diary technique would

have enabled a more accurate way of ascertaining which types of strategies were most effective for women sufferers, by instructing when to use particular strategies and rating their effectiveness (e.g. Totterdell & Parkinson, 1999).

The sample used for the combined methodological study was self-selecting, and so carried all of the potential confounding factors that can occur in this kind of sample. For example it may have been that only women with major problems, or who are very unhappy generally, responded to the study and so were not representative of women with premenstrual syndrome. Also the participants were all members of a self-help group and so would naturally have more to say about the disorder.

Strengths

The use of a combined methodological approach had several main advantages. Firstly this approach incorporated both *at the time* measures of mood with *over time* measures, allowing the tracking of mood as it naturally unfolded against daily activities. The methods included a standard one-time questionnaire technique, a standard questionnaire which also incorporated the collection of personal accounts, interviews, and the intensive time-sampling procedure (also known as the diary technique). This combination enabled the clarification of the way timing is often considered to be important for premenstrual syndrome. Although no associations were evident from the research on cycle phase and other affect variables in the studies using a standard one-time questionnaire technique, women had stated

that timing was an important part of the way they experienced their menstrual cycle. Here the use of language and the standard measures within one study had exposed a discrepancy in the information by the same sample of women, which is interesting in itself. One reason for the discrepancy could be that the one-time standard questionnaire measure was not sensitive enough to detect differences between cyclical phases. Without further investigation using the diary technique it would not have been possible to clarify whether timing was an issue, and in what way. Tracking mood over time also meant the information was more ecologically valid, as it was collected in a natural environment rather than in an artificial experimental setting with the deliberate manipulation of naturally occurring phenomenon. Indeed this combined approach has shown that premenstrual emotional discomfort is complex and integrated with stressful life events and difficult social positions that are the direct result of being female. It is argued that a more conventional approach would not have been able to reveal the depth of meaning that was found in the research due to the way it was undertaken. The use of the static measure supplemented the research by establishing that mood monitoring is associated with negative mood and affect intensity, and that mood monitoring is likely to be an important factor in emotional control. The diary technique revealed how high monitors were using different regulation strategies than low monitors.

Secondly this causes one to consider the theoretical aspect of the benefits to this kind of combined approach. It is argued that the two main methods went together extremely well: namely a discourse analytic interpretative approach and the diary technique. Discourse analytic work enabled the exploration of certain dominant

ideologies for the way they shape lived emotional experience, and at the same time support the debate in menstrual cycle research which argues that the *real* material body is experienced against socially changing meanings and beliefs about women's biology. The diary technique, although attempting to *measure* some aspect of the participants emotional reality, was at the same time allowing for mood to be tracked as naturally as possible whilst incorporating time as a framework. Finally the approach used in this thesis has enabled emotional lived experience to be conceptualized as a fluid process, and acknowledged how fragmentation can lead to misunderstanding and alienation from the self.

Overall in practical terms the combined method approach has been extremely valuable. In theoretical terms a critical realist approach was used to frame the thesis on a general level. It must be accepted, though, that this thesis would not bridge the gap between the two competing paradigms of post-positivism and constructionism. It was not intended for any one part of the thesis to be able to relate completely to both ontological relativism and ontological realism. Rather the critical realist framework was intended to allow for methods from the two paradigms to be used successfully alongside one another, which it has.

Suggestions for Future Research

There are several lines of inquiry that would be useful to pursue, which have become apparent from this research. There is a definite need for more diversity in the

way research is conducted into premenstrual syndrome. More research is required that takes account of subjective experience so that a clearer picture can emerge of what premenstrual syndrome means for women who believe themselves to be sufferers. Also it would be useful to attempt to examine further the tensions created out of private singular experience and the public domain. Exploring tensions in lived emotional experience would allow more insight in to coping resources, and possible triggers for self-regulatory failure at the emotional level. There is also a strong need to examine various forms of language to gain a current insight in to the debate surrounding premenstrual syndrome in the public arena. Diversifying the type of material selected for data would allow for a broader overview, such as current televised programs and magazines.

Although the power of labeling in a medical sense is acknowledged in certain debates, there is little research available on self-labeling for women who attach the premenstrual syndrome label to themselves. It would be interesting to establish what is involved in the process of a woman reaching the decision that she is suffering from premenstrual syndrome. For example is the label attached by significant others in the first instance, or do some women gradually accrue information from health care professionals and other informational sources? Also what are the deciding factors that finally compel women to make such an important decision, and how do they perceive such a decision for its potential to impact on their lives? Finally what do women expect will result from the label?

Mood monitoring was found to be a significant factor in the way participants experienced mood, particularly during the premenstrual phase, and for active upward mood regulation. Although there was partial support for Swinkels & Giuliano's (1995) argument, there were also some findings that were not consistent. High mood monitors, compared to lows, had actually engaged in active mood regulation more and had also reported a greater degree of success. Clearly more research is required into the individual difference characteristic of mood monitoring and its effects on aspects of mood regulation. Also more research on the types of regulation strategies used would be useful, such as instructing when to use particular strategies and rating effectiveness (Totterdell & Parkinson, 1999). Behavioral diversion strategies were rated as being the most successful way of changing mood in an upward direction. Their uses and effectiveness should be examined further because of their potential for alleviating negative mood. Finally it would be interesting to establish if women suffering premenstrual emotional discomfort could be instructed to use various strategies, such as behavioral diversion in the premenstrual phase, to improve their ability to alleviate negative moods.

Conclusion

The thesis demonstrates that there is a strong need to take account of cultural perspectives for the way they influence beliefs about what is considered *normal*. Although the research has tapped general cultural ideas, and some might argue such conceptions are already known to be in existence and therefore is not necessary, it is argued we still need to do this because of the immense power unsupported

assumptions continue to have. Despite there being no consensual definition of premenstrual syndrome, women are at risk of being labeled as disordered in some way because of a normally occurring menstrual cycle. Also the emotion/premenstrual syndrome debate is as salient as ever with the inclusion of Late Luteal Phase Dysphoric Disorder in the most up-to-date revised issue of DSM-IV.

This thesis has not been able to provide a definition of premenstrual syndrome, although this was never the objective. However what it does provide is insight in to women's experiences of what premenstrual syndrome means for them, and the function the label is providing. Premenstrual syndrome is a label with which most women can easily identify, even those who do not consider themselves to be sufferers. Therefore it is not helpful to suggest to women sufferers that premenstrual syndrome does not exist, but rather to reconceptualize it with them through a process of active discovery and insight that can be achieved through counselling. This way the most appropriate form of help can be identified and offered.

After over seventy years of research medical science has failed to provide answers to women's emotional premenstrual distress, or furnish an effective *cure*. If the causal association between women's emotional lability and the premenstrual phase of a normally occurring menstrual cycle were straightforward, then surely we would no longer still be searching for answers? Therefore it is now time to allow women themselves to be able to contribute to the debate.

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Appendices

Appendix 1	318
Appendix 2	319
Appendix 3	329
Appendix 4.1	338
Appendix 4.2	340
Appendix 4.3	341
Appendix 5	345
Appendix 6	354
Appendix 7	363

Appendix 1

Semi-structured interview schedule.

- Question 1 How would you describe feelings/emotions?
- Question 2 Do you think there are different types of emotions? (e.g. happiness, joy).
- Question 3 Would you be willing to talk about personal emotional experiences by recalling a recent (or not so recent) time when you had experienced particularly strong emotions/feelings?
- Question 4 Could you describe moods?
- Question 5 Do you think about what type of mood you are in at the time of the experience, or not?
- Question 6 Do you ever try to change the way you are feeling?
- Question 7 Do you tend to express the way you feel?
- Question 8 Do you have any thoughts about gender differences and emotions, such as are men and women similar emotionally?

Appendix 2

Written instructions and questionnaire, which were given to participants taking part in the study reported in chapter 7.

Instructions for the 'aware' condition:

You are going to be participating in a study which is concerned with moods, emotions, and the premenstrual syndrome, or PMS. The study is interested in whether people regularly try to change or maintain their mood in some way, and if so what types of strategies they might use.

All that is required of you is to complete a questionnaire. The questionnaire is divided into four sections. Each section contains instructions on how it is to be completed. It will take you no more than twenty minutes to complete. Please remember to answer all of the questions.

After you have completed the questionnaire put your hand up and wait for somebody to come to you.

You may begin now.

Instructions for the ‘unaware’ condition were the same, apart from the first sentence, which instead went as follows:

You are going to be participating in a study which is concerned with how people control their moods and emotions during a typical working week.

Questionnaire concerning mood and emotion.

This questionnaire contains a number of questions about your moods, feelings and emotions. It is divided into four sections. Each section is headed with a set of instructions explaining how the particular section is to be completed. It is important that you complete all of the sections. The questionnaire will take you approximately twenty five minutes to complete. All questions are answered by selecting a number which you believe most accurately represents your answer. There are no right or wrong answers, rather we are interested in how YOU personally feel. Thank you for your support.

Section 1 Personal details

Age

Gender.....

Are you currently taking any form of medication? Yes / No (Delete as appropriate)

If so please state the name(s)

.....

.....

.....

.....

.....

Section 2: General information about your moods and emotions

Instructions: Below are some words describing different feelings and emotions. Please indicate the extent to which you were experiencing each of these feelings and emotions NOW.

Very slightly or not at all 1	A little 2	Moderately 3	Quite a bit 4	Extremely 5
interested.....	guilty.....	irritable.....	determined.....	
distressed.....	scared.....	alert.....	attentive.....	
excited.....	hostile.....	ashamed.....	jittery.....	
upset.....	enthusiastic.....	inspired.....	active.....	
strong.....	proud.....	nervous.....	afraid.....	

Instructions: The following statements refer to your moods and emotions. Please indicate how much you agree or disagree with each of these statements by placing a number from the following scale in the blank space next to the each statement. Please base your answers on how YOU personally feel, not on how you think others feel or how you think a person should feel.

Disagree very much 1	Disagree somewhat 2	Disagree slightly 3	Agree slightly 4	Agree somewhat 5	Agree very much 6
1.	I have a hard time putting my feelings into words.				.....
2.	I'm usually "tuned in" to my emotions.				.....
3.	I find myself thinking about my mood during the day.				.....
4.	I am sensitive to changes in my mood.				.....
5.	I have trouble explaining my feelings.				.....
6.	On my way home from work, school, shopping, or carrying out other chores, I find myself thinking about my mood.				.....
7.	Right now I know what kind of mood I'm in.				.....
8.	I often weigh up my mood.				.....
9.	I'm never really sure what I'm feeling.				.....
10.	I don't pay much attention to my moods.				.....

Instructions: The following items are designed to find out what people believe they can do about emotions or feelings that are upsetting. Please read each statement, answer by placing a number from the scale into the space provided next to each statement. There are no right or wrong answers. Remember, the items are about what you believe you can do, not about what you actually or usually do.

Strongly disagree	Mildly disagree	Agree and disagree equally	Mildly agree	Strongly agree
1	2	3	4	5

When I'm upset, I believe that

1. I can usually find a way to cheer myself up
2. I can do something to feel better
3. Wallowing in it is all I can do
4. I'll feel okay if I can think about more pleasant times
5. Being with other people will be a drag
6. I can feel better by treating myself to something I like
7. I'll feel better when I understand why I feel bad
8. I won't be able to get myself to do anything about it
9. I won't feel much better by trying to find some good in the situation
10. It won't be long before I calm myself down
11. It will be hard to find someone who really understands
12. Telling myself it will pass will help me calm down
13. Doing something nice for someone else will cheer me up
14. I'll end up feeling really depressed
15. Planning how I'll deal with things will help
16. I can forget about what is upsetting me pretty easily
17. Catching up with my work will help me calm down
18. The advice friends give me won't help me feel better
19. I won't be able to enjoy the things I usually enjoy
20. I can find a way to relax

21. Trying to work the problem out in my head will only make it seem worse
22. Seeing a movie won't help me feel better
23. Going out to dinner with friends will help
24. I'll be upset for a long time
25. I won't be able to put it out of my mind
26. I can feel better by doing something creative
27. I'll start to feel really down about myself
28. Thinking that things will eventually be better won't help me feel any better
29. I can find some humour in the situation and feel better
30. If I'm with a group of people, I'll feel "alone in a crowd"

Section 3: Information concerning your moods and emotions from yesterday.

Instructions: Below are some words describing different feelings and emotions. Please indicate the extent to which you were experiencing each of these feelings and emotions YESTERDAY.

Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
1	2	3	4	5
interested.....	guilty.....		irritable.....	determined.....
distressed.....	scared.....		alert.....	attentive.....
excited.....	hostile.....		ashamed.....	jittery.....
upset.....	enthusiastic.....		inspired.....	active.....
strong.....	proud.....		nervous.....	afraid.....

Instructions: The following statements refer to your moods and emotions from yesterday. Please indicate how much you agree or disagree with each of these statements by placing a number from the following

scale in the blank space next to each statement. Please remember to base your answers on how YOU personally felt..

Disagree very much 1	Disagree somewhat 2	Disagree slightly 3	Agree somewhat 4	Agree very much 5	Agree 6
1.					Yesterday I had a hard time putting my feelings into words
2.					Yesterday I was <i>tuned in</i> to my emotions
3.					Yesterday I found myself thinking about my mood
4.					I was sensitive to changes in my mood yesterday.
5.					Yesterday I had trouble explaining my feelings
6.					On my way home from work, school, shopping or carrying out other chores yesterday, I found myself thinking about my mood
7.					Yesterday, I knew what kind of mood I was in
8.					I frequently weighed up my mood yesterday
9.					Yesterday I wasn't really sure of how I was feeling
10.					I did not pay much attention to my moods yesterday

Section 4 Mood regulation strategies

Instructions: The following statements refer to the types of strategies that you people sometimes use to improve their mood. Please indicate how much you used each type of strategy YESTERDAY by making a thin mark on the line at the point that best represents your answer, where 0 means that you “don’t use the strategy”, and + means that “you used the strategy a great deal”.

For example, if you only rarely improved your mood by getting support from other people then you would mark the line thus:

3. Got support from others 0---/-----+

but if you used this strategy a lot then you would mark the line thus:

3. Got support from others 0-----/----+

Do something else: relaxing/enjoyable

This means that you engaged in a pleasant activity in order to take your mind off your worries, problems or bad feelings.

1. Eg. Treated myself

Went somewhere nice
Listened to the radio/CDs
Watched movie/TV
Read a book/magazine
Had a drink/food/cigarette
Took a bath/shower

0-----+

Did something else: energetic/active

This means that you exerted yourself or did something constructive in order to take your mind off your worries, problems or bad feelings. Kept busy

2. Eg. Did some house-work
Washed the car
Focused my energy on a hobby/project
Went for a walk
Played a sport
Exercised

0-----+

Got support from others.

This means that you addressed your worries, problems, or bad feelings by getting reassurance, help, or advice from someone else.

3. Eg. Told someone how I feel
Shared the problem
Complained to another person
Asked for help/advice
Sought reassurance/sympathy
Got affection from someone who cares

0-----+

Thought about something else.

This means that you thought about something pleasant or something different in order to take your mind off your worries, problems, or bad feelings.

4. Eg. Thought about people who are close to me
Recalled happy memories
Thought about things that make me happy
Thought about good things in my life
Fantasized about pleasant things
Thought of a good looking girl/boy
Thought about a future event I am looking forward to

0-----+

Tried to solve things.

This means that you addressed your worries, problems, or bad feelings by devoting attention or effort to understanding or solving them.

5. Eg. Evaluated why things aren't going well
 Thought rationally about the problem
 Made plans to solve the problem
 Tried to solve the problem
 Tried to understand my feelings
 Tried to work out if my feelings are justified
 Thought about why I am in a bad mood

0-----+

Looked at things differently.

This means that you addressed your worries, problems, or bad feelings by trying to see things in a more favourable light.

6. Eg. Thought about people worse off than me
 Got things into proportion
 Tried to be philosophical about the problem
 Adopted a fresh perspective
 Looked on the bright side
 Thought positively

0-----+

Avoided thinking about things.

This means that you withdrew your attention from your worries, problems, or bad feelings.

7. Eg. Mentally switched off
 Removed myself from the situation
 Tried to put things out of my mind
 Tried to think of nothing
 Buried my head in the sand

0-----+

Let my feelings out.

This means that you addressed your worries, problems or bad feelings by releasing or giving expression to your feelings.

8. Eg. Shouted
 Screamed
 Let off steam
 Cried
 Started a fight/argument
 Broke something
 Got it out of my system

0-----+

9. Generally tried to improve my mood 0-----+

The average duration of the menstrual cycle is usually twenty-eight days. Below you will see a line which has been divided into three sections to represent particular phases in the cycle. Please make a mark on the line to indicate where you currently are in your own menstrual cycle.

2 = Intermenstrual phase. Between your menstrual and premenstrual phase.

3 = Pre-menstrual phase. A week or so before bleeding recommences.

A horizontal line is divided into three segments by two vertical tick marks. The segments are labeled 1, 2, and 3 from left to right.

Please say how often you experience each of the following symptoms by placing a number from the scale in the space provided next to each symptom.

Never	Infrequently	Quite often	Most of the time
1	2	3	4
1.	Mood changes		.....
2.	Irritability		.....
3.	Tension		.....
4.	Depression		.....
5.	Anxiety		.....
6.	Fluid retention (abdominal bloating, breast tenderness).		.....
7.	Pain		.....
8.	Fatigue		.....

- | | | |
|-----|----------------|-------|
| 9. | Muscle tension | ..... |
| 10. | Hot flushes | ..... |
| 11. | Food cravings | ..... |

Please would you refrain from discussing the study you have just taken part in with first year students for the next three weeks. Your co-operation in this matter would be appreciated.

Thank you very much for your time.

The final section of the questionnaire (section 5) was included for the 'aware' condition only.

Appendix 3

Questionnaire used for the study reported in chapter 8.

Questionnaire concerning mood and premenstrual syndrome

This questionnaire contains a number of questions about your moods, feelings and premenstrual symptoms. It is divided into four sections. Each section is headed with a set of instructions explaining how the particular section is to be completed. It is important that you complete all of the sections. The questionnaire will take you approximately twenty five minutes to complete. Please try to complete the questionnaire in a single session, rather than filling half of it in one day and completing the remainder at a different time. All questions are answered by selecting a number which you believe most accurately represents your answer. There are no right or wrong answers, rather we are interested in how YOU personally feel.

Thank you for your support.

Section 1 Personal details

Date commencing the questionnaire/...../..... Time.....am/pm

Age/Occupation.....

Marital status (Delete as appropriate): Married/ Single/ Divorced/ Living with partner/Widowed

Are you currently taking oral contraceptive pills? Yes / No

Are you currently taking any other form of medication? Yes / No

If so please state the name(s)

.....
.....
.....
.....

Section 2: Information concerning the menstrual cycle.

Although there are obviously some similarities, it has become increasingly evident that each woman's menstrual cycle is different and unique to her. We are interested to learn about YOUR experience of the menstrual cycle. Below a space is provided for you to write freely and honestly about how your own cycle affects you if you wish to do so. Should you run out of space, continue on a separate piece of paper and include it when you return the questionnaire.

[illegible]

The average duration of the menstrual cycle is usually twenty-eight days. Below you will see a line which has been divided into three sections to represent particular phases in the cycle. Please make a mark on the line to indicate where you currently are in your own menstrual cycle.

- 1 = The menstrual phase. When bleeding occurs.**
- 2 = Intermenstrual phase. Between your menstrual and premenstrual phase.**
- 3 = Pre-menstrual phase. A week or so before bleeding recommences.**

Instructions: Please say how often you experience each of the following symptoms by placing a number from the scale in the space provided next to each symptom.

Never	Infrequently	Quite often	Most of the time
1	2	3	4
1.	Mood changes		.....
2.	Irritability		.....
3.	Tension		.....
4.	Depression		.....
5.	Anxiety		.....
6.	Fluid retention (abdominal bloating, breast tenderness).		.....
7.	Pain		.....
8.	Fatigue		.....
9.	Muscle tension		.....
10.	Hot flushes		.....
11.	Food cravings		.....

Section 3: General information about your moods and emotions

Instructions: The following questions refer to emotional reactions to typical life events. Please indicate how you would react to these events by placing a number in the space next to each question. Remember to base your answers on how YOU react, not on how you think others react or how you think a person should react.

Never	Almost never	Occasionally	Usually	Almost always	Always
1	2	3	4	5	6
1.	When I accomplish something difficult I feel delighted or elated				.....

2. When I feel happy it is a strong type of exuberance
3. I enjoy being with other people very much
4. I feel pretty bad when I tell a lie
5. When I solve a small personal problem, I feel euphoric
6. My emotions tend to be more intense than those of most people
7. My happy moods are so strong that I feel like I'm in heaven
8. I get overly enthusiastic
9. If I complete a task I thought was impossible, I am ecstatic
10. My heart races at the anticipation of some exciting event
11. Sad movies deeply touch me
12. When I'm happy it's a feeling of being untroubled rather than
zestful and aroused
13. When I talk in front of a group for the first time my voice gets
shaky and my heart races
13. When something good happens I am usually much more jubilant
than others
15. My friends might say I'm emotional
16. The memories I like the most are of those times when I feel
content and peaceful rather than zestful and enthusiastic
17. The sight of someone who is hurt badly affects me strongly
18. When I'm feeling well it's easy for me to go from being in a
good mood to being really joyful
19. "Calm and cool" could easily describe me
20. When I'm happy I feel like I'm bursting with joy
21. Seeing a picture of some violent car accident in a newspaper
makes me feel sick to my stomach
22. When I'm happy I feel very energetic
23. When I receive an award I become overjoyed
24. When I succeed at something, my reaction is calm and content
25. When I do something wrong I have strong feelings of shame
and guilt

26.	I can remain calm even on the most trying days					.....
Never	Almost never	Occasionally	Usually	Almost always	Always	
1	2	3	4	5	6	
27.	When things are going well I feel “on top of the world”					.....
28.	When I get angry it’s easy for me to still be rational and not over-react					.....
29.	When I know I have done something very well, I feel relaxed and content rather than excited and elated					.....
30.	When I do feel anxiety it is normally very strong					.....
31.	My negative moods are mild in intensity					.....
32.	When I am excited about something I want to share my feelings with everyone					.....
33.	When I feel happiness, it is a quiet type of contentment					.....
34.	My friends would probably say I’m a tense or “highly strung” person					.....
35.	When I’m happy I bubble over with energy					.....
36.	When I feel guilty, this emotion is quite strong					.....
37.	I would characterise my happy moods as closer to contentment than to joy					.....
38.	When someone compliments me, I get so happy I could “burst”					.....
39.	When I am nervous I get shaky all over					.....
40.	When I am happy the feeling is more like contentment and inner calm than one of exhilaration and excitement					.....

Instructions: The statements in this section concern your personal reactions. Answer as frankly as you possibly can by placing a number from the following scale in the space provided next to each statement.

Not at all of me				Very true of me	True of me
0	1	2	3	4	
1.	I'm always trying to figure myself out				.....
2.	Generally, I'm not very aware of myself				.....

3. I reflect about myself a lot
4. I'm often the subject of my own fantasies
5. I never think about myself
6. I'm generally attentive to my inner feelings
7. I'm constantly examining my motives
8. I sometimes have the feeling that I'm off somewhere watching myself
9. I'm alert to changes in my mood
10. I'm aware of the way my mind works when I work through a problem

Instructions: The following items are designed to find out what people believe they can do about emotions or feelings that are upsetting. Please read each statement, answer by placing a number from the scale into the space provided next to each statement. There are no right or wrong answers. Remember, the items are about what you believe you can do, not about what you actually or usually do.

Strongly disagree	Mildly disagree	Agree and disagree equally	Mildly agree	Strongly agree
1	2	3	4	5

When I'm upset, I believe that

1. I can usually find a way to cheer myself up
2. I can do something to feel better
3. Wallowing in it is all I can do
4. I'll feel okay if I can think about more pleasant times
5. Being with other people will be a drag
6. I can feel better by treating myself to something I like
7. I'll feel better when I understand why I feel bad
8. I won't be able to get myself to do anything about it
9. I won't feel much better by trying to find some good in the situation
10. It won't be long before I calm myself down
11. It will be hard to find someone who really understands

- | | | |
|-----|--|-------|
| 12. | Telling myself it will pass will help me calm down | ..... |
| 13. | Doing something nice for someone else will cheer me up | ..... |
| 14. | I'll end up feeling really depressed | ..... |
| 15. | Planning how I'll deal with things will help | ..... |
| 16. | I can forget about what is upsetting me pretty easily | ..... |
| 17. | Catching up with my work will help me calm down | ..... |
| 18. | The advice friends give me won't help me feel better | ..... |
| 19. | I won't be able to enjoy the things I usually enjoy | ..... |
| 20. | I can find a way to relax | ..... |
| 21. | Trying to work the problem out in my head will only make it seem worse | ..... |

Strongly disagree	Mildly disagree	Agree and disagree equally	Mildly agree	Strongly agree
1	2	3	4	5

When I'm upset, I believe that

- | | | |
|-----|--|-------|
| 22. | Seeing a movie won't help me feel better | ..... |
| 23. | Going out to dinner with friends will help | ..... |
| 24. | I'll be upset for a long time | ..... |
| 25. | I won't be able to put it out of my mind | ..... |
| 26. | I can feel better by doing something creative | ..... |
| 27. | I'll start to feel really down about myself | ..... |
| 29. | Thinking that things will eventually be better won't help me feel any better | ..... |
| 29. | I can find some humour in the situation and feel better | ..... |
| 30. | If I'm with a group of people, I'll feel "alone in a crowd" | ..... |

Section 4: Information concerning your moods and emotions from yesterday.

Instructions: Below are some words describing different feelings and emotions. Please indicate the extent to which you were experiencing each of these feelings and emotions YESTERDAY.

Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
1	2	3	4	5
interested.....	guilty.....		irritable.....	determined.....
distressed.....	scared.....		alert.....	attentive.....
excited.....	hostile.....		ashamed.....	jittery.....
upset.....	enthusiastic.....		inspired.....	active.....
strong.....	proud.....		nervous.....	afraid.....

Instructions: The following statements refer to your moods and emotions from yesterday. Please indicate how much you agree or disagree with each of these statements by placing a number from the following scale in the blank space next to each statement. Please remember to base your answers on how YOU personally felt..

Disagree very much	Disagree somewhat	Disagree slightly	Agree somewhat	Agree very much	Agree
1	2	3	4	5	6
1.	Yesterday I had a hard time putting my feelings into words				.....
2.	Yesterday I was <i>tuned in</i> to my emotions				.....
3.	Yesterday I found myself thinking about my mood				.....
4.	I was sensitive to changes in my mood yesterday				.....
5.	Yesterday I had trouble explaining my feelings				.....
7.	On my way home from work, school, shopping or carrying out other chores yesterday, I found myself thinking about my mood				.....
7.	Yesterday, I knew what kind of mood I was in				.....
8.	I frequently weighed up my mood yesterday				.....
9.	Yesterday I wasn't really sure of how I was feeling				.....
10.	I did not pay much attention to my moods yesterday				.....

Any comments?

.....

.....

.....

.....

.....

.....

Date at completion of questionnaire:...../...../.....

Time.....am/pm

Accompanying letter:

Dear Madam

The department of psychology at the University of Leicester is currently undertaking research into the area of mood and premenstrual syndrome. This research involves asking women about their moods and experience of premenstrual syndrome. A particular emphasis is for women to feel confident enough to be able to frankly and honestly share their own experience of premenstrual symptoms. We acknowledge that each woman is very different and her experience of PMS is unique to her. Although there are many commonly known symptoms documented, your experience of PMS may be quite different to that of other women. This is why we would like to hear from you about your PMS, as we do value and appreciate the nature of such differences.

If you feel you would like to take part in this research all that is required of you is to complete a questionnaire. The questionnaire asks a series of questions about your premenstrual symptoms, feelings and moods that are answered simply by selecting a number which you feel best represent your answer.

Participation is completely voluntary. If you do decide to complete the questionnaire your confidentiality will be strictly maintained. Your name is not required, and your responses shall be used for this research purpose only. Returning the questionnaire is quite straightforward. Just place the questionnaire in the pre-addressed freepost envelope provided and place it in the post. Freepost means that no stamp is required.

We very much hope you can be of assistance to us in completing the questionnaire. Thank you very much for your time.

Appendix 4.1

Information relating to the diary study reported in chapter 9 and chapter 10.

Consent form:

Although unlikely, it is possible that participation in this study may draw your attention to problems that you experience of may make them worse. If this happens, then we would advise you to take no further part in this study until you have discussed the matter with us. We would also strongly advise that you contact your GP if you are worried that the problems are serious. If your GP can not help you, then he or she should be able to put you in contact with someone who can help.

If you agree with the following statements and are happy to give your voluntary consent to take part in the study on mood regulation then please sign the form below and write your name and the date.

I agree that:

- The general purpose of the study has been explained to me.
- I understand what I have to do in the study.
- I know that I can drop out of the study at any time.
- The reward on completion of the study will be £80.
- The information that I provide will be treated in confidence.
- Further details of the study will be provided at the end.

- I can contact the researcher if I have any problems concerning the study.
- I understand that if the study draws my attention to any problems that I experience or make them worse then I should take no further part in the study until I have contacted the researcher. I should also contact my GP if I am worried by the problems.

Signature

Name

Date

Appendix 4.2

Instructions on how to use the pocket computer:

(Were given as a separate sheet for participants to refer to)

You can press any key to stop the alarm.

Press ON to turn the pocket computer on, then type in your ID number and press EXE to get you to the main menu.

Using the arrow keys move the cursor through the main menu to get to the program you wish to use.

OR

Type Q at the main menu to turn the pocket computer off.

Type A at the main menu to manually turn the alarms on and off.

Type S at the main menu to so start of the day tasks.

Type T at the main menu to do the 2 hourly tasks.

Type E at the main menu to do the end of day tasks.

Rating scales:

Use the keys with the arrows on them to position the cursor along the scales and then press EXE.

Appendix 4.3

Examples of mood regulations strategies were given as a separate sheet for participants to refer to. They were as follows:

Did something: relaxing/enjoyable.

This means that you engaged in a relaxing or pleasant activity in order to take your mind off your worries, problems or bad feelings.

E.g., Treated myself

Went somewhere nice

Listened to the radio/ records.

Watched a movie/TV

Read a book/magazine.

Had a drink/food/cigarette.

Did something: energetic/active.

This means that you exerted yourself or did something constructive in order to take your mind off your worries, problems, bad feelings.

E.g., Kept busy.

Did some housework.

Washed the car.

Went for a walk.

Played a sport.

Exercised.

Thought about something else.

This meant that you thought about something pleasant or something different in order to take your mind off your worries, problems, or bad feelings.

E.g., Thought about people who are close to me.

Recalled happy memories.

Thought about things that make me happy.

Thought about good things in my life.

Fantasised about pleasant things.

Thought about a future event I am looking forward to.

Avoided thinking about things.

This means that you withdrew your attention from your worries, problems, or bad feelings.

E.g., Mentally switched off.

Removed myself from the situation.

Tried to put things out of my mind.

Tried to think about nothing.

Buried my head in the sand.

Got support from others.

This means you addressed your problems, worries or bad feelings by getting reassurance, help, or advice from someone else.

E.g., Told someone how I feel.

Shared the problem.

Asked for help/advice.

Sought reassurance/sympathy.

Got affection from someone who cares.

Tried to solve things.

This means that you addressed your worries, problems, or bad feelings by devoting attention or effort to understanding, or resolving them.

E.g., Evaluated why things aren't going well.

Thought rationally about the problem.

Made plans to solve the problem.

Tried to understand my feelings.

Tried to work out if my feelings are justified.

Thought about why I am in a bad mood.

Looked at things differently.

This means that you addressed your worries, problems, or bad feelings by trying to see things in a more favourable light.

E.g., Thought about people worse off than me.

Got things into proportion.

Tried to be philosophical about the problem.

Adopted a fresh perspective.

Looked on the bright side.

Thought positively.

Let my feelings out.

This means that you addressed your worries, problems, or bad feelings by releasing or giving expression to your feelings.

E.g., Screamed.

Shouted.

Let off steam.

Cried.

Started a fight/argument.

Broke something.

Got it out of my system.

Appendix 5

Interview transcript from the qualitative interview study reported in chapter 4, 5 and 6.

Interview W1 Transcript of interview with Lucy

1 In. I would like to ask you a few questions about feelings or emotions and um,
2 perhaps the way you would describe feelings?
3 J. Um ().
4 In. Would you describe them in terms of words, or from instances of personal
5 experience?
6 J. Experiencing mood, feeling, sort of a (). Yea it's a mood, it's a way you, it
7 colours your whole () the way that your whole life is. Yea, yea()
8 In. So you might say it's very pervasive?
9 J. Yea, mm ().
10 In. Do you think there are different kinds of feelings?
11 J. Yea, I would divide it into positive and negative, there are feelings that make
12 you feel good and there are feelings that make you feel bad. Controlling you
13 In. What about anger? What do you think about anger?
14 J. It's a, it's quite I suppose it's there. It's there a lot of the time a lot of things
15 make me angry. It's usually injustice type things that make me angry. It's um
16 () the results over frustration that you can't always let everybody know how
17 angry you are, because sometimes it just doesn't get you anywhere. Conceding any
18 Sometimes you have to sit on it and think I'm not gonna', I'm not gonna' sort
19 of get sort of anywhere if I, if I let this out so you tend to, I tend to bottle it up
20 In. Right, so (). Conceding, but eventually it comes
21 J. And then explode every so often [laughs] out.
22 In. [laughs] Um, can you recall a recent experience when you had particularly
23 strong feelings, very strong emotions?
24 J. Yea this morning with my son [laughs]. Yea I mean he was being deliberately
25 difficult, as is his way first thing in the morning, and yea I mean I actually had
26 to grip my hands as if to avoid hitting him because I was so angry with him, Directed to son
27 because he was being so difficult and I was in a hurry to get to work and I had
28 the little ones to get to school. And he was just making me incredibly angry
29 and I could feel it, you know it was like a knot in my stomach and I'm
30 thinking this is not gonna' get you anywhere, if you you know, you call him
31 names () you, but it doesn't actually achieve anything. Un you know that the
32 logical side that you try to reason with him actually () reason it through, Logic associ-
33 you'd probably get more result but () your angry because you haven't got
34 time to stand there and reason with him you just want him to do something, with reasoning
35 get himself off to school so you can get on with the rest of the day. But yea I
36 mean it was, it was [laughs] very strong at the time [laughs]. not experiencing
37 In. Um I was going to ask you if you would differentiate between feelings and
38 moods, how would you describe moods? the affect
39 J. Moods? ()
40 In. Do you see it as the same thing?
41 J. No not necessarily no cause' I mean I think () I think feelings to me are more
42 immediate. I can feel incredibly happy about something or incredibly angry
43 about something or sad about something, but as (). I mean some days you get
44 up and your mood is, your down for no particular reason. You can't, there's
45 something specif

47 no specific reason, there's no specific reason why you feel that way. It's just
48 that sometimes you get out of bed and you can't sort of, shake off this feeling
49 of things not being quite right. Yet other days you get up () and the sun's
50 shining and everything's alright but it might be no different, there'll be
51 nothing different happening in your life, but some mornings you get up an'
52 it's something that actually colours the whole day. Rather than being an

53 immediate thing, like an anger or a happy or a sad feeling (). Yea (). *Metaphor. Affects the whole*

54 In. Um, do you ever find yourself thinking about what type of mood your in? *day, unlike a*
55 J. Yea, yea quite often (). Mainly when it's pointed out to me. *momentary feeling*

56 In. Yea (). *less monitoring perhaps.*

57 J. It's like your in a bad mood today, or you know your in a good mood today
58 what's happened. Then you actually think well perhaps I am in a bad mood or
59 perhaps you know. It might not have been a conscious thing until somebody
60 actually say's what, why are you in such a bad mood (). And sometimes you
61 can't really say why your in a bad mood, there's no particular reason. Or you
62 can say things like being in a good mood, sometimes you can't really explain
63 why your in a good mood. But it's usually other people point it out to me I'll
64 say, why are you so happy today or why are you so miserable today, so yea ()
65).

66 In. Okay, um do you ever try to change your mood?

67 J. Yea

68 In. What sort of things might you try?

69 J. I would try (), I would try and make myself. I would try and snap out of it,
70 being depressed. Although I'm not sort of talking about clinical depre' I'm *Anxious to*
71 talking about feeling down (). Because () I try un' give it a perspective, I *disassociate myself*
72 think well you know I haven't really got anything to be miserable about you *from clinical*
73 know an' you talk about being all the positive, you know the kids are healthy *mental mess.*
74 and I'm healthy and I've got a job, yes I've got that, un you try and talk
75 yourself out of feeling miserable. You know and things like the house is a *Social factors*
76 total state and washing's piled up to the ceiling () un the cooker's filthy, and
77 you've got a pile of marking to do. Doesn't really matter you know [laughs]
78 it's not. When you put it into perspective you like, if you think about a friend
79 who's particularly, who's going through a very bad time or is ill or somethink,
80 like I've had the experience of recently(). You think well compared with that
81 person I'm extremely lucky, so you' I try to turn it round and think well
82 perhaps I haven't really got anything to be miserable about. *Counting ones*
83 In. So yours is like a mental thinking of things through, rationalising? *blessings*

84 J. Yea, of trying to ().

85 In. Okay, um well you've perhaps covered this a bit anyway but, I wa going to
86 ask you about expressing your feelings, do you feel you can always do that?

87 J. No, not always no. Particularly if there's no really good reason for getting
88 uptight about something or for getting upset about something (). Um

89 sometimes it's easier to keep it in to keep the peace. Because you know that
90 if you let it all out it's gonn' end up causing an argument and it's gonna' end
91 up causing a confrontation so sometimes it's easier to actually think hey I'll
92 walk away from it, I'll go and take the dog for a walk or something, an' *With the consequences*

Association of emotion (partic expressions) with meaning.
Keeping affect 'in', working it through, concealing it somehow
until it subsides. Control - of expression.

93 actually try and work through it rather than actually letting it out (). But that's
94 to avoid confrontation rather than anything else.

95 In. Do you feel perhaps that you can express feelings more openly at home rather
96 than say, being in a work environment?

97 J. Yes, to a certain extent. Yea () I mean at work I think I've only exploded at
98 work once at a collegu which did not go down very well an' I felt very bad
99 about. It was actually a straw breaking a cammel's back situation. Things had
100 built up an' this particular person was in the wrong place at the wrong time, an
101 I just I felt a lot worse about it cause' it was at work, than I would have if I'd
102 been at home with people I knew, who's fault it really was [laughs]. It wasn't
103 really this person's fault, he just happened to be in the wrong place at the
104 wrong time, an' caught the [laughs]. *Diluting her reason.*

105 In. Do you think that men and women are different emotionally, or the same?

106 J. A few years ago I would have said yes () but now I'm not so sure I mean I
107 think, I don't think you can generalise. I think there are some men () who feel
108 a lot, who are () more, quite happy about expressing their feelings, are more
109 comfortable with it. There are other men who are still wrapped up with this
110 idea of being () not. You know it's not manly to show your feelings. I think it
111 it's changing. I find younger men tend to be more () hpaay to accept that ()
112 emotion expression is fine. A lot of older men do I think () wouldn't be quite
113 as very happy to show emotions. It seems to be more acceptable for women to
114 () get upset about things. *Contradicts way she is?*

115 In. Yea, um do your moods follow any particular pattern?

116 J. [laughs] Yea () I mean I think it's, it's, well. You always assume it's, you
117 tend to blame it on being pre-menstrual. I mean whether it actually would be
118 if I actually kept a diary of when I actually explode an' when I don't (). But
119 it's usually () other people who will put that label on it who actually say
120 o'leave her alone she's got P.M.T. () I'm, there are times some months when
121 I do find it harder to do the controlling bit, the walking away bit. There are
122 times when, you know sometimes I will just explode (). And I can hear
123 myself saying things, and thinking this is not a good idea. Not gonna' get you
124 anywhere, but it still comes out anyway you know it's almost as if the voice is
125 working independent of the brain (). I know it's not goin' do any good () but
126 somehow I can't stop it. But whether that is actually, it would actually tie up
127 with particular dates I don't know. I always assume it would do, but () I
128 don't know. I've never actually checked it. I I'm always more conscious of
129 being () more likely to do that () when about a week or so before I'm due on.

130 In. Do you feel, at these times particularly, the pre-menstrual phase, a week or ten
131 days before your period, um. Do you feel at those tomes, have you ever
132 consciously thought about trying to change

133 J. Yea

134 In. The way you feel?

135 J. Yea

136 In. Do you feel you have () the level of control?

137 J. No, no that's the whole point you know. I can usually rationalise it un' walk
138 away from it, but I tend to find that () if it if it's going to all come out. An'

*Again expression
associated with
the affect.*

*Gender
can't generalise*

*Stereotype,
etc. to*

*Assumes is
PMS. Lot of
contradiction.
Other people
using the label
Harder to control
expression.*

in control.

*Whole thing is
questioning the legitimacy
of PMS for this woman*

Perhaps she feels able to express
when she's honest the way she
has been feeling.

Issue of
storing up things

Again expressive
associated with
irrationality.

Contradicts
earlier notion
of being
rational.
Others.
Her mood affects
entire family.
• Responsibility
sense of.
• Guilt
metaphor

Working this
with the
w.

Constant
change

139 the trouble is is because it's all bin' stored away, the whole lot comes out.
140 You know all the stored up things, an you did this at such and such a time, and
141 you did that, you said that to me. An' it's all like dragging it up from like a
142 couple of weeks before, but suddenly at this particular time it all seems
143 important to get it out, an I don't seem to be able to stop myself an' it just
144 comes out like a big jumble a lot of the time un' there's no sort of rational
145 reason for it some of the times. And some times something can trigger it off,
146 but () other times probably wouldn't. It can be something quite trivial, it can
147 be somebody () leaving a bag on the floor or it can be something really
148 pathetic und'. But then it's almost like like a catalyst excuse then to start
149 having a go about everything else that. Un then everything else comes out
150 [laughs].

151 In. Yea, that's interesting this idea of storage. Storing almost, storing up all these
152 feelings that, perhaps, you may have wanted to express. But at the time you
153 had got the issue of control, an' then all or a sudden, um, they just come out
154 spontaenously in a mass of jumble. But also perhaps you feel you can express
155 J. Yes, mm, yes because he'll say, it'll be a case of well she's pre-menstrual.
156 You sort of expect that to happen. Maybe maybe it's not anything that's
157 different about me. Maybe it's just because I've got that to be able to sort of,
158 blame it on if you like. It's not really me it's because I'm premenstrual. But I
159 can allow all these things to come out, they're there anyway. It's it's not
160 feelings feelings don't change (). It's just I think, being able to sort of let it all
161 out that changes. So maybe it's just me rationalising, I don't know.

162 In. That's great, umm. That's sort of the main things I wanted to cover. I don't
163 know if there's anything else you wanted to say?

164 J. Umm, not r'. I would say that other peopl'. The main thing is that other people
165 notice my moods more than I do. Other people point it out to me. An' the
166 other thing I find is that my mood affects the entire family (). You know if I
167 I'm in a bad mood, then it sort of filters through everythin' else. But if I'm in
168 a good mood the whole atmosphere of the house changes. I feel quite guilty
169 about that some times cause' it's cause' it's quite a responsibility some times
170 really. Knowing that I've got to keep this sort of good mood bit going because
171 it effects everybody else. It's sort of like a waterfall it's like, moves down
172 through the family. If I get angry with my husband () then he starts shouting
173 at the kinds and the kinds start shouting at eachother. An' then they come
174 back an' blame me, because I've made him angry. You know it's like a
175 circular thing. So I do feel this sort of constant pressure to sort of () keep a
176 good face un sort of for the sake of the family. Not just, not for me but for
177 everybody else.

178 In. So it's almost like you see yourself at the top, say, if your talking about
179 waterfalls

180 J. In terms of moods yea

181 In. That's quite fascinating, your at the top and so there's this tremendous
182 pressure () for you

183 J. Yea

184 In. Your sort of carrying the atmosphere of the whole house?

Constant
Only time takes 349

about expressing emotion is

185 J. Yea definitely, very much yea.
186 In. Wouldn't you ever thing of casting it differently?
187 J. Yea, I mean it's it's it's because that's the way he puts it across I think. I
188 mean it's okay for him to come in in a foul mood. He's had a bad day you
189 know, just leave him alone, but I mean with me it's always oh she's got
190 P.M.T. oh leave her. The other thing is I've got a daughter and our cycles do
191 coincide within a couple of days of each other. Und' we get oh we've got two
192 women in the house with it now you know that kind of thing. It is something
193 that is sort of *blamed* for a lot of mood swings.
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96 than say, being in a work environment?

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98 work once at a college, which did not go down very well an' I felt very bad
99 about. It was actually a straw breaking a cammel's back situation. Things had
100 built up an' this particular person was in the wrong place at the wrong time, an'
101 I just I felt a lot worse about it cause' it was at work, than I would have if I'd
102 been at home with people I knew, who's fault it really was [laughs]. It wasn't
103 really this person's fault, he just happened to be in the wrong place at the
104 wrong time, an' caught the [laughs].

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120 o' leave her alone she's got P.M.T. () I'm, there are times some months when
121 I do find it harder to do the controlling bit, the walking away bit. There are
122 times when, you know sometimes I will just explode (). And I can hear
123 myself saying things, and thinking this is not a good idea. Not gonna' get you
124 anywhere, but it still comes out anyway you know it's almost as if the voice is
125 working independent of the brain (). I know it's not goin' do any good () but
126 somehow I can't stop it. But whether that is actually, it would actually tie up
127 with particular dates I don't know. I always assume it would do, but () I
128 don't know. I've never actually checked it. I I'm always more conscious of
129 being () more likely to do that () when about a week or so before I'm due on.

130 In. Do you feel, at these times particularly, the pre-menstrual phase, a week or ten
131 days before your period, um. Do you feel at those times, have you ever
132 consciously thought about trying to change

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138 away from it, but I tend to find that () if it if it's going to all come out. An'

Use
Work

PMS.
Mood changes
assumed, and
blamed upon.

Brain-emotional
at a control
distinctio

Admits is
not certain.

Can't control

139 the trouble is is because it's all bin' stored away, the whole lot comes out
140 You know all the stored up things, an you did this at such and such a time, and
141 you did that, you said that to me. An' it's all like dragging it up from like a
142 couple of weeks before, but suddenly at this particular time it all seems
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147 be somebody () leaving a bag on the floor or it can be something really
148 pathetic und. But then it's almost like like a catalyst excuse then to start
149 having a go about everything else that. Un then everything else comes out
150 [laughs].

PM's time
all the repressed
comes out.
Or as she says
is the one time
can do it
something small -
triggers it.

151 In. Yea, that's interesting this idea of storage. Storing almost, storing up all these
152 feelings that, perhaps, you may have wanted to express. But at the time you
153 had got the issue of control, an' then all or a sudden, um, they just come out
154 spontaneously in a mass of jumble. But also perhaps you feel you can express
155 J. Yes, mm, yes because he'll say, it'll be a case of well she's pre-menstrual/
156 You sort of expect that to happen. Maybe maybe it's not anything that's
157 different about me. Maybe it's just because I've got that to be able to sort of
158 blame it on if you like. It's not really me it's because I'm premenstrual. But I
159 can allow all these things to come out, they're there anyway. It's it's not
160 feelings feelings don't change (). It's just I think, being able to sort of let it all
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167 I'm in a bad mood, then it sort of filters through everythin' else. But if I'm in
168 a good mood the whole atmosphere of the house changes. I feel quite guilty
169 about that some times cause' it's cause' it's quite a responsibility some times,
170 really. Knowing that I've got to keep this sort of good mood bit going because
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172 through the family. If I get angry with my husband () then he starts shouting
173 at the kids and the kids start shouting at each other. An' then they come
174 back an' blame me, because I've made him angry. You know it's like a
175 circular thing. So I do feel this sort of constant pressure to sort of () keep a
176 good face un sort of for the sake of the family. Not just, not for me but for
177 everybody else.

How as 'w' has
emotional responsibility
for whole
household
She is blame

178 In. So it's almost like you see yourself at the top, say, if your talking about
179 waterfalls

180 J. In terms of moods yea

181 In. That's quite fascinating, your at the top and so there's this tremendous
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190 P.M.T. oh leave her. The other thing is I've got a daughter and our cycles do
191 coincide within a couple of days of eachother. Und' we get oh we've got two
192 women in the house with it now you know that kind of thing. It is something
193 that is sort of *blamed* for a lot of mood swings.
194 In. That's fascinating, thank you very much.

PMS blamed a lot
for mood swings.

Appendix 6

ANOVA Summary Tables and Summary Data from Chapter 7

ANOVA Summary Tables from Chapter 7

Mean Symptoms by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	.059	1	.059	.38	.539
Residual	9.259	60	.154		
Total	9.318	61	.153		

Positive Affect Yesterday by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	3.180	2	1.590	2.16	.122
Residual	53.692	73	.736		
Total	56.872	75	.758		

Positive Affect Now by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	..567	2	.284	.70	.497
Residual	29.319	73	.402		
Total	29.886	75	.398		

Negative Affect Yesterday by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	1.387	2	.693	.96	.386
Residual	52.453	73	.719		
Total	53.839	75	.718		

Negative Affect Now by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	.966	2	.483	1.99	.143
Residual	17.633	73	.242		
Total	18.599	75	.248		

Mood Monitoring by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	.013	2	.006	.007	.992
Residual	60.594	73	.830		
Total	60.606	75	.808		

Mood Labelling by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	5.020	2	2.510	2.60	.081
Residual	70.262	73	.962		
Total	75.282	75	1.004		

Regulation Strategy 1 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	9.741	2	4.871	.95	.390
Residual	372.416	73	5.102		
Total	382.158	75	5.095		

Regulation Strategy 2 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	48.180	2	24.090	3.86	.025
Residual	455.504	73	6.240		
Total	503.684	75	6.746		

Regulation Strategy 3 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	15.968	2	7.984	1.02	.363
Residual	567.137	73	7.769		
Total	583.105	75	7.775		

Regulation Strategy 4 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	3.512	2	1.756	.28	.756
Residual	455.685	73	6.242		
Total	459.197	75	6.123		

Regulation Strategy 5 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	6.900	2	3.450	.55	.576
Residual	452.508	73	6.199		
Total	459.408	75	6.125		

Regulation Strategy 6 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	2.819	2	1.410	.29	.749
Residual	354.918	73	4.862		
Total	357.737	75	4.770		

Regulation strategy 7 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	10.457	2	5.228	1.19	.307
Residual	318.280	73	4.360		
Total	328.737	75	4.383		

Regulation strategy 8 by Awareness of Nature of Study					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Main Effects Condition	54.268	2	27.134	4.06	.021
Residual	486.929	73	6.670		
Total	541.197	75	7.216		

Current Negative Affect by Cycle by Condition					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Cycle Condition	.496	1	.496	3.382	.071
	.129	1	.129	.880	.352
2-Way Interactions Cycle Cond.	.118	1	.118	.801	.375
Residual	8.367	57	.147		
Total	9.134	60	.152		

Current Positive Affect by Cycle by Condition					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Cycle Condition	.111	1	.111	.269	.606
	.422	1	.422	1.026	.315
2-Way Interactions Cycle Cond.	.635	1	.635	1.544	.219
Residual	23.426	57	.411		
Total	24.613	60	.410		

Negative Affect Yesterday by Cycle by Condition					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Cycle Condition	4.273	1	4.273	6.529	.013
	1.267	1	1.267	1.936	.170
2-Way Interactions Cycle Cond.	.329	1	.329	.502	.481
Residual	37.304	57	.654		
Total	43.396	60	.723		

Positive Affect Yesterday by Cycle by Condition					
Source of Variation	Sum of Squares	DF	Mean Square	F Value	Significance of F
Cycle Condition	.000	1	.000	.000	.859
	.250	1	.250	.304	.991
2-Way Interactions Cycle Cond.	.014	1	.014	.017	.896
Residual	46.906	57	.823		
Total	47.170	60	.786		

Summary Data Printout from SPSS

Number of valid observations (listwise) = 61.00

Variable	Mean	Std Dev	Minimum	Maximum	Valid	Label
					N	
NANOW	1.36	.50	1.00	3.80	76	current negative affe
NAYEST	1.91	.85	1.00	4.90	76	negative affect yeste
SYMPTOMS	2.41	.39	1.18	3.18	62	mean symptoms
PANOW	2.52	.63	1.20	3.90	76	current positive affe
PAYEST	2.69	.87	1.00	4.70	76	positive affect yeste
NMRE	3.35	.60	1.60	4.30	76	negative mood regulat
MDMNTYST	3.83	1.20	1.00	6.00	76	mood monitoring yeste
MDLBLNG	4.14	1.00	2.00	6.00	76	mood labeling
MDLBLYST	4.22	.93	2.00	6.00	76	mood labeling yesterd
MDMNTRNG	4.22	.90	2.20	6.00	76	mood monitoring
AGE	20.47	6.05	18.00	47.00	76	age

CYCLE cycle phase

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	1.00	8	10.5	13.1	13.1
	2.00	32	42.1	52.5	65.6
	3.00	21	27.6	34.4	100.0
	.	15	19.7	Missing	
	Total	76	100.0	100.0	

Valid cases 61 Missing cases 15

CYCLE2 cycle (recoded)

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Premenstrual or mens	1.00	29	38.2	47.5	47.5
Intermenstrual	2.00	32	42.1	52.5	100.0
	.	15	19.7	Missing	
	Total	76	100.0	100.0	

Valid cases 61 Missing cases 15 These include the male participants.

Appendix 7

Summary Data from National Association of Premenstrual Syndrome Study, Reported in Chapter 8.

Summary Data from NAPS Study reported on in Chapter 8

Number of valid observations (listwise) = 85.00

Variable	Mean	Std Dev	Minimum	Maximum	Valid N	Label
MLYEST	15.66	3.62	5.00	25.00	99	
NAFFECT	18.86	7.92	10.00	40.00	97	
MLNOW	19.60	4.38	11.00	30.00	99	
PAFFECT	22.72	8.91	9.00	44.00	96	
SYMPTOMS	31.06	4.99	20.00	44.00	98	
MOODAWYE	32.40	8.03	15.00	50.00	99	
AGE	36.16	6.48	21.00	52.00	95	
MOODAWAR	39.63	6.81	23.00	55.00	99	
NEGMOODR	92.35	8.99	71.00	127.00	99	
AFFECTIN	152.36	21.67	93.00	205.00	99	

Su

AGE

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	21.00	1	1.0	1.1	1.1
	23.00	1	1.0	1.1	2.1
	25.00	3	3.0	3.2	5.3
	26.00	3	3.0	3.2	8.4
	27.00	3	3.0	3.2	11.6
	28.00	4	4.0	4.2	15.8
	29.00	1	1.0	1.1	16.8
	30.00	4	4.0	4.2	21.1
	31.00	2	2.0	2.1	23.2
	32.00	4	4.0	4.2	27.4
	33.00	5	5.1	5.3	32.6
	34.00	5	5.1	5.3	37.9
	35.00	5	5.1	5.3	43.2
	36.00	5	5.1	5.3	48.4
	37.00	6	6.1	6.3	54.7
	38.00	7	7.1	7.4	62.1
	39.00	6	6.1	6.3	68.4
	40.00	7	7.1	7.4	75.8
	41.00	7	7.1	7.4	83.2
	42.00	6	6.1	6.3	89.5
	43.00	1	1.0	1.1	90.5
	44.00	1	1.0	1.1	91.6
	45.00	1	1.0	1.1	92.6
	46.00	2	2.0	2.1	94.7
	47.00	1	1.0	1.1	95.8
	49.00	1	1.0	1.1	96.8
	51.00	1	1.0	1.1	97.9
	52.00	2	2.0	2.1	100.0
	.	4	4.0	Missing	
	Total	99	100.0	100.0	
Valid cases	95	Missing cases	4		

ANYMED

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
no	1.00	53	53.5	53.5	53.5
yes	2.00	46	46.5	46.5	100.0
	Total	99	100.0	100.0	

Valid cases 99 Missing cases 0

OCCUPATI

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
domestic	1.00	25	25.3	26.0	26.0
employed	2.00	67	67.7	69.8	95.8
unemployed	3.00	4	4.0	4.2	100.0
.	.	3	3.0	Missing	
	Total	99	100.0	100.0	

Valid cases 96 Missing cases 3

ORALCONT

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
yes	1.00	34	34.3	34.3	34.3
no	2.00	65	65.7	65.7	100.0
	Total	99	100.0	100.0	

Valid cases 99 Missing cases 0

PREM

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	.00	59	59.6	61.5	61.5
	1.00	37	37.4	38.5	100.0
	.	3	3.0	Missing	
	Total	99	100.0	100.0	

Valid cases 96 Missing cases 3

MENS

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	.00	76	76.8	79.2	79.2
	1.00	20	20.2	20.8	100.0
	.	3	3.0	Missing	
	Total	99	100.0	100.0	

Valid cases 96 Missing cases 3

INTER

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	.00	57	57.6	59.4	59.4
	1.00	39	39.4	40.6	100.0
	.	3	3.0	Missing	
	Total	99	100.0	100.0	

Valid cases 96 Missing cases 3