The displacement of blame of PMDD onto the fecund body: Medical gaslighting, or just gaslighting?

El desplazamiento de la culpa del TDPM al cuerpo fecundo: ¿*Gaslighting* médico o solo *gaslighting*?

Teiki S. Sosa López[1]
Universidad de Puerto Rico, Recinto de Río Piedras

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Abstract

The methodology of this study was the qualitative method, employing content analysis as the technique and working within a social constructivism theoretical framework to deconstruct women's experience of PMDD, considering that they are subjected to socially preassigned scripts of femininity. Accordingly, I analyzed women's position within society, particularly how the social construction of PMDD functions to segregate women and focuses not on their experience but on their perceived negative effect on others. Analyzing the position of women within society posed a counter to the medical discourse which aims to readapt women into their socially assigned roles, redirecting the blame for their unaccepted behavior to their "hormonally imbalanced" bodies, and consequently dismissing their claims as products solely of biological processes. Alternatively, I propose we should attempt to approach women's emotions and behaviors not ascribed to the ideal femininity without immediately villainizing and irrationalizing her, instead by restituting a space for her voices and her experiences to be acknowledged.

Keywords: DSM-5-TR, PMDD, feminity, medical discourse, anger

Resumen

La metodología de este estudio fue el método cualitativo, empleando el análisis de contenido como técnica y trabajando en un marco teórico del constructivismo social para deconstruir la experiencia de las mujeres con el TDPM, considerando que están sujetas a guiones de feminidad socialmente preasignados. En consecuencia, analicé la posición de las mujeres dentro de la sociedad, particularmente cómo la

[1] Estudiante subgraduada en el Departamento de Psicología de la Universidad de Puerto Rico, Recinto de Río Piedras. Toda correspondencia relacionada con este artículo debe ser dirigida a: teiki.sosa@upr.edu. ORCID: https://orcid.org/0009-0005-3486-3263.

construcción social del TDPM segrega a las mujeres, enfocándose en su efecto negativo en los demás. Analizar la posición de las mujeres dentro de la sociedad supuso una contraposición al discurso médico el cual tiene como objetivo readaptar a las mujeres en sus roles socialmente asignados, redirigiendo la culpa de su comportamiento no aceptado a sus cuerpos "hormonalmente desequilibrados" y, en consecuencia, descartando sus reclamos como productos únicamente de procesos biológicos. Alternativamente, propongo intentar abordar las emociones y los comportamientos no aceptados dentro de la feminidad ideal sin villanizar e irracionalizar a la mujer para restituirle un espacio donde se reconozca su experiencia.

Palabras clave: DSM-5-TR, TDPM, feminidad, discurso médico, ira

I will analyze the diagnosis of Premenstrual Dysphoric Disorder (PMDD) as detailed in the DSM-5-TR by the American Psychiatric Association (APA, 2022), alongside a video by SBS The Feed (2019) titled *Is Medical Gaslighting Silencing Those with PMDD?* This video narrates the experiences of two women diagnosed with PMDD and their ongoing battle with the condition and its effects on their bodies. I chose this topic because I feel it is pertinent to discuss how dangerous the statements made in this video are and how the paradigm that upholds them affects all menstruating people within society. Thus, I will explore the underlying motives for diagnosing women with PMDD using the DSM-5-TR criteria and examine how this relates to societal expectations of women's roles within the family, home, and workforce. Additionally, I will explore the objectification of PMDD as something that women "suffer" from, and how this linguistic perspective functions as a dismissal to any real claims of anger or discomfort. Finally, I will examine the commercial aspects of PMDD, focusing on the profitability derived from its medicalization and the impact on women who are targeted by and through this marketing.

My approach to these topics will utilize social constructivism, primarily to challenge the established medical-biological paradigm that suggests a direct link between mental health issues and neurochemical, hormonal, or hereditary factors. This paradigm often overlooks the social

influences that shape and sustain certain behaviors in women, particularly those deemed disordered. Under the theoretical framework established by Kenneth Gergen in 1985, which emphasizes the crucial role of social interactions in constructing our reality, I will analyze the selected texts and media. This analysis will be guided by qualitative methods that prioritize interpretation over quantitative measures, as outlined by Sampieri et al. (2010). Additionally, content analysis will be employed to explore deeper, latent meanings within the material, which Piñuel (2002) describes as essential for uncovering the unspoken understandings and paradigms that are not immediately obvious.

Historical and Social Contexts of PMDD Diagnosis: Gender Roles and Workplace Dynamics

The social context in which PMDD, initially termed PMS among other names, began to gain recognition was during the Great Depression in the 1930s, a time when women's increasing presence in the workforce was viewed as problematic for returning war veterans. Accordingly, "pressure was placed on women from many sides to give up waged work and allow men to take the jobs" (Martin, 1987, as cited in Figert, 2005, p.9). Therefore, a reason to displace women from the workforce in the 30s arose after the arrival of unemployed men, and coincidentally this was around the same time the popular interest for what was called PMS emerged; stating that most women were suffering from abnormal hormonal cycles, which implied they were unfit for work. This conveniently creates a movement to return women to their domestic labor and leaves men with a perfect excuse to portray themselves as better and more "stable" fit workers. The disorder is popularized at a time when women are perceived as hindrances in the workplace, and it is defined by the extent to which the diagnosed woman poses problems for those around her, demonstrating the degree to which she does not fit into her social script as server, caregiver, mother, wife, and others. Figert (2005) confirms this in her text upon analyzing studies in the 50s, saying that "These

medical studies have a distinct focus on the effect of a woman's PMS on her social roles of wife, mother and worker" (p.9). Hence, it is apparent that throughout the social construction of the disorder there is a clear focus on the disruption caused by the woman's behavior on others, and a desire to "fix" her.

Currently, in the DSM-5-TR, within the criteria for the diagnosis it specifies it can only be qualified as a disorder when it interferes with "work, school, usual social activities, or relationships with others" (APA, 2022, p. 198). That is to say that the symptoms within criteria B (see appendix for full list of criteria), such as marked irritability, and Criteria C, such as hypersomnia or insomnia, do not matter if they do not affect the productivity of the woman. Further in the manual this is restated, saying that the symptoms must occur consistently and "must have an adverse effect on work or social functioning" (APA, 2022, p. 199). Therefore, there is very little focus in the woman's experience, how they are feeling and how this affects them; PMDD is constructed as a problem for the husbands, the families, the bosses (etc.) who must deal with these "unstable and irrational" women. For example, in the video by SBS The Feed (2019) we can see this discourse repeated by the diagnosed woman herself, Lynda, while talking about her experience as she says, "it affected my relationship with my husband, I had conflicts with people in my family" (3:15). This suggests that the disorder is considered significant and real only when it impacts those around the diagnosed individual. This tendency unveils the ideological subcurrent which directly targets those who don't fit into the socially constructed utility of women, of femininity, within society to readapt them into the social structure. This discourse continues, linguistically and conceptually internalized in our culture, functioning to undermine women, and further upholding their ideological roles as existing to serve others; they're either useful or they are a hindrance. PMDD as a diagnosis, as posed in the DSM-5-TR, functions to displace women out of the useful category,

labeling their "disordered" behavior as a hindrance to society and therefore inherently negative and requiring treatment.

Additionally, women's social role implies a receptive position, a concept Ussher (2006) tackles in her text, stating that PMS is continuously described as a *thing* that women suffer from that is objectively measurable and definable, thus a dichotomy between "PMS sufferers" and non-sufferers is established. This reification positions women in a docile receptive role to their body's monthly *malady*, placing all blame onto the fecund body and all hope on a medical intervention based "cure." By consequence, now "It is not her that is the monster, it is 'PMS', and an unruly body which must be constrained and contained" (Ussher, 2006, p.16). This leads to self-policing, an internalization and reproduction of the socially established scripts of ideal femininity, which places the responsibility of managing the "excess" femininity, or failure of managing it, onto the individual woman. Goswami et al. (2023) corroborates the presence of these feelings, concluding that for many women diagnosed with PMDD the intervals that are free of symptoms are, however, "tainted by feelings of guilt and over compensatory behaviour" (p.44). We can also see a concrete example of this internalization of blame when Lynda is asked what she would say to her husband; she replies, while crying and showing difficulty speaking, "I'd probably first say I'm sorry… and that I'm thankful for not leaving me" (SBS The Feed, 2019, 3:42). Clearly, Lynda is showing a high degree of guilt over the effect she perceives she's had on her husband, to the point where she feels she must do anything to fix her body, as she seems to find herself entirely culpable. On the other hand, the alternative that it might not be medical scares her, she says that if there was no medical basis to their feelings then "…that would mean that I was broken" (SBS The Feed, 2019, 7:39). However, at no point does Lynda seem to consider the last alternative, that she may not physically or mentally broken, but that her feelings might be valid and based on her social

experience as a human being, that there might also be external influences in her contextual existence that could be influencing her experience and behavior. Here, medical discourse functions to uphold Lynda's original idea of herself, as it states that the root cause for PMS "… no matter how it was originally triggered, is physical and can be treated" (Lever, 1981, as cited in Martin, 1988, p. 161). Hence, the conceptual shift that places the fecund body as the root, and generally only significant, cause of PMDD, functions to leave her powerless against the situation, a victim to her own body, her own hormones, and, therefore, "her feelings are positioned as irrational, as symptoms of 'PMS', and thus the woman is pathologized and dismissed" (Ussher, 2006, p.14). This isn't only reproduced and perpetuated by others, but is also internalized by the diagnosed woman herself, as we previously saw with Lynda.

On the other hand, the second woman in the video, Kim, describes her experience with PMDD as a tsunami, saying that suddenly "you just feel it's sort of bubbling up and you're just like: rage man, rage" (SBS The Feed, 2019, 5:18). Consequently, when asked what kind of rage it was, she replies "just irrational" (SBS The Feed, 2019, 5:27). Her dismissal of her own rage, her own titling of herself precisely as *irrational* ties to Martin's (1988) argument on women's anger: how women are not allowed to be angry, much less admit to themselves that they may be angry for legitimate reasons without displacing it away from themselves onto their body, consequently internalizing and auto-regulating themselves. Here the medical model dictates that "the solution for this situation is to seek medical advice and obtain treatment," that in the case of Kim takes the form of what they quirkily refer to in the video as "menopause in a box" (Martin, 1988, p.168; SBS The Feed, 2019, 9:03). Consequently, this makes it so that "The content of her remarks, the substance of what she is objecting to, escape notice," as there is a clear dismissal of anything but the possibility of physiological, hormonal, problems as the root cause (Martin, 1988, p.168).

Women expressing anger is problematic in our society because it "make(s) it hard for a woman to carry out her expected role" (Martin, 1988, p.173). A woman's anger, therefore, cannot be allowed to affect others, and if it does it is construed as being her fault for allowing it to; a woman's anger is just a disturbance that obstructs her from existing for others, for acting within her script as a "good" woman. Additionally, while men's problems have had some acknowledgement of outside circumstances (most noticeably and recurrently that of the women in their lives, particularly their mothers), when it comes to women it is seen as if "the problems of women are caused by their own internal failure, seen as a biological malfunction" (Martin, 1988, p. 174). Applying this to Kim's situation, we can see her extreme guilt, where she blames herself for not being able to control her anger and identifies the root of this anger in her body as this internal failure.

Kim experiences her anger as a suffering because she feels guilty for it. However, we must consider that women are placed under extreme pressure socially to uphold their expected roles; there is a systemic social web of rules that prohibit them from expressing things that bother them within their scripts as mother, caregiver, wife, that place them in a second-class status within society, always existing for someone else, always having to place others above themselves. Hence, there are many valid reasons for anger to manifest itself and dismissing them instantly and experiencing anger as a decisively negative "illness" is very damaging for the women who are experiencing these feelings. Instead, we could try to understand women's position within society and the intricate implications of their existences as an oppressed collective group, accepting that anger, within other feelings, are not inherently negative nor are they abnormal to the human experience. Martin (1988) states that "In order to see anger as a blessing instead of a curse, it may be necessary for women to feel their rage is legitimate" (p.178). Moreover, not only legitimize it, but also attempt to understand the sources of the unnamed anger instead of only treating the

symptoms by suppressing women's behavior with medical treatments, such as the "menopause in a box" that was administered to Kim. Some recent studies attempt to precisely explore some of these possible external factors at play, finding that "childhood adversity represents a distal risk factor for severe clinical manifestations of PMDD" (Nayman et al., 2023, p.9). Similarly, Nayman et al. (2023) also mentions the worsening effects lifetime trauma and stress have on PMDD; stress and trauma which aren't uncommon or unliked experiences to existing as a woman. Furthermore, according to Babapour et al. (2023), there is a significant relationship between PMDD and general poor health, and, according to Cabral and Dillender (2021), there are also strong gender disparities in the healthcare industry that place women in an often-disregarded position. This highlights quite well the relationship between women's reality within society and PMDD, like a cyclically recurring pattern of dismissal which only feeds into continually deeper issues; it is the gender disparity on the social level which causes the poor health conditions on the physical level, which both lead to PMDD. While beginning to understand some of these factors is a start, maintaining a focus on comprehending and legitimizing the feelings that proceed is just as important if we are to start deconstructing the guilt and self-depreciation that comes from demonizing something as human as anger, particularly when there is so much to be legitimately angry about.

Nonetheless, Professor Kulkarni states that while the whole concept of PMDD hasn't yet caught the mainstream attention "it is real and there is help" (SBS The Feed, 2019, 8:42). The implication, while seemingly harmless, is that the *medical* disorder PMDD *is* real, however, the feelings (of anger, for example) that are presented alongside it, are very much *not* real (or more specifically, are not *legitimate*) much like Lever's statement cited earlier, therefore the only treatment that is plausible within this paradigm is, clearly, a medical one. Accordingly, PMDD opens up a wide range of commercial products, which becomes significantly lucrative for

pharmaceutical companies through the creation of a plethora of treatments. In a study about PMDD treatments in the United States, Chan et al. (2023) points out that "Many participants were prescribed around 5 different medications for PMDD," highlighting through this fact not only the variety of treatments that exist but also their common infectivity, hence the necessity to keep trying new ones (p.4). All of this to "manage" the PMDD affected woman, so that she will no longer be *symptomatic*, that is: so that she will stop being a disturbance to others and be useful instead. However, some treatments for PMDD can be quite extreme, like the ones Lynda and Kim underwent, and possibly traumatic not only physically but also psychologically, inflicting even more damage onto women. For example, Lynda states "I was petrified, I was terrified. I didn't want to have it; I didn't want to have my organs removed but I did really feel like I had no other option" (SBS The Feed, 2019, 4:26). Feeling devoid of alternatives due to societal expectations, it was construed as her fault and her responsibility to 'fix' her 'broken' body. Thus, by choosing not to undergo surgery to remove her reproductive organs, she would be seen as opting to fail her social role, harming those closest to her.

Subsequently, after the surgery Lynda becomes a "good woman" which is, effectively, the other, and possibly the most important, product of the PMDD industry: the well-behaved good woman, the good wife, the good mother, the good daughter, etcetera. This entails the creation of well adapted subjects who fit into their socially assigned roles as women, silencing any complaint they may have about these roles and directing them instead onto their "broken" fecund bodies. Braunstein (2011) states that an adapted subject is one that is productive (as defined by the current social norms), does not protest, does not want to protest, and does not make others want to protest. Hence, a good well adapted woman, is one who will not mind what is expected of her, much less speak about it, and one who will do anything and everything that is expected of her to fit into her

role, even if that may be subjecting herself to a plethora of, generally experimental, treatments until her behavior is finally acceptable and no longer "problematic" to others. Discursively, there is a direct placement of the blame for a woman's inadaptation onto her fecund body, her hormones, keeping her struggling to fit into the socially imposed role of a "good woman" whilst simultaneously constructing it as her fault if she does not fit, for not fixing her body, until she conforms and subjects herself to medical treatment. As Vale (2012) resumes perfectly, "Después de todo es lo que la psicología y la psiquiatría dominante persiguen: que nos adaptemos a los lugares sociales asignados de la forma más efectiva posible" (p. 156). Therefore, the main product being ideologically sold is the good woman, which ascribes to the socially established scripts of femininity and manages her "monstruous femininity," as Ussher (2006) puts it, which is attempted with the implementation of medical treatments, such as the hormone therapies and the surgeries to remove the reproductive organs. Hence, PMDD is profitable not only through the market of these medical "cures," but through selling the "cured" good woman herself, both to the women themselves who have been made to feel guilty for not adhering to their scripts of perfect femininity and to those who want useful women, the dominant figures of society that benefit from maintaining women as a socially oppressed, repressed and divided collective who feel guilt instead of rage for their position and existence within society.

Conclusion

Thus, the adapted woman is necessarily the main product of psychology and psychiatry, of which the diagnostic category of PMDD is just a tool that effectively functions to identify, label, and dismiss those women who don't fit into the current narrative, with the objective to either readapt or segregate them from society. Therefore, PMDD, as a medical discourse that displaces the blame of the woman's inadaptation, is the perfect paradox because it makes her "bad" behavior

either her hormonally unbalanced fecund body's fault, or her own fault for failing to fix her body. Either way, her behavior as a disturbance to those around her is construed as her fault and hers only with little to no consideration of the possibility that, as a social subject, her behavior can have a very real basis that ties into her complex existence as a woman within a patriarchal and intricately sexist society. Ironically, this means that her effect on society is very much considered, but not the other way around, hence an alternative would be to consider women's experience as the cyclical and mutually influential process of socialization that it is and listen to what she is saying without immediately irrationalizing her words and reducing them to *just PMDD talking*. Treating only the medical symptoms cannot attempt to mend the social behaviors that are presented because it only targets the manifested representations of a problem that originates in the social realm, starting with the constructions of femininity that attempts to entrap women into a specific, and only "right," way of existing (that is, existing for others).

While medical treatments can have their validity, and help ease some discomfort, they certainly cannot be the only and deafeningly exclusive approach to PMDD. Instead, we should hear their voices, even the ones who do not, or cannot, speak: "el grito de donde, o el silencio de donde?" (Larrondo, 2007, 55:19). Radio La Coalifata, a documentary about a radio station that attempts to return a voice to those who have been denied a space for it, those who are silenced and irrationalized of their condition (that being one of "suffering" from a mental health disorder), brings exactly this possible approach to mental health, one that attempts to include, share and hear all experiences. To conclude, if we return to the title of the video analyzed; *Is medical gaslighting silencing those with PMDD?* we can affirm that yes, those with PMDD are effectively being silenced, however it is not only by those doctors who affirm nothing is wrong with them but also

by those who delimit and reduce their diagnosis purely to the medical extent, posed as a consequence of a hormonally maladapted fecund body.

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Appendix

Full diagnostic criteria for PMDD as shown in the DSM-5-TR (APA 2022, p. 198)

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.

B. One (or more) of the following symptoms must be present:

1. Marked affective lability (e.g., mood swings, feeling suddenly sad or tearful, or increased sensitivity to rejection).
2. Marked irritability or anger or increased interpersonal conflicts.
3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

C. One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms from Criterion B above.

1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
2. Subjective difficulty in concentration.
3. Lethargy, easy fatigability, or marked lack of energy.
4. Marked change in appetite; overeating; or specific food cravings.
5. Hypersomnia or insomnia.
6. A sense of being overwhelmed or out of control.
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating,” or weight gain.

Note: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms cause clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder, or a personality disorder (although it may co-occur with any

of these disorders).

F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (**Note**: The diagnosis may be made provisionally prior to this confirmation.)

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).