# A qualitative investigation of women's perceptions of premenstrual syndrome: implications for general practitioners

JACQUELINE REILLY

JOHN KREMER

*SUMMARY*

***Background.*** *Many women consult general practitioners each year, seeking treatment for premenstrual syndrome. This qualitative study presents evidence of women's own perceptions of this problem, which may assist in the provision of individualized health care.*

***Aim.*** *To explore women's constructions of premenstrual syndrome using grounded analysis.*

***Method.*** *A qualitative, semi-structured interview study carried out in Northern Ireland. Thirteen women were interviewed individually. Thereafter, 33 women participated in group discussions. Five health visitors then commented individually on the findings.*

***Results.*** *Seven themes emerged from the analysis. These themes suggested that women tend to view the menstrual cycle holistically and that premenstrual syndrome is regarded as debilitating by only a small minority of women. Participants indicated an awareness of the intra- and interpersonal variability of menstrual experience. They were ambivalent about menstruation, viewing it as natural but, at the same time, unnatural in terms of day-to-day existence. Talking to other women served two functions, first by providing a yardstick against which to evaluate their own experiences, and secondly by providing support and advice. In contrast, women tended to talk about menstruation only to selected men, mainly partners, primarily in the interests of educating them. Women viewed menstruation as potentially disempowering by virtue of its uncontrollability, and felt that both a positive attitude and the use of a range of remedies were important for women wishing to become empowered with respect to this aspect of their lives.*

***Conclusions.*** *Women's own constructions of premenstrual syndrome differ markedly from those as presented in medical textbooks and research literature: secondary sources that have significantly impacted upon general practitioners' attitudes towards this condition. The provision of a range of treatment options, including support groups, is suggested, on the basis of evidence gathered using qualitative methods, as likely to be viewed by women as more appropriate than offering treatment based on the evidence provided by traditional randomized controlled trials.*

*Keywords: women's health; menstruation; premenstrual syndrome; qualitative study.*

J Reilly, BSSc, PhD, lecturer in psychology; and J Kremer, BSc, PhD, CPsychol, reader in psychology, The Queen's University of Belfast, Northern Ireland.

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## Introduction

THE incidence of premenstrual syndrome (recently relabelled premenstrual dysphoric disorder in DSM IV, but still almost universally referred to as PMS) is difficult to determine, principally because of a lack of consensus among researchers as to its definition.[1-4] Estimates have ranged from below 5% to over 90%, depending on the classification criteria used.[5,6] Moreover, general practitioners (GPs) may seek to prescribe treatments for PMS on the basis of research evidence as to their relative efficacy. However, clinical trials have tended to produce conflicting results, undoubtedly, at least in part, because they use treatment groups that have been highly selective, using a variety of criteria.[2,7,8] In addition, the strength of the placebo response in PMS research is well documented,[9,10] with many studies being of too short a duration to establish whether the initial response to treatment is maintained over time.[11] While recent double-blind, placebo-controlled trials have indicated that selective serotonin reuptake inhibitors do provide effective symptom relief,[12-14] some women prefer to avoid taking drugs for a variety of reasons, including unpleasant side-effects and concerns about long-term consequences.[15]

Given the various definitions of the problem, together with the confusing array of conflicting evidence provided by quantitative research, it was deemed appropriate to examine women's own perceptions of premenstrual syndrome. As yet, few studies have adopted a qualitative approach to the understanding of premenstrual syndrome,[16] although some[17-19] have examined the menstrual cycle in general. Laws[19] has used qualitative methods to provide a male perspective, and has also examined representations of the condition in medical textbooks. However, as core components of premenstrual syndrome include subjective experiences such as mood disturbance, an approach that allows the exploration of this perspective would appear to represent a logical and important addendum to the existing literature.[20]

## Method

### *Design and participants*

An emergent design was employed to facilitate a data-driven approach;[21] that is, only the focus and initial framework of the investigation were decided *a priori* in order to allow the research process to be developed in response to ongoing analysis of the data. In the initial stage of the investigation, semi-structured interviews were tape-recorded. A purposeful sampling technique was used; i.e. participants were recruited until saturation of the data was achieved and no new themes had emerged (13 participants, parous and nulliparous, with and without self-reported premenstrual syndrome, ages ranging from 20 to 42 years). Data were analysed using a grounded analysis technique as described below.

A synopsis of the results was later presented to each participant for comment, confirming the validity of the analysis from the participants' perspective. To check the validity of, or triangulate, the results further with reference to a different sample, a series of six tape-recorded discussion groups was conducted (three groups each of parous and nulliparous women). These

were based on the focus group format but were smaller in size (five to six participants), as it was believed that this would encourage frank discussion of a sensitive topic. Analysis again confirmed the results. Finally, five health visitors from a local health centre were invited to comment on the findings; thus providing a perspective informed by extensive, relatively informal, professional contact with women.

### *Interviews*

A semi-structured schedule was used. Topics included menstrual experience, conversations about menstruation, and social and personal attitudes towards premenstrual syndrome. Participants were also free to introduce any issues they considered relevant, and a conversational style was adopted throughout. Duration of interviews ranged from 30 minutes to two hours and all were conducted by the first author.

### *Grounded analysis*

A grounded technique was employed.[22] Interview transcripts were coded into meaning units and, in an iterative process involving constant comparison, these were clustered into data-generated categories. A hierarchy of categories was thus developed, culminating in seven themes which represented the distillation of the data. These themes were then summarized and used to gain feedback from the interviewees, and also formed the basis for the group discussions (see above). Transcripts of the discussions were analysed by noting points of agreement and, more especially, disagreement with the results, and by determining whether contradictory evidence could be accounted for by the unabridged content of the theme in question.[23]

## Results

The seven themes that emerged from the analysis are summarized below. Quotations are taken from transcripts of individual interviews; participants' names have been changed to preserve confidentiality.

### *Variability*

While inter-individual variability in menstrual experience is given due consideration in the research literature, the issue of intra-individual or inter-cycle variability rarely has been considered beyond confirmation of PMS by prospective data from two or three cycles.[24,25] Almost all of the participants (both in individual interviews and in the group discussions) noted that their menstrual experience, and associated premenstrual changes, often varied considerably from one month to the next.

> *'It's … it differs from period to period. Sometimes it would come every 28 days, sometimes it would be every two weeks, sometimes it can be really light unless it … it differs every time. …sometimes I'm OK and other times I feel really depressed and tired and generally fed up.' (Jan)*

This degree of variability was not noted as being unusual or symptomatic of medical problems, but as part of the normal experience of menstruation. This suggests not only that two or three cycles may be inadequate to confirm a diagnosis in some cases, but also that any attempt to dichotomize women into those who do and do not experience PMS omits the possibility that some women may experience PMS intermittently.[20]

### *Ambivalence about menstruation*

Women regarded menstruation as an integral part of their identity and as a natural process associated with being a woman. At the same time, it was also seen as unnatural in comparison with their 'normal' state during the larger part of the menstrual cycle. This ambivalence is captured in the remark:

> *'…people will describe it as "natural" but they don't describe it as "It's really nice, it's class!"' (Bev).*

### *Talking to peers*

Women derived benefits from talking to peers about menstruation in two main ways. First, they felt they were thus able to locate their own experiences within a spectrum of possible menstrual experiences. Second, they could obtain support and advice if they were having any problems or had noticed any changes. One major problem reported by many was that their mothers had provided them with only factual information about menstruation at menarche, and hence that they had been unprepared for the emotional impact of the event. It was often only in later years that full and frank discussion of the topic between mothers and daughters took place:

> *'When I was younger she wouldn't have discussed it with me. Erm, not until I was in my late teens, you know, when, when you're sort of, you're more sexually aware and that…' (Jill)*

### *Talking to men*

In contrast, most women talked only to a selected group of men about their menstrual experience, in order, so they maintained, to avoid embarrassing men. For some women this group included fathers and brothers, but more often it was restricted to sexual partners. The motivation behind this communication was primarily an educational one: they believed that men generally did not understand menstruation:

> *'…well, I know* my *husband understands about it, but I don't know whether* all *men understand it, you know!'(Mona)*

### *Cultural change*

Most women believed modern society to be more open about menstruation than was previously the case, and that this was a good thing. This openness was regarded as somewhat superficial, however, and few participants were comfortable discussing their own menstruation in mixed company. Moreover, some were embarrassed by open discussion of what they regarded as a private, female matter:

> *'I think it's probably becoming more open now that we have the television ads and so on; it's* becoming *more open, but it's* still *a taboo subject.' (Nancy)*

### *Disempowerment*

The participants believed for the most part that menstruation had an inherent potential to be disempowering, it's timing and symptoms being often perceived as uncontrollable. GPs were often regarded as unhelpful (regardless of their sex), attributed most often to the fact that they did not really understand the problem:

> *'If you speak to [a GP] that hasn't [experienced premenstrual syndrome], well, she's maybe read a bit in a book about it, doesn't mean to say she actually knows what you're suffering! She's read about it, but sure* I've *read about lots of things — I've read about flipping going to the moon in a rocket!' (Lucy)*

*Towards empowerment*

At the same time, most participants believed that personal attitudes, belief systems, and self-esteem were important factors in 'not letting it get them down', and that women who have problems with premenstrual syndrome should try a variety of measures in order to find the one that is most efficacious in their own circumstances. These could include prescribed drug treatments (although some participants expressed reservations about side-effects and long-term consequences of taking drugs) or changes in lifestyle — according to the participants it was important to stick with whichever strategy was found to be personally effective:

> *'Gain as much knowledge as you can and do whatever suits* you, *if you find something that works.' (Lucy)*

## Discussion

Several aspects of this analysis are of particular salience to GPs. First, women in this study did not believe GPs (regardless of their sex) to be uniformly understanding about PMS, and women who did and did not report experiencing PMS themselves believed that doctors in woman-centred services, such as family planning centres and well-woman clinics, were more likely to be helpful. Secondly, women were reluctant to draw a distinction between premenstrual and menstrual experience, as they looked upon their menstrual cycle in holistic terms or as a 'package' regardless of whether they reported experiencing PMS or not. Thus, attempts by medical researchers or GPs to delineate the two may be inappropriate. Thirdly, women readily accepted immense variability in menstrual experience, not only between women but also within their own experience; again, regardless of whether they themselves did or did not experience PMS. Diagnostic criteria often do not correspond with this experience, assuming intra-individual variation to be negligible (for example, diagnosis on the basis of prospective assessment of only two cycles), and evaluation of treatments is also complicated by such variations.[26] Fourthly, women's reported experiences bore little resemblance to the descriptions typically presented in the medical literature. Few in this sample found physical symptoms to be of much significance for example, yet most definitions of premenstrual syndrome in the research literature continue to include such symptoms.[27-29] Lastly, one of the most striking aspects of the analysis was the similarity, rather than the difference, between women who did and did not report that they experienced PMS: those participants who had sought medical advice on PMS had similar conceptions of the problem to those who had never personally perceived themselves as affected.

Most research into PMS clearly involves the selection of samples according to strict criteria that do not closely correspond to the issues that women feel are important in their experience of the condition. The major feature of PMS for the women in this study related to emotional response, and, for the most part, those who complained that they had suffered from premenstrual syndrome had not found that it affected their day-to-day functioning in any material way. Despite this, they perceived PMS as a problem that they should seek to address because it affected their quality of life, including their close relationships. Thus, the condition was not viewed as debilitating but nevertheless was perceived as impacting in a significant way on experience, and thus merited attempts to control it.

Laws[19] noted the construction of premenstrual syndrome in medical textbooks as having either a hormonal or psychological aetiology. This representation, coupled with the differences in conceptualization of the condition between medical researchers and women themselves, places GPs in possession of knowledge that may bear little relation to the experience or individual treatment preferences of the patient presenting with premenstrual problems. The present study presents an alternative view, grounded in the experiences of women themselves.

Interestingly, the triangulation of the results with a group of health visitors produced a perspective more closely aligned to that of the participants than that found in the research literature. They regarded premenstrual syndrome as simply another possible source of stress in women's lives, and one that could usually be managed by simple lifestyle adjustments. They argued that women are often inclined to overlook their own needs and could be assisted effectively by encouraging them to eat and sleep well, take adequate exercise, and to relax or perhaps be self-indulgent occasionally, and by talking about their experiences. Perceived benefits of support groups for premenstrual syndrome have been documented[30] and further research into specific components of group treatments and long-term follow-up studies have been recently recommended.[31] As such support groups are often most effective if they have professional input, it may well be appropriate for GPs to investigate the possibility of setting up such groups in association with health visitors and, therefore, forge a closer relationship between the range of treatment options and women's own experiences.

**Key points**

- There are important differences in the ways in which the term premenstrual syndrome is understood by women themselves and the ways in which it is represented by medical researchers and textbook authors.
- Randomized controlled trials using highly selected treatment groups may be of limited value in providing evidence-based health care for individual women reporting premenstrual syndrome.
- Evidence based on qualitative research may be useful for general practitioners seeking to provide individualized health care for women complaining of premenstrual syndrome.

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### Address for correspondence

Dr Jacqueline Reilly, School of Psychology, The Queen's University of Belfast, Belfast BT7 1NN, N. Ireland. E-mail: jreilly@qub.ac.uk