

**Relationships, psychological distress and stigma: a counselling
psychology perspective**

Zoe Starnawski

**This thesis is submitted in fulfilment of the
Professional Doctorate in Counselling Psychology (DPsych)**

City University London

Department of Psychology

November 2015



**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN
REDACTED FOR DATA PROTECTION/CONFIDENTIALITY
REASONS:**

- pp 225-227:** **Appendix H.** Background information about participant couples.
pp 235-238: **Appendix M.** Example of annotated transcript of couple.
pp 239-246: **Appendix N.** Example table of emergent themes for couple.
pp 253-288: **Section C.** Professional practice-case studies 1 and 2.
Case study 1: Masculine norms, help-seeking and stigma: a
cognitive behavioural therapy (CBT) case study of depression.
Case Study 2: Cognitive behavioural therapy (CBT) for self esteem:
empowerment and assertiveness.

**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN
REDACTED FOR COPYRIGHT REASONS:**

- pp 291-317:** **Section D.** Journal article for publication. 'The norms and expectations
of Premenstrual Syndrome (PMS) in heterosexual couples' accounts of
PMS: an interpretative phenomenological analysis.'
pp 318-321: **Appendix A:** Author guidelines for Psychology and Psychotherapy:
research and practice.
[http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-
8341/homepage/ForAuthors.html](http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%292044-8341/homepage/ForAuthors.html)

Contents

List of Tables and Figures	7
Acknowledgements	8
City University Declaration	9
A Note on the Terms Used in the Portfolio	10
Section A: Preface	11
Section B: Doctoral Research	18
Couples' experiences of premenstrual syndrome (PMS): an interpretative phenomenological analysis	
Abstract	19
Chapter 1: Introduction: Experiences of PMS – A Literature Review	20
1.1 PMS: The Woman's Perspective	20
1.1.1 PMS: Definitions, symptoms and prevalence	20
1.1.2 The impact of PMS on women	23
1.1.3 Aetiology	27
1.1.4 Treatment for PMS	29
1.1.5 Summary	32
1.2 PMS: A Relational Perspective	33
1.2.1 Rationale for a relational focus	33
1.2.2 Impact of PMS on the couple	35
1.2.3 Impact of PMS on the partner	37
1.3 PMS: The Heterosexual Couple's Perspective	39
1.3.1 Rationale for a focus on the heterosexual couple	39
1.3.2 Heterosexual couples' experiences of PMS	40
1.3.3 The partner's role	41
1.3.4 The woman's role	44
1.3.5 Treatment interventions for couples	45
1.3.6 Summary	46
1.4 A Review of Qualitative Studies Investigating Couples' Experiences of Living with Other Difficulties	47
1.4.1 Outline	47
1.4.2 Couples' experiences of endometriosis	48
1.4.3 Couples' experiences of breast cancer	49

1.4.4 Couples' experiences of depression	51
1.4.5 Couples' experiences of stigma related to mental illness	53
1.5 The Current Study	55
1.5.1 Research aims and rationale	55
 Chapter 2: Methodology and Research Method	58
2.1 Outline	58
2.2 Methodology	58
2.2.1 Research design	58
2.2.2 Rationale for adopting a qualitative research paradigm	58
2.2.3 Methodological approaches considered	59
2.2.4 Rationale for adopting IPA	60
2.2.5 Overview of IPA	60
2.2.6 The decision to interview couples together	62
2.2.7 Epistemological standpoint	65
2.2.8 Ethical considerations	67
2.2.9 Reflexivity	69
2.3 Research Method	70
2.3.1 Research aims and questions	70
2.3.2 Sampling and participants	71
2.3.3 Recruitment of participants	76
2.3.4 Interview procedure	79
2.3.5 Transcription	80
2.3.6 Analytic strategy	81
 Chapter 3: Analysis	85
3.1 Introduction	85
3.2 The “Curse” of PMS	86
3.2.1 PMS as a burden	87
3.2.2 Vicious cycles: the adverse emotional consequences	92
3.2.3 The unexpected deviation from “normality”	95
3.2.4 Summary	100
3.3 Connection and Disconnection: The Importance of Communication and Intimacy	101

3.3.1 The couple in conflict	101
3.3.2 Barriers to intimacy	108
3.3.3 Summary	115
3.4 Beyond the Couple: Socio-cultural Influences on the Relationship	115
3.4.1 Turning the spotlight on gender norms and expectations	116
3.4.2 Stigma and privacy	121
3.4.3 The struggle for validation	126
3.4.4 Summary	130
3.5 Final Summary	130
 Chapter 4: Discussion	132
4.1 Introduction	132
4.2 Key Findings in Relation to Existing Research	132
4.2.1 PMS as a negative relational experience	134
4.2.2 PMS as a negative relational experience: suggestions for professional practice	141
4.2.3 Positioning of PMS as “my” or “your” versus “our” problem	144
4.2.4 Positioning of PMS as “my” or “your” versus “our” problem: suggestions for professional practice	145
4.2.5 PMS as a gendered experience	147
4.2.6 PMS as a gendered experience: suggestions for professional practice	151
4.2.7 The role of stigma	152
4.2.8 The role of stigma: suggestions for professional practice	155
4.2.9 Feeling unsupported	156
4.2.10 Feeling unsupported: suggestions for professional practice	160
4.3 Summary	161
4.4 Evaluation of the Validity and Quality of the Research	161
4.5 Limitations of the Study and Possible Directions for Future Research	164
4.6 Personal Reflexivity	167
4.7 Conclusions	170
References	173
Appendices	
Appendix A: Ethics Release Form	206
Appendix B: Consent Form for Interviews and Questionnaires	212
Appendix C: Debrief for Participants	213

Appendix D: Participant Recruitment Material	219
Appendix E: Shortened Version of Premenstrual Assessment Form (PAF)	221
Appendix F: Calendar of Premenstrual Experiences (COPE)	222
Appendix G: Website Participant Recruitment Advertisement	224
Appendix H: Background Information About Participant Couples	225
Appendix I: Example of Participant Screening Interview (Telephone or Email)	228
Appendix J: Participant Information Sheet	231
Appendix K: Demographics Form	233
Appendix L: Interview Schedule	234
Appendix M: Example of Annotated Transcript of Couple – Joe and Olivia	235
Appendix N: Example Table of Emergent Themes for Couple – Elaine and Mark	239
Appendix O: Cluster Theme Table Across Participant Couples	247
Appendix P: Table of Master Themes	249
 Section C: Professional Practice - Case Studies 1 and 2	 253
1. Outline	254
Case study 1: Masculine norms, help-seeking and stigma: a cognitive behavioural therapy (CBT) case study of depression	255
Part 1: Introduction and the Start of Therapy	255
1.1 Rationale	255
1.2 Theoretical Framework – CBT	255
1.3 Client Profile	256
1.4 The Referral and Context of the Work	256
1.5 The Presenting Problem	256
1.6 Initial Assessment and Formulation	257
1.7 Contract and Psychological Counselling Plan	258
Part 2: The Development of the Therapy	258
2.1 The Therapeutic Plan and Main Techniques Used	258
2.2 Key Content Issues and the Pattern of Therapy	259
2.3 The Therapeutic Process and its Change over Time	260
2.4 Difficulties with the Work	261
2.5 The Therapeutic Ending	261
Part 3: The Conclusion of Therapy and the Review	262
3.1 Evaluation of the Work	262

3.2 What I Learnt About Psychotherapeutic Practice and Theory and Myself as a Therapist	262
References	264
Appendix A – Figure 1. Formulation for Max Based on Beck’s (1976) Cognitive Model for Depression	266
Appendix B – Figure 2. Max’s Cycle of Depression	267
 Case study 2: Cognitive behavioural therapy (CBT) for self-esteem: empowerment and assertiveness	268
Part 1: Introduction and the Start of Therapy	268
1.1 Rationale	268
1.2 Theoretical Framework – CBT	268
1.3 Client Profile	268
1.4 The Referral and Presenting Problem	269
1.5 Initial Assessment and Formulation	269
1.6 Contract and Psychological Counselling Plan	270
Part 2: The Presented Session	270
2.1 Introduction to Session	270
2.2 Transcript and Commentary	271
Part 3: The Conclusion of Therapy and the Review	283
3.1 Discussion	283
References	285
Appendix C – Figure 3. Formulation for Lara Based on Fennell’s (1999) CBT Model for Self-esteem	288
 Section D: Journal article for publication	289
The norms and expectations of Premenstrual Syndrome (PMS) in heterosexual couples’ accounts of experiences of PMS: An interpretative phenomenological analysis	290
Abstract	290
Background	291
Rationale for the Current Study	293
Method	294
Participants	294
Recruitment	294

Data Collection	294
Data Analysis	295
Findings	296
Turning the Spotlight on Gender Norms and Expectations	296
Stigma and Privacy	298
Discussion	301
Limitations of the Present Study	305
Some Implications for Practice	306
Conclusions	306
Table 1. Participant details	308
Table 2. Key themes	309
References	310
Appendix A – Author Guidelines for <i>Psychology and Psychotherapy: Theory Research and Practice</i>	318

List of Tables and Figures

Section B: Doctoral Research

Table 1. <i>The RCOG's types and definitions of PMS</i>	22
Table 2. <i>Participant characteristics</i>	77
Figure 1. <u>The three superordinate themes and their relation to each other</u>	86
Figure 2. <u>Superordinate theme (1): The "curse" of PMS and related subordinate themes</u>	86
Figure 3. <u>Superordinate theme (2): Connection and disconnection: the importance of communication and intimacy and related subordinate themes</u>	101
Figure 4. <u>Superordinate theme (3): Beyond the couple: socio-cultural influences on the relationship and related subordinate themes</u>	115
Figure 5. <u>Overview of the key findings</u>	133

Acknowledgements

I would sincerely like to thank the couples who took part in this study. Their openness, honesty and willingness to take the time to share their personal experiences are greatly appreciated.

I would like to thank Dr Maggie Mills for her encouragement, insight and understanding during the early stages of the research process and Dr Jacqui Farrants for her support and feedback throughout the final stages of the DPsych.

My deepest thanks go to my very special family and friends, here and in Australia, for their understanding and encouragement. Special thanks go to my dear husband for his never-ending love and faith in me and my boys for understanding when I couldn't play and had to do my 'work'.

City University Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

A note on the terms used in the portfolio

I have used the term PMS in the current report to refer to the diagnostic category ‘premenstrual syndrome’, the label generally used to define women’s experiences of moderate to severe premenstrual symptoms. I have used the term PMDD to refer to the diagnostic category of ‘premenstrual dysphoric disorder’.

From here forth, the term ‘premenstrual symptoms’ will refer to the variety of symptoms that participants report they experience. I acknowledge that feminist writers, such as Parlee (1992), Showalter (1987) and Laws (1991), argue that labelling such experiences could be considered to contribute to pathologising the reproductive body and women’s experiences of premenstrual distress. Nonetheless, in the current study it is argued that not using the label of PMS may have created confusion about the nature of the investigation, further adding to the stigma around women’s menstruation and premenstrual experiences.

The terms ‘counselling psychologist’, ‘therapist’, ‘psychologist’, ‘clinician’, ‘practitioner’, ‘health practitioner’ and ‘counsellor’ are used interchangeably throughout this portfolio.

Section A: Preface

In this doctoral thesis, I present four separate pieces of work that relate to my training as a counselling psychologist and my developing interests over this journey. The work is divided into three sections linking to the areas of psychological distress and relationships, which are all relevant to the field of counselling psychology. While each piece is distinct, they share a common thread that ultimately seeks to explore how particular distressing experiences may affect relationships. The aim of the portfolio is to increase awareness among clinicians of the need to be mindful of the stigma that surrounds particular health issues, such as PMS. It also aims to raise awareness of how this stigma may contribute to the distressing impact of such issues on clients' psychological well-being and lives, including their relationships with close others, such as partners and family.

Although traditionally academic writing is presented in the third person, I have chosen to write this thesis in the first person. This decision is based on my experience as a practitioner and my undertaking of a qualitative research study that employs IPA. I am interested in how people subjectively make sense of their experiences. I believe that my own sense-making of their experiences leads me to become part of the work myself. This is the case in my therapeutic work, as well as in the research process. Therefore, it would seem congruent to present the current work in a way that does not distance me from it.

In the following section, I will present an overview of each part of the portfolio and its objectives. The preface concludes with a personal reflection on my training and the learning that has taken place.

Section B: Doctoral Research

Section B of this portfolio presents a piece of exploratory qualitative research on couples' experiences of PMS. I interviewed seven heterosexual couples where the woman identified herself, or was identified by her partner, as suffering from PMS. Their accounts were analysed using interpretative phenomenological analysis (IPA) (see Smith, Flowers & Larkin, 2009). The focus of the study was to gain an insight into couples' meaning-making around the PMS experience, including the impact of PMS on their ways of relating. An in-depth analysis of the couples' accounts revealed three main themes, which encapsulated the shared aspects of the couples' experiences. These themes and the research findings are discussed with reference to the existing literature and I explore their relevance to the field of counselling psychology.

Section C: Professional Practice

Section C of the portfolio presents two pieces of my clinical work in the form of a cognitive behavioural therapy (CBT) case study and a CBT process report, both of which aim to demonstrate clinical competence in the chosen therapeutic model. It is noted that a possible perceived tension may exist between the therapeutic model of CBT presented in my client work pieces, and the phenomenological approach of IPA employed in the research study; thus, I will discuss these issues briefly here. The philosophical underpinnings of CBT have been described by some authors as being “silent” (Emmelkamp, Ehring & Powers, 2010), or as not having one single philosophical system of science (Curran, Houghton & Grant, 2010). Therefore, the discipline and practice of CBT may benefit from further exploration of its epistemological foundations (Emmelkamp et al., 2010). However, some authors have cited the influence on the CBT approach of stoicism, rationalism (Dryden, 2007) and postmodernism (Lyddon & Weill, 1997). For others, CBT is based on the assumptions of positivism, realism and empiricism, exemplified by a quantitative experimental research (for example, see Hoffman & Asmundson, 2008). Further claims made by Dobson and Dozois (2009) are that the philosophical foundations of CBT can be seen in constructivism, which asserts that reality is a socially created phenomenon that exists as a function of the observer who constructs it, and that it is embodied in dynamic and subjective knowledge.

IPA is influenced by the phenomenological and existential perspectives of Heidegger, Merleau-Ponty and Sartre, which regard the person as being embodied and embedded in the world, in a particular historical, social and cultural context. Shinebourne (2011) expresses that IPA is derived from these movements of phenomenology in the context of psychology, as it focuses on the exploration of a person’s lived experience and the meanings they attribute to these. IPA is an idiographic approach, which aims to offer insights into how a particular person, in certain context, makes sense of a given phenomenon. It could be argued that CBT takes a similar approach to working with clients, by investigating how certain situations and events have led to the generation of cognitive schemas, core beliefs and emotional, physical and behavioural responses, through which a particular client makes sense of their experiences. Therefore, a counselling psychology approach to CBT would focus on individual meaning and formulation of client issues within a social context, using cognitive and constructivist ideas. According to Mahoney (2003), a constructivist approach to therapy views the client’s experience in the world as an ongoing process of

their developing 'self' in comprehensive and engaging relationships. There is, therefore, an emphasis on meaning and social context and less focus on the content (for example, in CBT, having negative beliefs about the self, the world and others) and viewing 'dysfunctions' or 'difficulties' as pathology. As Mahoney and Gabriel (2002) assert, cognitive therapies are being influenced by more constructivist theories, creating a movement away from the historical realist epistemological position, as evidenced in the practice of 'third wave' CBT practices; for example, mindfulness-based cognitive therapy (MBCT) and acceptance and commitment therapy (ACT). Research supports this; for example, Matthew, McManus, Muse, and Williams (2011) investigated the use of third-wave CBT therapy (in the form of MBCT) for health anxiety using IPA. As the authors propose in their rationale for the suitability of these approaches, they consider how MBCT and IPA view the clients and the research participants as having active roles in the construction and meaningfulness of their experiences (Eatough & Smith, 2008; Segal, Williams, & Teasdale, 2002).

Considering the issues outlined, the first case study describes the work I undertook with a client for symptoms of depression, using behavioural activation and cognitive restructuring within a CBT approach. In this piece, I reflect upon the importance of counselling psychologists in helping clients to become aware of, and challenge, the stigma attached to mental health issues and help-seeking. In the second report, I describe work undertaken with a client experiencing low self-esteem and difficulties with assertiveness after a relationship break-up and a distressing childbirth-related health issue. Using CBT techniques, including guided discovery, Socratic questioning, and problem-solving, the case demonstrates the importance of helping a client to take ownership over therapeutic discoveries, enhancing her sense of empowerment.

As a central theme of this portfolio is relationships, and as the research project is focused on heterosexual couples' experiences, I chose to present two pieces of work undertaken in my final year of training with a male and a female client. I also felt that these case studies highlighted particular gender issues that counselling psychologists should be aware of when working individually and with couples. Both of these pieces explore the way in which stigma may have an impact upon an individual's self-esteem and their experience of others, which, for these clients, resulted in symptoms of anxiety, depression and low self-esteem. As these clients were experiencing relationship difficulties, this work also demonstrates that it is important that counselling

psychologists attend to the therapeutic alliance and consider how stigma and shame may influence this relationship. Further, it demonstrates the importance of working collaboratively with clients, using targeted and effective CBT techniques that are tailored to meet the individual needs of each client.

Section D: Journal Article for Publication

Presented in Section D of the portfolio is an article intended to be submitted for publication in the “Qualitative methods” section of the journal *Psychology and Psychotherapy: Theory, Research and Practice*. The article follows the author guidelines as outlined in Appendix A of Section D: Journal article for publication. These specify employing the American Psychological Association (APA) editorial style.

The journal article presents part of the larger doctoral research and specifically focuses on the superordinate theme ‘Beyond the couple: social influences on the relationship’. I considered that this theme deserved further attention due to there being little available research examining these experiences, particularly in the context of heterosexual relationships. Of particular interest were how participants experienced gender norms and stigma concerning PMS and how these experiences may help to inform the practice of counselling psychology. By focusing on this under-explored area, I hoped to contribute to the field. The findings support the existing literature surrounding the impact of socio-cultural norms and the stigma of PMS and extend the literature, particularly with regard to the joint experience the male partner’s experience of these concepts. I discuss these results in relation to the existing literature by linking the findings to self-policing theory and current models of stigma. I conclude the article with the limitations of the study, the directions for future research and the implications for professional practice.

Personal Reflections

This portfolio represents my journey over the course of my training in the field of counselling psychology as a practitioner and as a researcher. The three different sections of the portfolio reflect the personal and professional learning, discovery and change that have occurred along the way. The process of conducting research, reflecting on client work and developing a paper for publication has highlighted the role that the many personal and professional relationships play in my own life and the meaning they hold for me. I entered the field of counselling psychology with the aim of trying to better understand my own relationship with my mother, who had been struggling for

many years with psychological distress in the form of psychotic depression. I wanted to improve my insight so as to be able to help her, myself and, hopefully, others not to feel so isolated by the distress experienced. On reflection, I also wanted to try to challenge the stigma around mental health issues. What helped me to do this was my relationship with my husband, my friends and my family, who, although did not always understand the struggles I encountered during my training, were always there to support me. This also improved my relationship with myself and the continuous journey of understanding who I am. At times, particularly when conducting the research, this journey was a lonely experience and what helped me through these difficult times was connecting with others when I felt anxious, unsure or bored. I sought out contact from research groups, course colleagues and my children to help me focus and enable me to carry on. Integral to the shaping of my development were the professional relationships I developed along my journey with supervisors, my personal therapist and clients. Through these relationships, I learnt the importance of being open and honest and the value and power of connecting with others. This has helped me to develop a better sense of myself, personally and professionally, and I believe these relationships will continue to shape my journey to becoming the counselling psychologist that I wish to be.

References

- Curran, J., Houghton, S., & Grant, A. (2010). *Providing CBT in different work settings*. In A. Grant, M. Townend, R. Mulhern, & N. Short (Eds.), *Cognitive behavioural therapy in mental health care*. (pp. 167–181). London: Sage Publications Ltd.
- Dobson, K., & Dozois, D.J.A. (2010). Historical and philosophical bases of cognitive behavioural therapies. In K. Dobson (Ed.), *Handbook of cognitive behavioural therapies*. (3rd ed.). New York: Guilford Press.
- Dryden, W., (2007). *Dryden's handbook of individual therapy*. London: Sage Publications Ltd.
- Eatough, V., & Smith, J.A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology*. (pp. 179–194). London: Sage.
- Emmelkamp, P.M.G., Ehring, T., & Powers, M.B. (2010). Philosophy, psychology, causes and treatments of mental disorders. In N. Kazantzis, M.A. Reinecke, & A. Freeman (Eds.), *Cognitive and behavioral theories in clinical practice*. (pp. 1–27). New York: Guilford.
- Hoffman, S.G., & Asmundson, G.J. (2008). Acceptance and mindfulness-based therapy: new wave or old hat? *Clinical Psychology Review*, 28(1), 1–16.
- Laws, S. (1991). *Issues of blood: The politics of menstruation*. London: Macmillan.
- Lyddon W.J., & Weill, R. (1997). Cognitive psychotherapy and postmodernism: Emerging themes and challenges. *Journal of Cognitive Psychotherapy*, 11(2), 75–90.
- Mahoney, M.J. (2003). *Constructive psychotherapy: A practical guide*. New York: Guilford.
- Mahoney, M.J., & Gabriel, T.J. (2002). Psychotherapy and the cognitive sciences: An evolving alliance. In R.L. Leahy & T.E. Dowd (Eds.), *Clinical advances in cognitive psychotherapy: Theory and application*. (pp. 127–147). New York: Springer Publishing.

- Parlee, M. (1992). On PMS and psychiatric abnormality. *Feminism Psychology*, 2(1), 105–108. doi:10.1177/0959353592021016
- Segal Z.V., Williams J.M.G., & Teasdale J.D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford.
- Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis*, 22(1), 16–31.
- Showalter, E. (1987). *The female malady: Women, madness and English culture, 1830–1980*. London: Virago.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Williams, M.J., McManus, F., Muse, K.J., & Williams, M.G. (2011). Mindfulness based cognitive therapy for severe health anxiety (hypochondriasis): An interpretative phenomenological analysis of patients' experiences. *British Journal of Clinical Psychology*, 50(4), 379–397. doi:10.1111/j.2044-8260.2010.02000.

Section B: Doctoral Research

**Couples' experiences of premenstrual syndrome (PMS): an
interpretative phenomenological analysis**

Supervised by: Dr Maggie Mills and Dr Jacqui Farrants

Abstract

Research indicates that premenstrual syndrome (PMS) can have a negative impact on various areas of life, including interpersonal relationships, productivity and emotional well-being. Existing research in the area of PMS is largely quantitative and has been conducted using a positivist framework; the few qualitative studies undertaken have examined women's individual experiences of PMS. Further, studies highlighting the relational impact of PMS have largely focused on marriage quality and have employed quantitative methods. These studies have investigated relational experiences of PMS from an individual perspective, or have looked at non-heterosexual relationship contexts, including lesbian relationships. Little attention has been paid to examining in depth, the relational experiences of heterosexual couples who experience PMS. The current study, therefore, aims to provide insight into the lived experiences of PMS among heterosexual couples by taking a qualitative approach. Interpretative phenomenological analysis (IPA) was used to explore the experiences of seven couples (14 participants) who either identified themselves or their partner as suffering from PMS. Semi-structured joint interviews were undertaken, in which the experiences of couples living together with PMS were discussed. The interviews were analysed using IPA and three superordinate themes emerged from the data: (1) The "curse" of PMS; (2) Connection and disconnection: the importance of communication and intimacy; and (3) Beyond the couple: social influences on the relationship. These themes support the conceptualisation of PMS as an overwhelming emotional experience that leads to confusion and isolation within the couple. It can also be seen as creating difficulties in communication, empathy and intimacy, which are reinforced by the social norms and stigma surrounding PMS. The current study aims to give a detailed relational account of PMS, which can be argued is missing from the existing literature. A perceived limitation of this study is its reliance on the joint accounts of a small sample of self-selecting cohabitating heterosexual couples. This could lead to various other couple relationships being excluded from the study. Nevertheless, the importance of the current findings and the implications for future research are discussed and suggestions for the clinical practice of counselling psychology are highlighted.

Chapter 1:

Introduction: Experiences of PMS – A Literature Review

1.1 PMS: The Woman's Perspective

As Smith, Flowers, and Larkin (2009) propose, a literature review in IPA research aims to develop knowledge in the area and identify any potential gaps that the study may address. With this in mind, I begin this chapter with a review of the PMS literature in order to understand the woman's perspective of living with PMS. I provide a background to PMS and present a brief review of the main aetiological theories. This examination of the concepts and theories of PMS aims to consider how PMS has developed and how it is currently approached in the research. Consideration of this knowledge is intended to help identify any potential limitations to the existing literature, which may provide opportunities for the focus of the current research.

To understand how women report experiencing PMS, I will discuss the ways in which PMS has been found to affect women and the treatments that are currently used. I will then present a rationale for the current study's focus on the relational experience of PMS, as well as a review of the literature examining how PMS affects the couple as a unit and how it affects the male partner. Next, I will provide an explanation of my focus on the heterosexual couple relationship, which is justified by a review of the research into heterosexual couples' experiences of PMS. Research looking at couple interventions is then presented, followed by a summary of the potential gaps that the current research aims to address. Finally, I will review some of the broader couple literature, with a focus on qualitative studies in some areas that are considered relevant to the current study. This includes heterosexual couples' experiences of endometriosis, breast cancer, depression, and stigma related to mental illness. The chapter ends with a discussion of the current study's aims and rationale.

1.1.1 PMS: Definitions, symptoms and prevalence

Historical definitions. Women's premenstrual symptoms were first formally recognised in 1931 by an American gynaecologist, Robert Frank, who created the diagnostic category of "premenstrual tension" (PMT). Frank (1931) attributed the physical and mood symptoms that occur before menstruation to hormonal increases in oestrogen. In the same year, feminist psychoanalyst Karen Horney disputed PMT as a "disorder". Instead, Horney 1931 (as cited in Ussher, 2006, p.26) described PMT as a psychological response to anxieties and fantasies associated with pregnancy, combined with frustration caused by the cultural restrictions surrounding women's expressions of

their sexuality. In 1953 Katharina Dalton, a London-based general practitioner, introduced the term “premenstrual syndrome” (PMS) to encompass the many symptoms other than tension that women experienced (Greene & Dalton, 1953). This broader description reflects contemporary definitions of PMS. However, defining PMS is still a matter of contention among researchers.

Current definitions. The Royal College of Obstetricians and Gynaecologists (RCOG) (2007) defines PMS as a condition that manifests itself in distressing physical, behavioural and psychological symptoms in the absence of an organic or underlying psychiatric disease. These symptoms regularly recur during the last few days of the luteal phase of each menstrual (ovarian) cycle, which generally lasts between 12 and 14 days, and disappear or significantly regress by the end of menstruation. This means that many women may have only 7 to 10 days each month when they do not experience premenstrual symptoms.

Severe PMS symptoms, which are primarily dysphoric and cause serious impairment, are classified as premenstrual dysphoric disorder (PMDD). Since 2000, PMDD has been included as an official diagnosis in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV) (APA, 2000). In 2013 it was classified as a depressive disorder in DSM-V (APA, 2013). However, the categorisation of PMDD is generally only applied in the USA (RCOG, 2007). Many feminists oppose PMDD’s classification as a psychiatric illness, due to a lack of validity of PMDD as a distinct mental illness (Caplan & Cosgrove, 2004). Feminist critics, such as Chrisler and Caplan (2002) and Ussher (2006), propose that premenstrual change is a usual experience, which, through such labelling, is viewed as a time of psychological disturbance. Table 1 outlines the RCOG’s (2007) different types and definitions of PMS.

Table 1. *The RCOG's types and definitions of PMS*

Type	Definition
Premenstrual syndrome	PMS symptoms leading up to menstruation and completely relieved by the end of menstruation
Mild	Does not interfere with personal/social and professional life
Moderate	Interferes with personal/social and professional life but still able to function and interact, although may be suboptimally
Severe	Unable to interact personally/socially/professionally – withdraws from social and professional activities (treatment resistant)
Premenstrual exaggeration	Background psychopathology, physical or other condition with incomplete relief of symptoms when menstruation exaggeration ends
Premenstrual dysphoric disorder	This is a research criterion, not in general use outside the USA. This definition of severe PMS has been adopted by the American Psychiatric Association

Source: Royal College of Obstetricians and Gynaecologists, Green Paper (2007)

PMS symptoms and prevalence. More than 300 symptoms have been associated with PMS across various areas, including mood, behaviour, cognition, gastrointestinal, pain, allergy and psychology (Halbreich, 2003). Recently, some research has tried to identify core symptoms, which include anxiety/tension, aches and cramps, cravings, disinterest in usual activities and mood swings (Freeman et al., 2011). Currently however, there is no consensus on the significant or specific symptoms that define PMS. This, as well as the diversity and changeability of symptoms that are reported by women, indicates the complexity of the PMS experience.

Studies suggest that PMS is distinct from depression and anxiety (Landén & Eriksson, 2003). Complicating this is research indicating that depression and anxiety are commonly experienced by women with PMS and PMDD (Forrester-Knauss, Zemp Stutz, Weiss, & Tschudin, 2011; Vickers & McNally, 2004). Explanations of these findings include women being more biologically vulnerable to developing depression than men (Kessler, 2003). Some recent research, however, also shows a lack of clear evidence to support a relationship between negative mood change and premenstrual change. For example, a review of 47 studies examining the prevalence of negative mood in the menstrual cycle by Romans, Clarkson, Einstein, Petrovic, and Stewart (2011)

found that while 25 studies reported an association between negative mood change and the premenstrual phase, 18 studies found no such association of mood with any menstrual cycle phase. The researchers suggest that these findings indicate a need to challenge widespread negative perceptions linking female reproduction with negative emotions.

Adding to the confusion around describing the PMS experience is the wide variation in prevalence estimates for PMS and PMDD. This is partly due to differences in the definitions and assessment measures used and the particular populations under study. The majority of prevalence studies use retrospective reports, which potentially introduce recall bias (Angst, Sellaro, Stolar, Merikangas, & Endicott, 2001). As such, it is recommended that prospective records taken over two cycles be used, such as the Daily Record of Severity of Problems (DRSP) (RCOG, 2009). PMS has been estimated to be experienced by up to 95% of women of child-bearing age (Bhatia & Bhatia, 2002; Lopez, Kaptein, & Helmerhorst, 2012), with severe PMS suggested as affecting only around 5% of women (RCOG, 2007). Some UK cross-cultural comparison studies suggest that Caucasian women report more emotional symptoms than Afro-Caribbean and Asian sub-groups (Hasin, Dennerstein, & Gotts, 1988). Furthermore, studies in India indicate a lack of reports of premenstrual psychological distress (Hoerster, Chrisler, & Gorman, 2003). Other research conducted with a sample of Chinese women, however, found that premenstrual and menstrual symptoms were commonly experienced, with these symptoms overlapping as well as distinct from those that are frequently reported by women in the West (Lee, So-Kum Tang, & Chong, 2009). Despite these contradictory findings, cross-cultural differences in women's reports have generally led researchers to conclude that PMS and PMDD are socially constructed labels or syndromes that are culture-bound (Chrisler, 2004). As Ussher, Perz, and May (2014) argue, this view of premenstrual change as a social construction does not deny that women really do experience PMS. Instead, it considers how a woman's embodied experience of PMS is intertwined with her social and cultural context (Einstein & Shildrick, 2009).

1.1.2 The impact of PMS on women

PMS has generally been reported as having an adverse impact on numerous areas of a woman's life (King & Ussher, 2013). Several qualitative studies have found that PMS has a negative impact on women's relationship with their intimate partner and on their family life (Slade, Haywood, & King, 2009; Sveinsdottir, Lundman, &

Norberg, 2002; Swann & Ussher, 1995; Ussher, 2002; Ussher & Perz, 2013). Other research has found women's social and leisure activities, sexual functioning and productivity at work are adversely affected.

Work life. Dean and Borenstein (2004) showed women with PMS, when compared with a control group, were more likely to miss more than two days of work per month for health reasons. Women also reported a 50% reduction in work productivity, having more than 14 days a month of impairment at work, in social activities and in relationships with others. Similarly, in their study of 1,045 women (aged 18–49) in the US, UK and France, Hylan, Sundell, and Judge (1999) found that of those women who worked, more than 50% reported their occupational functioning to be at least somewhat affected by negative premenstrual changes. The women who had to take time off work because of symptoms had missed one to seven days in the past year. Interestingly however, women's functional impairment in work situations was reported as being the lowest, with most impairment occurring in home situations, followed by social and educational contexts. This finding suggests that relational contexts, particularly the family, are likely to be significant to the PMS experience.

A further study by Robinson and Swindle (2000) investigated the social functioning and help-seeking behaviours of 1,022 menstruating women across the same countries as those in Hylan et al.'s (1999) study. Those women with more severe PMS were found to report a stronger interference with their lives. The results showed the women's work life was impacted by PMS, with 20.3% of the women reporting missing one working day during the year. The majority of the women studied also reported their relationship with their husband and children to be negatively impacted by PMS. The researchers concluded that severe PMS/PMDD may affect a woman's life in ways that extend beyond the typical emotional and physical changes associated with the premenstrual burden. Both studies also looked at women's help-seeking behaviour for PMS symptoms. In Robinson and Swindle's (2000) study it was reported that women were either reluctant to get help because of held negative attitudes toward PMS, including embarrassment and considering PMS symptoms as a sign of weakness. In Hylan et al.'s (1999) study, compared with women who had less severe symptoms, the women who reported experiencing greater functional impairment were more likely to have severe symptoms and to believe that no treatment was available. The authors suggested that such findings indicated women's unmet treatment needs in terms of severe PMS; thus, the need for increased awareness of PMS symptoms.

Stigma around menstruation and PMS. The finding that women's negative attitudes toward PMS can hinder their tendency to seek help, as reported by Robinson and Swindle (2000) and Hylan et al. (1999), is further supported by studies examining stigma around menstruation and premenstrual experiences. Johnston-Robledo and Chrisler (2013) suggested that the definition of 'stigma' signifies a stain or mark depicting that a person's body or character is flawed. Menstruation is, therefore, considered to be a hidden rather than a visible stigma, due to attempts to conceal it (Johnston-Robledo & Chrisler, 2013; Oxley, 1998). Several influences reinforcing the stigma around menstruation and, thus, PMS, have been identified. For example, Ussher (2006) has described that many girls are not told about the process before their first period, which leads to uncertainty and even trauma when it occurs. Contributing to this is a lack of menstruation education and the socio-cultural portrayal of menstrual products in the media, emphasising secrecy and maintaining sanitation (Coutts & Berg, 1993). Furthermore, as Neal (2013) proposes, women themselves may contribute to the stigma through attempts to avoid the label of PMS. Not using the label of PMS may help women to avoid experiencing the feelings of shame and the loss of self-esteem and social status that are associated with PMS stereotypes. However, hiding their PMS status from others may also perpetuate the stigma around menstruation and PMS by maintaining secrecy, shame, and misunderstanding. It seems that there are difficulties for women around naming PMS. At the same time, however, there are complications when PMS is not acknowledged.

Positive PMS experiences. Most research has focused on the adverse impact of negative changes in the premenstrual period. Limited quantitative studies have, however, also explored positive aspects. For example, women report experiencing increased sexual interest and enjoyment, tendencies to clean and tidy, a propensity to get things done, breasts that are more attractive, more energy and increased creativity (Stewart, 1989). A limited amount of qualitative findings also suggest that premenstrual change may not necessarily be experienced as debilitating or distressing (Cosgrove & Riddle, 2003; King & Ussher, 2013; Swann, 1997; Ussher & Perz, 2008). For example, King and Ussher (2013) held focus groups with 47 women, using a list of positive and negative premenstrual changes to prompt discussion. The details of these were then followed up by individual interviews. The majority of the women reported a variety of positive premenstrual changes. The explanations for these were diverse and variable, including feeling happy and energetic, releasing tension, legitimising self-care, feelings of increased attractiveness, and the indication of impending menstruation. Such findings

suggest that many women may experience positive premenstrual changes. This goes against the idea of premenstrual change as being an intrinsically negative and distressing experience (King & Ussher, 2013). It is interesting to note that the majority of the women in the study were not in long-term cohabiting relationships, potentially leading the women to be less likely to be affected by their partner's responses to premenstrual changes in behaviour, mood or both. Furthermore, they were less prone to be affected by familial responsibilities, which are shown to be a source of major distress for some women experiencing PMS (Coughlin, 1990; Ussher & Perz, 2013). Supporting the aims of the current study, this suggests there is scope for future research to explore in more detail how the positive aspects of women's premenstrual experiences are affected by cohabiting partner relationships (King & Ussher, 2013). Another interesting aspect of the study is that the participants were initially asked to take part in a study about positive premenstrual experiences. Thus, they were prompted with ideas about positive experiences, which potentially influenced their responses. As the authors suggest, however, a number of participants did not need prompting. As such, King and Ussher (2013) concluded that the common reporting of positive premenstrual changes was not due to research prompts only.

In contrast, Sveinsdottir et al.'s (2002) study of 17 Icelandic women found that the women never cited positive experiences of their own accord. Only when asked directly did two women consider their experiences as potentially positive. These were related to increased energy and achievement. The authors noted, however, that these were simultaneously considered to be negative because of their impact on the family. For example, one woman said that her higher energy and activity levels led her to make increased demands of her husband; in particular, that he should also be active. This is supported by Nichols (1995), who found that those women describing experiences of positive changes, such as increased energy, during the premenstrual time also reported that these were contrary to their expectations.

The influence of the family and partners on women's acceptance and enjoyment of premenstrual changes is reinforced by several other studies (Frank, Dixon, & Grosz, 1993; Ussher & Perz, 2013; Ussher, Perz, & Mooney-Somers, 2007). However, in contrast with the findings of Sveinsdottir et al. (2002), the changes reported by the women in King and Ussher's (2013) study, such as enjoyment of expressing aggression, are often considered to be negative within PMS research. Overall, though, these studies suggest that women's perceptions of changes occurring during the premenstrual time

are affected by perpetuating unhelpful cultural constructions of PMS (King & Ussher, 2013). This suggests that several contextual factors may influence women's PMS experiences, including their relationships (King & Ussher, 2013; Sveinsdottir et al., 2002). Therefore, the current research demonstrates the relevance of considering the context of women's PMS experiences.

1.1.3 Aetiology

Bio-medical explanations. To date, no specific aetiology of PMS has been identified. Since the beginning of the twentieth century the bio-medical model has been used to explain PMS. This places emphasis on the reproductive-related biological aspects of PMS and takes a psychosocial viewpoint. The key factors proposed as being involved in PMS are cyclical ovarian activity and the effect of estradiol and progesterone on the neurotransmitters serotonin and gamma-aminobutyric acid (GABA) (RCOG, 2007). Evidence for this comes from twin and family studies suggesting the heritability of PMS and PMDD (Condon, 1993; Treloar, Heath, & Martin, 2002). Additionally, pharmacological interventions, including serotonin-specific reuptake inhibitors (SSRIs) and oral contraceptives, have successfully been used to treat PMS (Marjoribanks, Brown, O'Brien, & Wyatt, 2013). Some critics, however, suggest there is a lack of evidence to support the existence of hormonal imbalances in women suffering with PMS compared with those who do not experience such symptoms (Bloch, Schmidt, Su, Tobin, & Rubinow, 1998; van Leusden, 1995).

Feminist authors, such as Ussher (2002), also argue that while bio-medical theories may help to explain PMS, physical bodily processes are viewed as being the cause. This means that the socio-cultural context in which women live is not considered, with the focus being on observable and measurable factors. As Ussher (2002) proposes, the idea that biology and the body are objective entities that are separate from socio-historical knowledge, experience or subjectivity has been widely critiqued by authors including Foucault (1979) and Henriques, Hollway, Urwin, Venn, and Walkerdine (1984). It could be argued, therefore, that women's interpretations of premenstrual bodily changes cannot be understood without considering the meaning that women place on their experience due to their social and historical contexts. Evidence for this comes from studies showing ethnic and cultural differences in women's reporting of premenstrual symptoms and perceptions of these as PMS; for example, Chandra and Chaturvedi (1989); Dan and Mongale (1994) and Takeda, Tasaka, Sakata, and Murata (2006). Furthermore, as women's understanding of their premenstrual experiences are

socially and historically situated, it follows that so is the medical knowledge and understanding of biological processes related to PMS.

Psychological and bio-psychosocial explanations. Early psychological models, including psychoanalytical perspectives, associate PMS with a “femininity complex”, ambivalent pregnancy desires and unconscious conflicts that are associated with sexual preference (Limosin & Ades, 2001). Other psychological theories include the idea of the denial of the female role or of particular personality characteristics (Coppen & Kessel, 1963; Paige, 1973). A more recent cognitive behavioural therapy (CBT) approach to PMS by Hunter (2003) suggests the importance of women’s negative appraisals of cyclic physiological changes. These may be based on cognitive assumptions that are related to traditional stereotypes of women, as well as developmental influences (Blake, Salkovskis, Gath, Day, & Garrod, 1998). Women’s assumptions are further reinforced by social and cultural perceptions of the menstrual cycle, by lifestyle factors and by a lack of coping strategies. Further contributing to premenstrual distress are the comparisons that women make between their mood and self during the non-premenstrual time and their mood and self during the premenstrual time (for example, perfect/not perfect, useful/useless) (Hunter, 2003).

Stress and trauma. Other psychological explanations include the influence of stress and life events, including trauma. For example, external stress at home and at work have been shown to increase the severity of PMS/PMDD symptoms (Beck, Gevirtz, & Mortola, 1990; Warner & Bancroft, 1990; Woods, Lentz, Mitchell, Shaver, & Heitkemper, 1998). Trauma, including experiences of abuse, has also been suggested as potentially leading to the increased severity of premenstrual symptoms (Girdler et al., 1998; Lustyk, Widman, & Becker, 2007; Pilver, Levy, Libby, & Desai, 2011). For example, in a study by Golding, Taylor, Menard, and King (2000), of the 77 participant women seeking treatment for severe PMS, 42 were interviewed about historical sexual abuse. Of these women, 95% reported experiencing sexual abuse.

Criticisms of psychological models include their focus on a woman’s temperament or psychology as the cause of fluctuations in their mood and well-being and the lack of clarity of a specific mechanism underlying such psychological processes (Taylor, 2006). Furthermore, similar to bio-medical models, psychological models also suggest that PMS either exists or does not exist, and that its existence is based on a psychological dysfunction of some kind (Taylor, 2006). More recent models of PMS, therefore, suggest an interaction between a combination of psychological, biological,

social and lifestyle factors that lead to premenstrual symptoms (for example, see Bancroft, 1993; Miota, Yahle, & Bartz, 1991; Walker, 1995), which are explained by way of a bio-psychological model of PMS. Commonly researched associated lifestyle factors include a high body mass index (BMI) (Masho, Adera, & South-Paul, 2005) and cigarette smoking (Bertone-Johnson, Hankinson, Johnson, & Manson, 2008). The social factors identified, especially in Western cultures, include negative expectations of menstruation; these are proposed as being influenced mainly by culture and the media. For example, Ruble (1977) showed that women who believed they were premenstrual reported significantly more severe physical symptoms than those considering themselves not to be premenstrual. Further, a study designed to positively reframe menstruation experiences demonstrated a significant reduction in impairments of women presenting with PMDD (Morse, 1999).

Material-discursive-intrapsychic (MDI) model of PMS. While bio-psychosocial models view PMS as a multi-factorial phenomenon, which contrasts with biological and psychological views, some researchers, including Ussher, Hunter, and Cariss (2002), argue that discursive representations of PMS should be recognised. This includes having a better grasp on the role of women's relationships in PMS, including those with their partners (Ussher, 2003). As such, Ussher et al. (2002) developed the MDI model, which includes discursive representations of PMS and femininity. The MDI model comes from a critical realist epistemological standpoint: supporting the existence of women's experiences of PMS, but also recognising its representations are characterised and mediated by culture and language. Additionally, it proposes an ongoing interaction between various factors that combine to produce responses classified as PMS. These include material factors (biological factors such as hormones and a history of abuse or trauma); discursive factors (language, visual representation, ideology, power and culture); and intrapsychic factors (low self-esteem, depression and psychological defences). However, more research is needed to determine how useful the MDI model is for understanding the PMS experience.

1.1.4 Treatment for PMS

As indicated, numerous factors are involved in the experience of PMS, leading many women to attempt various forms of treatment (Pearlstein & Steiner, 2008). The most common include pharmacological treatments (for example, anti-depressants, cycle-modifying hormones); lifestyle changes (for example, exercise, relaxation therapy and dietary recommendations); complementary therapies, such as nutritional and natural

supplements (for example, vitamin D, St John's wort extract and evening primrose oil); and CBT (Kues, Janda, Kleinstäuber, & Weise, 2014; Pearlstein & Steiner, 2008). The RCOG's guidelines describe CBT, exercise, vitamin B6, the oral contraceptive pill (OCP) and low-dose SSRIs as the first-line treatments for managing PMS (RCOG, 2007). However, the RCOG also acknowledges that there are existing shortcomings in the provision of care for PMS (RCOG, 2007); this suggests that women find it difficult to access useful support for PMS.

Pharmacological treatments. Although several meta-analyses support the efficacy of SSRIs (Brown, O'Brien, Marjoribanks, & Wyatt, 2009; Dimmock, Wyatt, Jones, & O'Brien, 2000; Marjoribanks et al., 2013; Shah et al., 2008), numerous common adverse effects have been reported. These include nausea, insomnia, headaches and decreased libido as well as gastrointestinal problems, suicide, aggression and harm to relationships (Gunnell, Saperia, & Ashby, 2005; Liebert & Gavey, 2009). The use of hormonal treatments is also associated with severe side effects; for example, deep vein thrombosis, menopausal symptoms and osteoporosis (Rapkin, 2003; Usman, Indusekhar, & O'Brien, 2008). Despite this, cycle-modifying hormones commonly used to treat severe PMS/PMDD include the combined OCP, which contains oestrogen, progesterone. Another hormone that is used commonly is the gonadotrophin-releasing hormone (GnRH). There is a lack of evidence to support the use of progesterone and for the use of second-generation combined OCPs (Rapkin, 2003; Vigod, Ross, & Steiner, 2009). The RCOG, however, currently recommends a new-generation combined oral contraceptive (COC) pill, Yasmin (RCOG, 2007).

Complementary and alternative medicines (CAMs). An increasingly popular alternative to pharmacological treatment, despite the lack of supporting research, is CAMs (for example, Corney & Stanton, 1991). Research suggests that when making decisions around suppressing their menstrual cycles, some women report a resistance to medical authority and question the use of pharmacological treatments for "natural" processes (Repta & Clarke, 2013). This suggests that women place importance on being able to trust their bodies (Dan, 2013).

CBT approaches. Due to the many difficulties associated with pharmacological treatment, researchers have suggested CBT as an alternative approach to dealing with PMS/PMDD (Busse, Montori, Krasnik, Patelis-Siotis, & Guyatt, 2009). Furthermore, CBT is recommended by the RCOG (RCOG, 2007). The CBT model for PMS/PMDD emphasises the significance of the influence of a woman's cognitive appraisals of her

experiences of premenstrual symptoms and related distress, as well as the usefulness of coping strategies. Several researchers, including Blake et al. (1998) and Hunter et al. (2002), have examined the use of CBT for reducing the negative effects of PMS. Studies using CBT interventions for PMS/PMDD have generally shown mixed results, with some reporting more promising outcomes (Busse et al., 2009) and others reporting less encouraging results (Kleinstäuber, Witthöft, & Hiller, 2012). For example, a meta-analysis of nine studies investigating randomised trials using CBT to deal with PMS found that CBT has a medium effect on reducing women's anxiety and depression (Busse et al., 2009). Another meta-analysis of 22 studies comparing CBT with SSRI treatment for PMS and PMDD, found small to medium effects for both the use of CBT and for the use of SSRIs. The researchers concluded that for both CBT and SSRIs, the efficacy in the treatment of PMS was found not to be satisfactory (Kleinstäuber et al., 2012).

Some researchers have begun to look at alternatives to face-to-face CBT for dealing with PMS. For instance, Kues et al. (2014) designed an internet-based CBT (iCBT) intervention. The treatment is based on CBT principles and is divided between cognitive strategies (for example, identifying and modifying dysfunctional cognitions specific to PMS) and suggestions for behavioural lifestyle changes (for example, stress reduction and a balanced diet). The reasons that researchers cite for its development are that it addresses the current lack of treatment for PMS available to women. Being an internet-based intervention, it also offers treatment for a larger number of women and addresses the difficulties of stigma that women may face. The implementation of this iCBT intervention is ongoing; thus, there are not yet any reported results. However, as the researchers propose, the study contributes to recognising the importance of validating women's feelings and thoughts about PMS by taking them seriously, which makes women feel supported.

The value of feeling supported and listened to in relation to PMS has been reported in other research. For example, in Blake et al.'s (1998) study of cognitive therapy (CT) for PMS, participants were assessed in their own homes, which meant that they were able to discuss their difficulties in relation to PMS with the recruiter before the treatment began. Many women reported that the assessment process was therapeutic in itself. The researchers concluded that such findings suggest that these women valued being listened to and supported. For these women, talking about problems with someone who was able to empathise may have been psychologically beneficial. An

additional benefit of CBT therapy reported by women is that it enables them to gain a better understanding and awareness of PMS (Ussher, 2008). This was described in an add-on study to the original research by Hunter et al. (2002), which examined the effectiveness of CBT and fluoxetine for treating PMDD. To explore their experience of the psychological intervention, Ussher (2008) conducted in-depth interviews with 36 women who had participated in Hunter et al.'s (2002) original study and had reported a 30% increase in premenstrual symptoms. After the women had engaged in the psychological intervention, their accounts included less focus on the physical symptoms, more acceptance of PMS as part of the self, less isolation and a decreased need to control their symptoms.

1.1.5 Summary

There does not seem to be any specific aetiological theory that can fully explain the varying and numerous premenstrual symptoms and the individual ways in which they are experienced by women. This is a view shared by other researchers, including Taylor (2006) and King (2013). It is suggested that a better understanding of women's experiences would help to uncover the idiosyncratic ways in which PMS is experienced. To achieve this, a more in-depth approach is needed, which the current study aims to achieve.

It also seems that no particular treatment has been shown to be consistently effective in reducing premenstrual distress in all women (Cunningham, Yonkers, O'Brien, & Eriksson, 2009; Kues et al., 2014). Pharmacological treatments, although beneficial, have many potential adverse side effects, making them a problematic treatment choice for women. Further, some women report negative attitudes toward medical treatment for menstrual issues, including PMS (Repta & Clarke, 2013). The predominance of the bio-medical approach to studying the aetiology and management of PMS has also, perhaps, contributed to the lack of research attention paid to more holistic ways of treating women. This is despite evidence suggesting that women have a growing interest in CAMs for PMS (Corney & Stanton, 1991).

Of the limited research published on psychological treatment for PMS, which has produced mixed results, it seems that CBT, including psychoeducational aspects and coping skills and strategies, may be useful. This suggests that women may benefit from an enhanced understanding and awareness of their PMS experience and ways of coping with the aspects that cause them distress. This is supported by the outcomes of Ussher's

(2008) qualitative add-on study and Blake et al.'s (1998) findings that women seem to benefit from the opportunity to discuss their PMS experience with someone supportive.

Overall, the multifaceted and complicated nature of PMS makes it difficult to treat. It seems that there are opportunities to add to the PMS treatment research, particularly from a counselling psychology perspective. I suggest that having a better understanding of the importance of some of the circumstances that may contribute to women's experiences of PMS, including their partner relationships, may help to accomplish this.

1.2 PMS: A Relational Perspective

1.2.1 Rationale for a relational focus

The research reviewed thus far, indicates that a woman's experience of PMS is predominately viewed as an objective, treatable, problematic "syndrome"; it is generally approached from a positivist stance, via bio-medical and psychological research models. Although it is recognised that there is a hormonal influence on PMS, as Taylor (2006) and Ussher (1996) argue, such views of PMS assume that it either exists or does not exist. PMS is, therefore, considered to be an individual problem. This means that the social and cultural contexts in which women operate, including their relationships, are not viewed as important to the PMS experience (Ussher, 1996; Walker, 1995). The literature reviewed demonstrates that a woman's premenstrual experience is subjective: it has different meanings for different women; thus, it is shaped by different social, cultural and historical contexts. The reported cultural differences in women's PMS experiences (for example, Chandra & Chaturvedi, 1989) further support this argument.

In agreement with other researchers, including King (2013), this study takes the stance that PMS is a subjective experience, occurring in the context of couple relationships; thus, it can be viewed as a relational experience. "Relational" refers to the idea that relations form the basis of individual and social life; therefore, relational concepts can help us understand the complexity of human experiences (Holmes, Paul, & Pelham, 1996). Several researchers across a range of disciplines have used a relational approach to understanding various life experiences, including personal life (Smart, 2007) and family life (Morgan, 1996). The social psychologist Mead (1934), for example, proposed that the self is inherently relational. Regarding the relational experience of PMS, other researchers, such as King (2013), have discussed relational approaches to understanding distress, as originally described by the psychoanalyst Mitchell (1988). Working within a psychodynamic paradigm, Mitchell (1988) argues

that “experience is understood as constructed through interaction” (pp. 3-4). Although the relational paradigm is rooted in the psychodynamic tradition, Holmes et al. (1996) propose that this framework could be integrated into the concepts and practices across the spectrum of counselling theory. As the current research aims to add to the field of counselling psychology, a relational model of understanding human experience is also considered to be relevant to understanding couples’ experiences of PMS. Furthermore, as Ussher and Perz (2013) and King (2013) argue, the intersubjective (or relational) framework is of vital importance to understanding how women experience PMS. It is within this context that women and men make sense of the premenstrual experience.

Additionally, distinct from existing research in the field of PMS, the current study employs an IPA approach; therefore, it recognises the importance of considering experiences in context, such as the couple relationship. IPA research has traditionally considered the individual as the unit of study by using a single homogenous sample group (Smith et al., 2009). More recently, IPA research has begun to employ designs that explore the shared experience from more than one perspective; for example, couples, families, social workers and foster carers in relation to a variety of experiences (for example, Dancyger, Smith, Jacobs, Wallace, & Michie, 2010; Loaring, Larkin, Explanations for the decision to take a couple interview approach in the current study are consistent with those of other IPA researchers in that they derive from Heidegger’s (1962) sense of the person as being always “in-relation-to the world”. This is the idea that the person and the world are co-constructed; thus, people exist in a world of shared meanings and understandings. As other researchers employing conjoint couple interviews have also suggested (for example, Racher, 2003), a couple exists in the world as a unit; thus, it is constructed by the world. It is through cooperation, sharing and the interdependency of the partners that the couple is able to exist and, thus, to experience and interpret their experiences (Racher, 2003). Also relevant are Merleau-Ponty’s (1964) ideas that an individual’s position in the world involves access to the world and having a perception of it. According to Merleau-Ponty (1964), human experience requires access to reality, which is represented in the four lifeworlds: space, time, body and human relation. The couple, therefore, exists in the realm of human relation, with the couple relationship existing over time and through space. The couple’s perception is different from those of the individuals who make up the couple; thus, a joint interview allows for investigating a couple’s experiences and perceptions as well as how the couple makes sense of its experiences as a unit.

To determine how PMS may be viewed as a relational experience, in the following section I will review the literature examining the impact of PMS on the heterosexual couple relationship. Additionally, I will examine research exploring how PMS may impact on the male partner. A rationale is presented for the current study's focus on the heterosexual couple relationship as opposed to other relationships women may be involved in (for example, lesbian couples, family relationships). Following this, I will discuss literature which examines the experience of PMS within heterosexual couple relationships, including the man's role and the woman's role in the relational experience of PMS.

1.2.2 Impact of PMS on the couple

Relationship satisfaction and quality. Several studies have examined the impact of women's premenstrual symptoms on heterosexual couple relationships. They have focused on the negative impact of PMS on the quality of the couple (usually marital) relationship; for example, relationship satisfaction or happiness, and certain difficulties, such as reported conflict, levels of intimacy and communication (Coughlin, 1990; Frank et al, 1993; Keye, Hammond, & Strong, 1986; Kuczmierczyk, Labrumb, & Johnson, 1992; Siegel, 1986). For example, Keye et al. (1986) found that women who experienced PMS reported a greater degree of marital unhappiness than those who were not experiencing premenstrual symptoms. Siegel (1986) also found levels of marital satisfaction and intimacy to be lower in women who experienced PMS, with women's assessment of satisfaction strongly related to the degree of premenstrual distress experienced. Another study, by Winter, Ashton, and Moore (1991), also found that women experiencing PMS reported significantly more dissatisfaction with their marital and sexual relationships than women who were not experiencing PMS. Similarly, Coughlin (1990) found that the negative effects of stress derived from the marital relationship contributed to the severity of PMS experienced, and that greater marital satisfaction contributed to less severe PMS symptoms. Interestingly, all of these studies were conducted from the woman's perspective on her marital relationship. Furthermore, evidence was derived from quantitative measures looking at associations between factors such as women's levels of relationship satisfaction, by using methods such as questionnaires; thus, a more in-depth understanding of these dynamics was not explored.

However, some studies have examined the impact of PMS on marriage quality and looked at both members of the couple. For example, Ryser and Feinauer's (1992) study of the effects of PMS on the marital relationship used reports from husbands and

wives. They found that the marital relationship's functioning deteriorated when premenstrual symptoms were present in the luteal phase of the cycle. A further study, by Brown and Zimmer (1986), used the reports of 83 women and 32 men. The findings reported a significant correlation between the extent of the PMS symptoms reported and marriage quality, family cohesiveness and interference with the marital relationship. The men and women both evaluated their marriages more negatively during the premenstrual phase as opposed to the post-menstrual period. Notable in this study was that the sample included more than twice the number of women than men. This may be perceived as not being representative of the heterosexual couple, and perhaps biased toward the women's reports.

Communication and conflict. Several studies examining the impact of PMS on communication and conflict within the couple relationship have generally found these areas to be adversely affected. For example, Brown and Zimmer (1986) reported that interpersonal exchanges between family members were altered and created relational friction when the women reported tension (anxiety, frustration, irritability, argumentativeness and agitation). Similarly, Kuczmierczyk et al. (1992) found that some of the study's sample of 73 women diagnosed with PMS described increased familial conflict, but also reduced direct emotional expressiveness within the family. Other research indicates that a lack of communication between the couple leads to higher levels of premenstrual distress (Ussher & Perz, 2010). Further supporting this is research showing that effective communication between couples is associated with lower levels of premenstrual distress (Schwartz, 2001; Smith-Martinez, 1995).

A further study by Frank et al. (1993) studied the impact of PMS on communication within the marital couple and included reports from both couple members. In this study, several measures of the Marital Satisfaction Inventory (MSI) were employed, including aspects of communication related to problem-solving and affect, in order to examine the impact of involving husbands in dealing with PMS. The husbands and wives both used a method to chart PMS symptoms. It was found that, compared with the women-only monitoring group, conjoint monitoring of PMS symptoms resulted in a greater improvement in several of the measures of the MSI, including those relating to distress, problem-solving communication and sexual dissatisfaction. The study found that conjoint monitoring of PMS symptoms assisted couples to discuss their individual and marital relationship needs and behavioural

strategies. Like those reviewed, this study examined married couples; thus, other kinds of couple relationships that are potentially affected by PMS were not examined.

Some suggestions given for the conflict that occurs in relationships due to PMS include unresolved issues between the couple that lead to tension, anger and frustration, in addition to poor conflict-resolution skills (Siegel, 1986). Further explanations include the occurrence of changing roles in the couple relationship (Jones, Theodos, Canar, Sher, & Young, 2000).

Intimacy. Levels of intimacy between the couple have also been found to be negatively affected by the woman's experience of premenstrual symptoms. For example, Siegel (1986) found that women describing low levels of intimacy, as recorded on the Waring Intimacy Questionnaire, also reported high levels of premenstrual distress. Rundle (2005) described similar findings, with some couples reporting decreased sexual desire during the premenstrual time. In contrast with this, however, in the same study some women also reported experiencing increased sexual intimacy and arousal in the premenstrual period. King and Ussher (2013) reported a similar finding in their study. They suggest that such findings indicate that PMS can have a positive impact on the couple relationship, particularly concerning intimacy. To date, however, little research has been conducted in this area.

1.2.3 Impact of PMS on the partner

Research exploring the impact of PMS on both couple members indicates that the male partners of women experiencing PMS are also affected. For example, Brown and Zimmer (1986) found that 76% of the 32 male participants in their study described being moderately to greatly disrupted by their partner's premenstrual symptoms. Being a questionnaire study, the details of this interference and its impact were not identified. However, the coping strategies used by the male partners were explored. It was found that the men used helping behaviours and sought counselling support, but they also employed avoidance, including avoiding the home and, thus, their partner. Similarly, Cortese and Brown (1989) found that the male partners of women who were reported as experiencing high or low levels of premenstrual symptoms used a variety of coping strategies, the most common included identifying their partner as not able to help it, trying to learn more about her symptoms and becoming angry with her. The researchers concluded that the impact of premenstrual symptoms extends beyond the woman. This is because the men respond to their partners' symptoms, potentially altering family dynamics. Further research, however, is needed to better understand how men's coping

responses reduce or exacerbate relationship disruption that is due to PMS. It is noted that the men's responses were derived from an interview questionnaire developed for use in the study: the PMS Partner's Coping Inventory (PMS-PCI). This encompassed a 29-item scale with a "yes" or "no" response for each item. Also included was one item labelled "other" to elicit additional or unique coping strategies. This form of data collection could be considered as potentially not allowing men's subjective experiences to be fully explored. Thus, the current study addresses this by adopting an IPA approach, which enables a more in-depth exploration of men's subjective experiences.

Of the limited in-depth research conducted with male partners, PMS is mainly reported to have a negative impact. For example, a study conducted as part of a wider investigation on PMS and relationships interviewed 15 male partners about their partner's PMS. The men's accounts evidenced experiences of distress due to premenstrual changes, including feeling exhausted by trying to work out how to support their partner (Ussher, 2011). For example, one participant reported that his partner's mood swings "just puts the whole family on edge", while another reported that "sometimes it's hard for me because if it's directed at me, I'm not really sure why she has to be so angry" (Ussher & Perz, 2011, p. 140). These accounts indicate that the PMS experience is difficult for these men as well as for their partners.

King (2013), who investigated the experiences of 12 male partners, reported similar findings. These findings were derived from a broader research project examining the relative efficacy of a couple-based psychological intervention for PMS compared with an individual psychological intervention and a wait-list control. Semi-structured interviews explored men's constructions, experiences and negotiation of premenstrual change (PMS) and how these were shaped by the PMS psychological intervention for couples. King (2013) found that the majority of the men described the negative impact of their partner's premenstrual changes on themselves and their intimate relationship with their partner. The men perceived the premenstrual time as a "challenge", a "problem", "personally frustrating" or "irritating" (King, 2013, p. 255).

This contrasts with the more positive accounts described by the same men following participation in the PMS psychological intervention. For example, the men's post-intervention interviews revealed that, for the majority of the men, PMS was rarely an issue or a disruptive event within their lives. This is illustrated by one of the men, who described how the intensity of disagreements due to PMS with his partner was perceived as much lower (p. 256). As King (2013) suggests, contributing to the men's

more positive perception of PMS within their relationships are discussions between the couple members that construct premenstrual change as a “normal” experience. Furthermore, learning more about premenstrual change seemed to enable the men to address the issues underlying their partner’s premenstrual distress, rather than focusing on the distress itself. Additionally, more effective couple communication contributed to better coping with the negative impact of PMS on the woman and the relationship. As noted by King (2013), the long-term impact of the positive effects of the intervention on the men’s experience and perception of PMS are unclear. Therefore, further longitudinal studies may help to understand this better.

Similar findings have also been reported by Rundle (2005). For example, one participant male partner in Rundle’s (2005) study discussed how the relational dynamics in the couple became more positive during the premenstrual time. This was due to increased communication and cooperation, resulting in flexibility within the couple concerning each other’s needs. However, Rundle (2005) noted that such accounts from the male partner participant group were not as common as reports of more negative aspects of the PMS experience.

Overall, only a few studies have examined the impact of PMS on men within couple relationships. Existing research indicates that men mainly report the negative impact of their partner’s PMS; however, the studies also indicate that this experience is not a straightforward one. This suggests that more research is required to understand the ways in which men in relationships with women experience PMS.

1.3 PMS: The Heterosexual Couple’s Perspective

1.3.1 Rationale for a focus on the heterosexual couple

Thus far, the literature reviewed demonstrates that many women and their partners are negatively impacted upon by PMS. However, the majority of existing PMS research has focused on the heterosexual woman. This is partly due to exclusion, but is also due to the lack of identification of the sexual orientation of women participants (Ussher & Perz, 2008). Furthermore, only a handful of studies have included the male partner’s perspective. Thus, PMS has generally been considered as an individual problem. However, there is a growing body of research that suggests women’s experiences of PMS are affected by their relationships, particularly by their partners in heterosexual and lesbian relationships (for example, Mooney-Somers, Perz, & Ussher, 2008; Rundle, 2005; Ussher & Perz, 2008, 2013). This research indicates gender differences in the way in which heterosexual and lesbian women experience PMS

within their relationships, particularly with regard to partner support and empathy (Ussher & Perz, 2008). These disparities have been explained as being due to gender roles (King, 2013): on the one hand, women in lesbian relationships adhering to female gender roles, encompassing support and empathy (Metz, Rosser, & Strapko, 1994); on the other hand, men following patriarchal principles that maintain relationship inequality and position them as unsupportive in their relationships with women (Clayton & Harris, 2004).

Several feminists; for example, Figert (1995) and Markens (1996), have argued that PMS is a gendered experience. Support for this comes from women's reported feelings of frustration and anger associated with their roles as wives and mothers being repressed through the process of self-silencing during the non-premenstrual time. Subsequently, these feelings are expressed in the premenstrual period, but then dismissed as PMS by both the women and their partners (Rodin, 1992; Ussher & Perz, 2010). The gendered experience of PMS is also evidenced by studies indicating that PMS is experienced differently in heterosexual and lesbian relationships (Ussher & Perz, 2008).

Despite such claims, little attention has been paid to the in-depth examination of the experience of PMS in the context of heterosexual relationships, particularly from the couple's perspective. The majority of existing studies are from the woman's standpoint only, or are taken from separate accounts of the relationships (King, 2013; Ussher, 2003, 2011) or a combination of individual and couple accounts (Rundle, 2005). Such approaches, particularly interviews with individual couple members, may generate different data and themes from those generated by a joint couple interview. Further, separate accounts could reinforce negative depictions of male and female gender roles. It seems, therefore, that further exploration of women's experiences alongside those of their male partners within the heterosexual couple context is likely to enhance current understanding of the heterosexual couple's experience of PMS.

1.3.2 Heterosexual couples' experiences of PMS

The suggestion that PMS is a relational experience derives from evidence from qualitative studies of heterosexual women. These studies report a shared sense of feeling out of control and overwhelmed by the demands placed upon them by their partners and children during the premenstrual time (Mooney-Somers et al., 2008; Ussher, 2003). Further supporting the notion of PMS as a relational experience is Ussher's acknowledgement that throughout her 30 years of researching PMS, women's

accounts have always included discussions about their partner (Armitage, 2012). Moreover, evidence suggests that PMS can affect male partners, leading to disruptions in the couple relationship (Rundle, 2005; Ussher & Perz, 2008, 2013).

Studies suggest several different ways in which the heterosexual relationship may affect the PMS experience. Such research has generally focused on how the partner may influence a woman's PMS distress; for example, how their behavioural and emotional responses exacerbate or decrease levels of PMS distress. For instance, an interview study by Sveinsdottir et al. (2002) found that women perceive men's references to PMS as belittling, indifferent and non-accepting. The women discussed men in terms of not taking PMS seriously, treating it nonchalantly and inferring that PMS is used as an excuse. A further qualitative study exploring men's understanding of women's bodies indicated a lack of understanding of women's menstruation, with men expressing negative attitudes toward menstruation, including that it is a "hassle" and is "disgusting" (Koch, 2006). Although these findings provide insight into perceptions and constructions of PMS in specific groups of men, they cannot be generalised. Additionally, some research suggests various ways in which women's responses to their partners during the premenstrual time lead to increasing or decreasing their own levels of PMS-related distress (Ussher and Perz, 2013).

To gain a more in-depth understanding of heterosexual couples' experiences of PMS, in the following section I will review research on the male partner's role in the experience of PMS as well as examine research on the woman's role. Following this, I will explore couple interventions currently used to treat PMS distress.

1.3.3 The partner's role

Increasing women's premenstrual distress. The majority of heterosexual women's qualitative accounts (the main perspective of qualitative studies in the area) generally describe male partners as the focus of premenstrual anger or irritation. For example, in a study of women's PMS experiences in lesbian and heterosexual relationships, Ussher and Perz (2013) describe two participants, both in heterosexual relationships, who had become irritated with their partners. One participant described herself as being less tolerant of her partner's shortcomings (that is, being a hoarder and a collector) during the premenstrual time, while the other discussed reacting angrily to her husband's efforts to help with washing clothing and how he "destroyed" her clothes (p. 135). The authors interpret these accounts as possibly being due to the surfacing of

women's deeper feelings of hurt or frustration during the premenstrual time. It is interesting to note that while the researchers describe a similar dynamic occurring in lesbian relationships, they do not present any examples from lesbian couples. This could be viewed as an unbalanced representation, contributing further to the general stereotyped view of men as exacerbating women's premenstrual distress.

Male partners have also been suggested as contributing to increasing women's premenstrual distress by providing negative evaluations of PMS, leading to premenstrual women being considered as "mad" or "incompetent" (Cortese & Brown, 1989; Ussher & Perz, 2008). For example, Ussher and Perz (2013) cite one participant who recounted her partner saying to her: "who am I talking to today? Is it schizo Elaine, nice Elaine, sexy Elaine or cranky Elaine?" (p. 139). Additionally, qualitative studies of women's experiences of PMS within heterosexual relationships have indicated other ways in which male partners respond during the premenstrual time that lead to increasing PMS distress. These include showing a lack of empathy, support or acceptance of PMS, or trivialising women's emotional responses (Mooney-Somers et al., 2008; Ussher & Perz, 2013). It has been suggested by several researchers, including Mooney-Somers et al. (2008) and Ussher and Perz (2010), that such responses from a partner can lead to a woman being unable to access the support and comfort she desires. This leaves the woman feeling unsupported and may sometimes damage the relationship.

In contrast, although limited, some studies have found that women's accounts include descriptions of their partners as being understanding and aware of their PMS. Thus, these partners are able to be respectful of the women's emotions and physical states and offer support during the premenstrual time (Hoga, Vulcano, Miranda, & Manganiello, 2010; Ussher & Perz, 2008). For example, one woman in Hoga et al.'s (2010) study reported: "My husband notices and he says: I know, it's PMT and he leaves me alone ... he understands it..." (p. 375). This study, however, is a narrative exploration of Brazilian women's accounts of male behaviour at the onset of PMS; thus, the male's perspectives went unexplored. Further, this experience seemed to be less common, with a predominant finding being a lack of knowledge among men about PMS. Nevertheless, these more helpful or positive responses from male partners are suggested to lead to lessening women's distress levels (Ussher & Perz, 2008). This indicates that male partners can play a positive role in women's experience of PMS. For example, support and understanding offered by partners can reduce feelings of guilt and

self-blame, which can lead to women engaging in self-care (Perz & Ussher, 2006; Ussher et al., 2007).

Positive responses: giving space and support. As mentioned, the majority of studies reviewed thus far describe accounts from the woman's perspective only. A small number of studies in which male partners' accounts have been directly explored have, however, found that these men adopt more positive responses to their partners' PMS symptoms. For example, Rundle (2005) found that five out of the six male partners interviewed reported providing their partner with physical and emotional space during the premenstrual time. However, it is noted that such interviews were not conducted with the woman partner present and were conducted by a female interviewer, perhaps leading to more positive responses from the men. Similar findings have also been reported by Ussher and Perz (2013), who found that a number of the men interviewed in their study gave accounts of providing their partner with physical space during the premenstrual time in order to avoid conflict. One participant described himself as trying to "tiptoe around her [his partner] a bit... give her a bit of space", saying, "It's a good time to be out doing a bit of gardening" (Ussher & Perz, 2013, p. 143). As noted by the authors, many of the partners reported that they understood the woman's need for time for herself during the premenstrual period, so they actively enabled this. This is viewed as significant, because self-care is considered to be an important way of increasing women's sense of well-being.

As well as giving their partners space, women have also reported that premenstrual distress is eased by their partners' efforts to provide practical and emotional support. For example, a study by Mooney-Somers et al. (2008) found that many women described their partners performing housework as a form of practical support, which, for some, helped to reduce their sense of responsibility at this time, thereby lessening their distress. Male partners have also been reported by women as providing emotional reassurance by demonstrating their understanding of the women's distress during the premenstrual time, verbally and physically (for example, hugs and kisses) (Mooney-Somers et al., 2008). In order for partners to be best able to support and empathise with women during the premenstrual time, it has been suggested that a couple's communication is important (Jones et al., 2000). However, as Ussher and Perz (2013) found, only around one-third of those women in heterosexual relationships who were interviewed reported facilitating open discussions with their partner about PMS and about how their partner could support them. Further, many women reported being

pessimistic about their partner's ability to understand if they attempted to explain their PMS distress. As Ussher and Perz (2013) explain, it seems that discussion around PMS becomes a "double-edged sword". This, perhaps, suggests that a dynamic occurs in the couple relationship that seems to maintain PMS distress and hinder couple communication. It seems that this aspect of couples' experiences may benefit from further exploration, which the current research aims to do.

1.3.4 The woman's role

As couple relationships are made up of two individuals, how a woman responds during the premenstrual time is also considered to be important for how PMS is experienced within the heterosexual relationship. For example, Ussher and Perz (2013) describe women's tendency to self-pathologise during the premenstrual time by using negative self-descriptions such as being "out of control" or a "nut case" (p. 141). This is more likely if a woman experiences their male partner as critical, lacking in understanding or unsupportive during the premenstrual time. Ussher (2011) draws on Benjamin's (1999) ideas to explain that this occurs due to some women experiencing their partners as unable to notice and emotionally "hold" their premenstrual distress. As such, these women look for an internal reason to explain their own negative premenstrual experience, including feelings of anger. This leads to self-blame, rather than considering any relational or social reasons for their premenstrual responses.

Self-silencing. This process has been explained as occurring in heterosexual relationships. Self-silencing refers to a woman's tendency to put the needs of others above her own, inhibiting the expression of her personal feelings in the relationship (Jack, 1991). As such, particular relationship needs are not addressed by women during the non-premenstrual time, leading to an outward expression of issues during the premenstrual time (Jack, 1991; Ussher & Perz, 2010). As Ussher (2004) suggests, a break in self-silencing during the premenstrual time may also serve as a positive function. For instance, being more openly communicative can give women opportunities to address particular relationship concerns. If the woman's partner acknowledges such concerns, this validates her emotional expression; thus, she is better able to cope with premenstrual changes (Ussher & Perz, 2013). Alternatively, if the partner dismisses these concerns, this may lead to the woman searching for an internal reason to explain her negative premenstrual experiences, possibly resulting in self-blame (Ussher, 2008).

1.3.5 Treatment interventions for couples

Despite several researchers suggesting that interventions involving both members of the couple may be beneficial to help develop more positive ways of coping with PMS (for example, Hunter et al., 2002; Ussher et al., 2002), there has been little research focus in this area. However, some evidence suggests involving both couple members in treatment for PMS is of value for the couple relationship, as well as for the woman and her partner. For example, a case study by Watson and Nanchoff-Glatt (1990) presented a nurse's approach to treating a childless married couple in a long-term relationship. The couple's presenting problem was the negative impact of the wife's PMS on the marital relationship. A family systems approach was used to conceptualise PMS as embedded in the marriage and the interactions of the relationship, rather than solely in the wife. The nurse sought the couple's understanding of the problem, with the objective of offering the couple an alternative view to enable them to increase their own problem-solving abilities. The treatment took place over two months for four sessions. PMS was viewed as the problem; however, after the first session, the focus shifted to considering the wife's need to be understood by her husband as the difficulty. This was revealed in the way in which the husband reflected upon the nurse's questioning about what he thought he wanted his wife to understand: "She wants me to understand how she feels. The physical feeling she's having, the mental thoughts she's having" (Watson & Nanchoff-Glatt, 1990, p. 6). After the first session, both couple members were asked to separately chart the wife's PMS symptoms and their perceived intensity. The husband was also asked to rate his own behaviour during the premenstrual time. The results indicated that he also experienced increased anxiety, irritability, anger and depression, which coincided with his wife's PMS symptoms. He also reported that he believed his wife handled her own PMS responses better than he coped with his own. In the fourth session, the couple reported that they had managed to cope with PMS with more ease than they had done previously. This suggested that they had developed a greater awareness of each other's responses and difficulties during the premenstrual time, along with enhanced coping strategies. An improved relational experience of PMS was evidenced in the way in which each couple member reported feeling more in "control" of their PMS responses, including feelings of anger. This study supports the idea that a couple's improved awareness and understanding of the woman's PMS can lead to reducing distress. Further, it shows that this is more possible if there is joint involvement in the intervention.

A further study by Frank et al. (1993) also demonstrates the benefit of involving both couple members when dealing with PMS distress within a relationship. In this study, Frank et al. (1993) examined the impact of involving husbands in the conjoint charting of PMS symptoms. Conjoint monitoring was found to assist the couples to be able to discuss their individual and marital relationship needs and their behavioural strategies. This suggests that including a woman's partner in interventions to treat PMS may be important for the development of the partner's positive experiences and responses to the woman's premenstrual mood and behavioural changes. This is explained as due to such interventions as increasing the partner's awareness of premenstrual changes. This leads to improving the couple members' understanding and empathy and encouraging more positive communication in the relationship during the premenstrual period.

In a later study by Frank (1995), conjoint behavioural marital therapy was also shown to improve relationship satisfaction and reduce the couple's levels of premenstrual distress. Five married couples with women who met the DSM III-R diagnostic criteria for late luteal phase dysphoric disorder (LLPDD) were compared to a group of four married couples who did not meet the same criteria. The couples underwent a two-month conjoint behavioural marital therapy treatment phase, involving four weekly 90-minute sessions. Before and after the treatment, the couples were assessed on their subjective experience and their appraisal of their marital relationship, marital distress and affect. Couple treatment was shown to improve overall relationship satisfaction and improved daily ratings of couple distress and menstrual cycle symptoms, regardless of the existence of a diagnosis of LLPDD. The researchers concluded that such findings indicate that, for reducing PMS-related distress, conjoint treatment may be more beneficial than individual treatment of the same women. It was also suggested that greater collaboration between psychologists and medical professionals treating women with PMS in couple relationships is needed to ensure the needs of the woman and couple are met.

1.3.6 Summary

The reviewed literature indicates that both partners within a couple relationship may contribute to improving or worsening levels of premenstrual distress. However, there is a dominant dialogue of male partners in heterosexual couple relationships behaving in ways that exacerbate women's premenstrual distress; for example, through negative evaluations of PMS, a reported lack of empathy and acceptance of their

partner's PMS responses, and a dearth of support for their premenstrual partner. However, the literature also demonstrates that the majority of these perceptions derive from women's accounts, with the partner's interpretations rarely being examined. Research recognising this and, thus, using male partners' direct accounts, has demonstrated that some men do respond more positively. This tends to help lessen women's PMS distress by giving both partners the emotional and physical space to avoid potential conflict and provide the woman with practical and emotional support. It seems there is scope to further understand the male partner's experience during the premenstrual time, which the current study aims to do through an in-depth examination.

Further demonstrated in the review was that women's own responses contribute to the relational experience of PMS, leading to an exacerbation of their distress. Studies show that women's self-pathologisation of their PMS self and their tendency to engage in a process of self-silencing leads to them internalising distress. Furthermore, women's reported pessimism about their partner's ability to understand their PMS seems to limit the couple's discussion around PMS, which maintains distress. This is further supported by research looking at the joint treatment of PMS, with studies involving both partners in some interventions resulting in improvements in the partner's understanding of, and empathy with, the woman's PMS, as well as increased communication between the couple.

Overall, it seems that the majority of the literature reflects the woman's perspective on the PMS experience in the context of the heterosexual relationship. Only a few partners' first-hand accounts are presented, and these indicate a mixture of undesirable and more positive responses. Furthermore, exploration of couples' experiences from a joint perspective has been limited. It is suggested that a shared viewpoint may help to better understand the interaction between the couple during the premenstrual time.

1.4 A Review of Qualitative Studies Investigating Couples' Experiences of Living with Other Difficulties

1.4.1 Outline

The current study aims to explore couples' experiences of PMS in depth. This is an area that has not previously been widely investigated, even less so from a qualitative dyadic approach. It would seem to be important to discuss previous research in which methodologies similar to those used in the present study have been followed. It is beyond the scope of this review to include the vast body of literature around the many

different conditions and areas of psychological distress that couples may experience. I have, therefore, chosen to focus on a few that are considered relevant to the topic area of PMS. In particular, I will present findings from previous research that has examined heterosexual couples' lived experiences of other health conditions that women may experience, including endometriosis and breast cancer. In addition, I will discuss studies on heterosexual couples' experiences of depression and stigma around mental illness.

1.4.2 Couples' experiences of endometriosis

Endometriosis is a chronic condition which affects women and is defined as the presence of endometrial tissue outside of the uterus. Like PMS, prevalence reports of endometriosis vary, with some studies reporting around 10% of women of the general female population being affected and 20-90% of women with pelvic pain or infertility (Moradi, Parker, Sneddon, Lopez, & Ellwood, 2014). Common symptoms experienced include chronic pelvic pain, fatigue and heavy menstrual bleeding. Evidence suggests that endometriosis has a considerably negative impact on women's quality of life, especially psychosocial functioning, which is likely to be exacerbated by the lack of an obvious cause and the likelihood of chronic, recurring symptoms (Culley et al., 2013). A limited number of studies have examined endometriosis from a couple perspective. However, one study by Denny et al. (2013) explored the experiences of 22 heterosexual couples living with endometriosis using a thematic analysis informed by an interpretivist and gender-relational approach. It was found that endometriosis seemed to challenge women's femininity and reinforce men's masculinity. Many women openly reported experiencing feelings of guilt and loss relating to sex and intimacy, anticipated or actual infertility, and an inability to undertake domestic tasks. Some women also reported not feeling feminine and several women suggested their partners should leave them in case they could not have children. Furthermore, the women gave positive reports of their partner's ability to undertake household tasks that are typically viewed as female work.

In contrast, the men's accounts described a "stoic" approach to supporting their partner and to coping themselves: they attempted to remain calm and in control and were inclined to hide their own emotions to "stay strong". Men also described feelings of worry and helplessness around not being able to alleviate symptoms. In addition, they expressed anger and frustration with the healthcare system and the lack of any "cure" for their partner's pain, which sometimes led to feelings of helplessness. In line with dominant masculine norms, the findings indicated that the men seemed to view

endometriosis as a problem to be solved, taking on a more assertive role as an advocate and protector of their partner, but that they felt helpless when they were unable to find a suitable solution. For example, one male partner described his perception of a need to stay strong for his partner: “I don’t really tend to show a lot of emotion ... if she breaks down and she sees me sort of faltering, it’s not going to give her much support. So I guess the old male stereotype kicks in and you have to be seen to be the stronger one” (Denny et al., p. 28). These findings highlight that gender roles shape the way in which these particular couples react to living with endometriosis.

1.4.3 Couples’ experiences of breast cancer

Another condition that affects women explored from a heterosexual couple’s perspective is breast cancer. I understand that there is only a limited similarity between the symptoms of PMS and the life-threatening condition of breast cancer. However, briefly reviewing some of the key studies using a similar methodology to the current study may help to illuminate some important aspects of the couple’s experience – in particular, couples’ experiences in relation to the woman’s body and to how they cope with the illness. For example, a recent IPA study by Loaring et al. (2015) focused on couples’ experiences of breast cancer surgery and its impact on body image and sexual intimacy. Employing a dyadic design, they conducted eight semi-structured individual interviews with four heterosexual couples in long-term relationships after the women had undergone a mastectomy with reconstruction. Interviews explored both partners’ experiences of diagnosis, decision-making, body image and sexual intimacy. Emerging from the interviews were three major themes: threat, the body and communication.

Threat. The first theme focused on the time of the diagnosis and considering treatment. The men and women reported playing different coping roles during that time, with the men taking on a more practical role by gatekeeping and looking after their wives to maintain normality in the relationship. Women reported a view of themselves as being overwhelmed with information but also being perceived by their partners as strong decision-makers. As the researchers suggest, these findings highlight how couples’ responses to breast cancer may be understood as dyadic and dynamic, rather than experienced only individually by the woman who is suffering from cancer.

The body. In the second theme, a reported divergence in the women and men’s accounts occurred. Gender expectations concerning the body emerged, as women’s anxiety about the body seemed to be underlined by an implicit normative image of the female body and the breast. All the women felt discomfort about their changed body

post-surgery, with their breasts, scars, or weight gain. Many women expressed beliefs that their partner would not find them attractive because of the surgical changes to their body. Interestingly, this contrasted with the men's reports of their perceptions of their partner's bodies, which were positive and did not affect their desires to be intimate. Such findings are consistent with other studies that found men provided positive accounts (Carver et al., 1998; Hilton, Crawford, & Tarko, 2000; Wimberly, Carver, Laurenceau, Harris, & Antoni, 2005). These findings highlight the power of gendered sexual scripts; that is, the patterns of sexual relating that are shaped by personal, relational and cultural contexts, including stereotypical gender roles, and how they influence the ways in which sexual desire is understood and enacted.

Communication. The third theme reflected the couples' varying communication styles. These ranged from negotiating their way together as a unit, through concerns about body image and sexuality after breast-cancer treatment, to women at times avoiding and not wanting to discuss their concerns, and their partners trying to read their non-verbal cues in relation to situations of affection or sexual intimacy. The couples' accounts also reflected their shared ideas in relation to thinking about the future and the need to communicate more clearly to develop a relationship with their bodies and each other.

Similar to the current study, Loaring et al.'s (2015) study employed an IPA approach; however, unlike the present study, the interview data was collected and initially analysed at an idiographic level. This was explained as best enabling the exploration of different views of sensitive experiences faced in the relationship and allowing for the safe articulation of the gendered aspects of their experiences. The analysis also reflected this, with the findings from the women and men, as well as across the couples, presented separately.

In another IPA study, Antoine, Vanlemmens, Fournier, Trocmé, and Christophe (2013) interviewed 11 young French couples separately to examine their experiences of the woman undergoing hormone treatment for breast cancer. The study revealed how at the beginning of the hormone therapy both partners reported a coming together and providing mutual support; however, during treatment the male partner did not notice signs of the cancer and wished for the couple to resume a normal life, which was experienced by the women as a denial of their suffering. The women's reports indicated feeling increased isolation and withdrawal from their partner and other support in preference to the possibility of aggressive exchanges with their partner. At the same

time, the male partners also reported that they felt isolated due to their feelings of not being acknowledged by the hospital or by other loved ones supporting them. Similar findings have been reported in other studies investigating male partners' experiences of other women's health issues, including endometriosis and gynaecological cancer (for example, Denny et al., 2013; Fernandez, Reid, & Dziurawiec, 2006; Maughan, Heyman, & Matthews, 2002). In their qualitative study of men's coping with their partners' gynaecological cancer, surgery and treatment, Maughan et al. (2002) found the men's reports described that they were dealing with their own, as well as their partner's, emotions, in addition to attempting to offer support.

1.4.4 Couples' experiences of depression

Given that research indicates that many women experiencing PMS also commonly experience symptoms of depression (for example, Forrester-Knauss et al., 2011), it is important to discuss studies examining couples' experiences of depression. Like PMS, depression has traditionally been understood as an individual problem, although a growing body of research is beginning to focus more on the interpersonal phenomena surrounding depression (for example, Beach, 2001; Joiner, Coyne & Blalock, 1999).

Research has shown that there is a strong association between marital distress and depression (for example, see a review by Gotlib & Hammen, 1992). Studies have shown that when one member of a couple is depressed, generally there are more negative interactions (for example, blame, withdrawal and verbal aggression) and fewer agreeable exchanges (for example, self-disclosure, problem-solving behaviours, smiling and eye contact) within the marriage compared with couples who are not experiencing depression (for example, Johnson & Jacob, 1997; McCabe & Gotlib, 1993). Other quantitative research has shown that when people interact with someone experiencing depressed mood, they may experience a worsening of their own mood and decline possibilities of further connections (Gotlib & Hammen, 1992). Furthermore, some research indicates that when one member of a couple becomes depressed, the relationship either can be a source of strength that contributes to recovery, or can harm both members of the couple (Cordova & Gee, 2001). Furthermore, evidence indicates that some partners of depressed individuals report substantial psychological problems in relation to their caring role and the disruption to their own life (Benazon & Coyne, 2000; Coyne et al., 1987).

Qualitative studies of heterosexual couples' experiences of depression are limited. One IPA study by Harris, Pistrang, and Barker (2006) did, however, examine the support process in couples in which one member is depressed. The findings highlight several issues that are potentially relevant to the current study. Nine participants who were, or had been, depressed – eight women and one man – were interviewed jointly with their partners on two separate occasions. Interestingly, despite the gender difference, the accounts of the one depressed man and his partner were consistent with those of the other couples.

Overall, the couples reported a pervasive sense of bewilderment and struggle regarding the support process in the relationship. The partners reported that they tried hard to find ways to support their husband or wife, with varying success. As such, there was a perception that they had to tread carefully for fear of doing harm. Complicating the support process further were troubles with the couples' ways of communicating and relating, leading to each couple member often feeling isolated and frustrated. Despite these difficulties, the non-depressed partners were generally determined to provide support and the depressed partners highly valued their efforts to help. The accounts also demonstrated how 'effective' support included experiences of trust, acceptance and open communication within the couple. A major difficulty within the couple was for the partner with depression to be able to communicate their experience in words. This led to the non-depressed partner often feeling confused about what their partner was experiencing. This meant that the non-depressed partners felt frustrated, angry and impatient: feelings that they avoided expressing due to fears about the impact this would have on their depressed partner. This resulted in the non-depressed partner feeling burdened with unexpressed feelings. The non-depressed partners expressed how opportunities to talk to others (friends and family) about their feelings and difficulties enabled them to cope. However, remarkably, as the researchers note, health professionals caring for the depressed partner seemed to overlook the non-depressed partner's needs, as there was no mention of such support in their accounts.

This study's findings highlight that one partner's experience of support while suffering depression can affect the other partner and ultimately the couple relationship, leading to difficulties in communication and fewer experiences of empathy. It also demonstrates that one partner's emotional needs may go unnoticed when the other individual in the relationship is experiencing distress. This highlights the importance of including the partner in interventions intended for the depressed individual. This has

been described in more detail by other researchers as spouse-aided therapy for depression (Emanuel-Zuurveen & Emmelkamp, 1997) or as the use of healthy relationships to treat depression (Cordova & Gee, 2001).

In another narrative study, which investigated the ways in which depression is talked about in the early stages of couple therapy processes, Rautiainen & Aaltonen (2010) examined the kinds of narratives concerning depression and how couples co-construct these. Accounts were taken from three couples undergoing systemic couple therapy for depression (Jones & Asen, 2000). In two couples, the depressed individual was the wife; in the third, it was the husband. Research material was gathered from the first four therapy sessions. The study found that the depressed partner talked about depression as an individual experience that had changed their way of being in the world. Additionally, they discussed several interactional aspects of depression; for example, the practical ways in which depression affected the couple's lives, together and individually, and the lives of their children. Similar to the non-depressed partners' accounts presented in Harris et al.'s (2006) study, the non-depressed partners in this study also described depression as something that was difficult to understand and be involved in. This highlights the challenges that depression may create for the depressed person and for their partner. As the authors concluded, it is crucial to focus on the individual narrative of depression. However, it is also important to attend to the depressed partner's narrative as an interactive part of the non-depressed partner's account, as well as the couple's shared narrative of depression. It is noted that this study focused on the couples' accounts during the early stages of therapy; thus, different themes may have emerged later in the therapy process. Furthermore, the therapists' potential impact on the findings was not explored in detail.

1.4.5 Couples' experiences of stigma related to mental illness

Given that it has been suggested that stigma affects women's individual experiences of menstruation and PMS (for example, Johnston-Robledo & Chrisler, 2013; Ussher, 2006), it is proposed that couples' experiences of stigma may also be a relevant and significant area of research. The term 'stigma' refers to a distinctive, discrediting feature that leaves the individual tainted, flawed, or inferior as judged by others (Bos, Kok, & Dijker, 2001; Crocker, Major, & Steele, 1998). Theories of stigma (for example, Goffman, 1963) indicate that individuals in close relationships with someone with a stigmatised condition also suffer from the negative consequences of stigma, referred to as stigma by association (SBA). This occurs when a person is

devalued due to their relationship with a stigmatised individual (for example, someone with a disability). Goffman (1963) asserts that wider society often treats the stigmatised individual and those connected to them “as one” (p. 30). The concept of SBA is supported in other theoretical models of stigma, including one developed by Bos, Pryor, Reeder, and Stutterheim (2013). In this model, SBA encompasses the social and psychological reactions to people connected with a stigmatised person (for example, family and friends). Thus, SBA is the process through which those close to stigmatised people are also discredited (Pryor, Reeder, & Monroe, 2012). This is relevant to the current study, as the focus is on the woman and her partner’s experiences of PMS, which potentially also involves experiences of stigma.

SBA and mental illness. Studies examining the concept of SBA have looked at the stigma of mental illness in particular. For example, Pryor et al. (2012) found that experiences of SBA are strongly related to perceived public stigma (societal reactions to the stigma) and that they predict poorer psychological well-being across various stigmatised conditions. Their findings suggest that experiencing SBA is associated with psychologically distancing oneself from a stigmatised relative. Thus, SBA can directly affect the health and well-being of family members of individuals suffering with a mental illness (Angermeyer, Schulze, & Dietrich, 2003; Östman & Kjellin, 2002; Phelan, Bromet, & Link, 1998). The psychological distress caused by SBA has been described as including irritability, fatigue and pain (Angermeyer, Liebelt, & Matschinger, 2001). Furthermore, SBA encompasses experiences of social avoidance and exclusion (Larson & Corrigan, 2008).

In a recent study by Sanden, Bos, Stutterheim, Pryor, and Kok (2015), a qualitative analysis explored stigma among family members of people with a mental illness (PWMI). The study involved 211 male and 316 female family members aged between 18 and 85. The relationship of the participants to the PWMI varied, with 12.1% being spouses and the rest including parents, children, siblings, in-laws and ‘other’ family relations. The type of mental illness was selected from a list by the participant family member and included the following: schizophrenia or psychotic disorder; eating disorder; depressive disorder; addiction; personality disorder; attention deficit hyperactivity disorder (ADHD); autism; anxiety; and bipolar disorder. This cross-sectional survey study aimed to investigate the relationships between perceived public stigma, SBA, psychological distress, and perceived closeness and heredity of mental illness in family relationships. The study found that perceived public stigma and SBA

contribute to psychological distress among family members of PWMI. The findings also indicated that the belief that mental illness is hereditary is associated with greater psychological distress. Further, lower levels of perceived closeness were reported among immediate family members who had experienced SBA than among extended family members who had experienced SBA.

While this study highlights some important aspects of the relational experience of stigma related to mental illness, being a large-scale survey study, it does not allow for an in-depth study of people's experiences. Furthermore, the variety of relationships included meant that the couple relationship was not the focus. Nevertheless, these findings do provide support for clinical practice, including the benefit of involving family members in the treatment of individuals who are experiencing a mental illness. In particular, psycho-education might help to reduce SBA and reduce fears of genetic transmission. Being open about family members' mental illness within the family and with selective others may also help to encourage social support and lessen stigmatising responses (Bos, Kanner, Muris, Jansen, & Mayer, 2009).

1.5 The Current Study

1.5.1 Research aims and rationale

The principal aim of the current study is to explore the lived experiences of heterosexual couples where the woman experiences PMS. A literature search indicates that there are no existing published IPA studies investigating this topic. A further aim is to increase awareness and understanding of these couples' experiences within the health professions, in particular the counselling psychology field. In line with other researchers, such as Ussher et al. (2002) and King (2013), I believe taking a more holistic approach to PMS, encompassing biological, psychological, environmental and psychosocial aspects, may lead to providing better support for women and their partners, increasing their well-being. Through its findings, I hope to promote in the current study, the importance of women's health issues within counselling psychology; thus, I hope to challenge the stigma around PMS.

With the aims of the study in mind, I decided upon the most suitable methodology to employ. I believed semi-structured interviews seeking to examine the subjective lived experiences of participants, rather than a quantitative approach to investigate an objective reality, were most appropriate. A brief outline of the reasons behind my decision to adopt a qualitative approach and IPA is presented in the following section and is detailed further in Chapter 2.

As the literature review revealed, there is a prevalence of quantitative studies in the topic area. While these help to identify and understand how PMS may have an impact on the couple relationship, such as leading to conflict or relationship dissatisfaction (for examples, see Coughlin, 1990; Frank et al., 1993; Ryser & Feinauer, 1992), there is a focus on cause and effect. The positivist stance taken in quantitative research assumes that a “truth” exists and the “real” world can be known and described through observable and measurable variables (Ashworth, 2015). PMS is, therefore, approached in such studies from a reductionist standpoint, viewing it as an individual problem (Ussher, 1996). It is argued that women’s and their partners’ experience of PMS is subjective, meaning that it does not occur in socio-cultural isolation. This is demonstrated in the many different meanings that women and their partners give to their experience of PMS within the context of relationships and is evidenced by findings, such as experiences of over-responsibility and communication problems (Mooney-Somers et al., 2008; Perz & Ussher, 2006; Ussher, 2004). As the current study aims to gain a deeper understanding of heterosexual couples’ subjective lived experiences of PMS, I believe that this cannot be achieved from a positivist stance using objective measures.

To gain a deeper insight into the PMS experiences of heterosexual couples, I consider that a qualitative methodology should be employed. Such an approach endeavours to understand how the world is constructed (McLeod, 2001) by examining the meanings of how individuals experience realities and make sense of their worlds (Willig, 2008). Qualitative research is concerned with investigating the quality of experiences and the meaning attributed to events, rather than trying to reduce experience down to measurable quantifiable factors to examine cause-and-effect relationships (Willig, 2008). This meaning is subjective and comes from the participant’s own account of their experience, leading to rich and multi-layered subjective data. In the current study, I considered that the most useful way to access the participant couples’ subjective perspective would be to use semi-structured interviews.

Gaining a greater understanding of the subjective and intersubjective experiences of PMS among heterosexual couples has been the objective of other research in the field (for example, Rundle, 2005; Ussher & Perz, 2013). However, both of these studies are considered to be methodologically different to the current study, with Ussher’s (2013) using separate as opposed to joint couple interviews and Rundle’s (2005) being framed from a family systems perspective. The decision to use a

qualitative approach and IPA in this study was, therefore, also driven by the dearth of such research. Further, I believed that IPA would lead to producing work that would provide new insights into the heterosexual couple's experiences of PMS.

The importance of seeking out a new understanding of the phenomenon of PMS as experienced within the context of the heterosexual relationship also relates to the aim of contributing to the field of counselling psychology. Therefore, it seemed important to employ a methodology encompassing the values and ideas of counselling psychology. Rafalin (2010) describes counselling psychology as being concerned with an individual's subjective experience, being appreciative of the complexity of difference and having a focus on well-being rather than on cure. A search for understanding and attending to an individual's experience, rather than investigating universal truths, is valued. The current study's findings hope to contribute to the field of PMS research in terms of increasing awareness and insight into couples' experiences of PMS. To do this, the focus should be on the views of those who experience it. The current study, therefore, aims to adopt a phenomenological perspective to gain an insight into the subjective lived experiences of couples who encounter PMS.

To summarise, there is little in-depth understanding of how PMS affects both members of a heterosexual couple. This study attempts to fill this gap and add to current knowledge by qualitatively exploring the relational experiences of couples affected by PMS symptoms through semi-structured interviews. The use of a qualitative approach will allow for an in-depth investigation of participant couples, potentially leading to new and unexpected findings (Barker, Pistrang, & Elliot, 2002). A greater insight into relational issues concerning PMS will initiate further studies in the area, adding to the existing body of knowledge. In turn, this will inform relevant therapeutic interventions that may be professionally employed to help couples to better cope with PMS in their relationships.

Chapter 2:

Methodology and Research Method

2.1 Outline

This chapter outlines the research design and describes my rationale for using a qualitative research paradigm. A description of the methodological approaches I initially considered and reasons for selecting IPA is presented. I then provide a summary of IPA's philosophical underpinnings. Following this, I evaluate the use of couple interviews. In the methodology section I explain the epistemological standpoint taken and the ethical considerations arising and provide a reflexive summary. Next, I will present a review of the research methods, including sampling and participants and my decision to include heterosexual couples. Finally, I discuss interview procedures, transcription and the analytic strategy.

2.2 Methodology

2.2.1 Research design

The current study employed a qualitative methodology using semi-structured interview data gathered from a sample of seven heterosexual couples. Data was analysed using IPA (Smith, Flowers, & Larkin, 2009).

2.2.2 Rationale for adopting a qualitative research paradigm

Chapter 1 outlined the limited research on relational experiences of PMS, particularly those of heterosexual couples, with the majority of existing studies employing quantitative and positivist methods and a bio-medical approach to PMS. The current study aims to gain insight into the thoughts and feelings of participants to increase the understanding of PMS and its relational impact; therefore, I believed that quantitative measures, such as questionnaires, would be unsuitable. I also considered the goals of qualitative research (see McLeod, 2001) in relation to the current study. Additionally, I reflected on the objectives of the qualitative researcher, including being interested in people's sense-making and their experience of events (Willig, 2008). My use of a qualitative approach was also influenced by the advantages of qualitative methods. These included enabling in-depth and detailed studies of individuals; the freedom for participants to respond to research questions in their own way, rather than via structured quantitative methods; and the opportunity it would give me to be open to new findings (Barker et al., 2002). In addition, I considered a qualitative approach allows the accounts of potentially overlooked people to be noticed (Willig, 2001). I

hope that the current study contributes to enabling the voices of couples experiencing PMS to be heard, adding to the existing research.

2.2.3 Methodological approaches considered

Having decided upon a qualitative research paradigm, I then determined the most suitable approach to employ. I considered grounded theory (GT), discourse analysis (DA) and IPA. GT methods emphasise the generating of a theoretical-level account of a specific phenomenon and are suited to studying individual or interpersonal processes and experiences (Charmaz & Henwood, 2008). IPA and GT both have a generally inductivist approach to inquiry. However, as Smith et al. (2009) propose, IPA is likely to give a more detailed analysis of the lived experience of a small number of participants, whereas GT may use individual accounts to generate a theoretical-level account of a phenomenon. GT may have been useful if this research had aimed to develop a theory to explain couples' experiences of PMS instead of endeavouring to explore and understand the subjective experiences of a particular group of participants.

I considered using DA for this study. Willig (2001) indicates there are two main branches of DA: discursive psychology (DP) and Foucauldian discourse analysis (FDA). DP is concerned with the use of available cultural resources to achieve interactive ends (Potter & Wetherall, 1987). The current study aimed to focus on participant experience, encompassing context, cognition, emotion and language. Thus, the constructionist position of DP and its main concern with language was considered potentially too restrictive. DP does not relate verbal reports to underlying cognitions, instead aiming to explain the interactive tasks that these reports are used to perform, how they are achieved and the linguistic resources that are used. IPA is concerned with understanding participants' thoughts and beliefs regarding the investigated subject (Chapman & Smith, 2002). DP may have been more appropriate if the study had aimed to examine how couples use language to construct experiences of PMS in their relationship (Willig, 2008).

FDA describes and critiques participants' discursive worlds and examines what they mean for subjectivity and experience (Willig, 2001). FDA differs from DP because it is less concerned with interpersonal communication and more with the role of language in the constitution of social and psychological life (Willig, 2008). The current research aims to investigate the thoughts, beliefs and meaning-making of couples, rather than the ways in which social constructions could be drawn from their accounts. Therefore, I deemed IPA to be the most suitable research method.

2.2.4 Rationale for adopting IPA

My rationale for using the established analytic strategy of IPA is based on the aims of the current research to examine couples' lived experience of PMS, how they make sense of that experience and the meaning it may hold for them (Eatough & Smith, 2008). Many IPA studies have investigated experiences of living with pain and illness (for example, Reynolds & Lim, 2007; Thompson & Marriott, 2008), which are considered to be relevant to the topic area of this study. In addition, as Smith (2004) states, IPA is appropriate when the topic is dynamic, contextual, subjective or relatively under-studied, and where issues relating to identity, the self and sense-making are important. These criteria are viewed as relevant to the research aims, as the literature reviewed in Chapter 1 highlights how little is known about the relational experiences of PMS.

It could be claimed that IPA sits well with counselling psychology. Established in humanistic and existential-phenomenological psychology, counselling psychology is concerned with the examination of understanding, meaning, subjective experience, values and beliefs, and behavioural science. Counselling psychologists are encouraged to respect individuals' accounts as valid and to "elucidate, interpret and negotiate between perceptions and world views not assuming the automatic superiority of any one way of experiencing, feeling, valuing and knowing" (BPS, 2010). It is suggested that the skills required and the process of undertaking IPA research are comparable to the client work of counselling psychologists, as both involve developing relationships and engaging with the client's or participant's narrative (Morrow, 2007). Based on these points, I considered IPA to be the most appropriate approach for this study.

2.2.5 Overview of IPA

Emerging in the UK in the mid-1990s, IPA is a qualitative, experiential and psychological research approach that is committed to examining how people make sense of major life experiences. IPA was developed as a way to return to the disregarded ideas of subjective experience and personal accounts that were initially envisaged by the philosopher and psychologist William James in the 1800s. Widely applied in health psychology and increasingly in clinical, counselling, social and educational psychology (Smith et al., 2009), IPA is informed by three key areas of philosophy and knowledge: phenomenology, hermeneutics and idiography.

Phenomenology. Phenomenology is the philosophical approach to the study of "being" and experience, the ways in which humans gain knowledge of the surrounding

world and the phenomena that appear through conscious engagement with it. IPA draws upon the ideas of philosophers, including Husserl (1927), who argued we should “return to the things themselves” and focus on transcendental approaches; that is, the idea that the essential features of an object can transcend the circumstances of their appearance and be illuminated to others (Willig, 2008). Relevant to IPA are Husserl’s ideas emphasising experience as worthy of understanding and that, through ‘bracketing’, natural and taken-for-granted understandings and past knowledge can be temporarily put aside in order to see the explored phenomenon in “essence”. Husserl emphasised the importance of reflecting on things or experiences to focus on perceptions of these, which involves stepping out of our “natural attitude” (Husserl, 1970, p. 145) and adopting a “phenomenological attitude” to examine our perception of that experience. IPA’s phenomenological aspect is concerned with the in-depth investigation and clarification of an individual’s subjective account of their lived experience, rather than objective reports.

Hermeneutics. The concept of hermeneutics introduced by Heidegger (1962) is the theory and practice of interpretation. Heidegger suggests the bracketing described by Husserl is not possible and refers to “dasein” or “being there” to describe how we are always involved in the world and in relationships with others; thus, we do not have the ability to step into an objective stance (Langdridge, 2007, p. 29). IPA adopts this idea by acknowledging that the unique intersubjective experiences of the individual are inevitably embodied, and placing an emphasis on the existence of social, historical and contextual influences on the lifeworld (Eatough & Smith, 2008), with IPA analysis involving interpretation. As Smith et al. (2009) claim, Heidegger’s notion of ‘appearing’ illustrates IPA interpretation involving a double hermeneutic, with the participant trying to make sense of their experience and the researcher attempting to make sense of the participant’s sense-making. IPA also uses a double hermeneutic by combining the hermeneutics of questioning with empathy. An empathic stance attempts to appreciate an experience from the participant’s point of view, while a questioning stance aims to critically query participants’ responses, encouraging interpretative research work. Within hermeneutic theory is the hermeneutic cycle of the research process. In IPA this is both linear and iterative, with the researcher using step-by-step stages and moving backwards and forward, engaging with the data.

Idiography. IPA is strongly influenced by idiography, as opposed to the nomothetic approach that underpins the majority of psychological research. There is a focus on the particular, in terms of detail, rather than an attempt to make group- or

population-level claims (Smith et al., 2009). IPA's idiographic, rather than universal, focus may be understood in terms of its consideration of the experiences of certain people in particular contexts; therefore, IPA studies typically use small, purposely selected samples (Smith et al., 2009). IPA focuses on gaining particular detail through an in-depth examination of individual cases before making any universal claims. This ability to connect with significant themes that are central to the lives of us all is argued as leading us closer to the universal (Eatough & Smith, 2008).

2.2.6 The decision to interview couples together

Methodological issues. The first major challenge of using couple interviews for data collection and from the methodological position of IPA is IPA's preference for employing in-depth individual interview data and its focus on idiosyncratic experiences. As such, joint interviews may be viewed as departing from IPA's commitment to idiography. For example, one partner may dominate, limiting the richness of interview accounts (Tecimer et al., 2011). Other researchers have discussed similar issues concerning the balance between data at individual and group levels in IPA research with focus groups. For example, Tomkins and Eatough (2010) suggest that the group as a unit of analysis can mask the idiosyncrasy of individual views through the development of general group-level themes. Alternatively, individual accounts may be highlighted in the analysis at the expense of the group dynamic, losing rich experiential data. This idea resonated with my initial reasons for employing joint interviews, as I viewed couple interaction as possibly stimulating individual accounts in a way that separate interviews may not. In light of Tomkins and Eatough's (2010) suggestion, I attempted to find a balance by analysing and representing data at couple and individual levels; thus, multiple readings were involved, illuminating couple patterns and dynamics as well as idiographic accounts, as presented in the analysis (Chapter 3).

Further issues related to using IPA with focus groups, which are also considered relevant to couple interviews, have been discussed by Tomkins and Eatough (2010) and Palmer, Larkin, de Visser, and Fadden (2010). Epistemological concerns, such as the difficulty of "negotiating part-whole relationships" and favouring the group over the individual and vice versa, have been discussed by Tomkins and Eatough (2010). It is also suggested that the double hermeneutic process takes on an additional dimension in focus-group work; the process becomes a "multiple hermeneutic" as the researcher tries to make sense of the participants trying to make sense of their own as well as each other's experience. Additionally, Smith et al. (2009) claim multiple voices may create

difficultly in inferring and developing the phenomenological aspects of IPA. There appear to be potential benefits and problems related to using IPA with focus groups (Smith, 2004; Dowling, 2007), which I also viewed as being important to the current research.

Another important consideration is the lack of existing research in the area, which is potentially a disadvantage to the current study, particularly due to my inexperience as a qualitative researcher and the limited IPA procedural guidelines for interviewing couples and analysing such data. Existing IPA research with couples is limited; however, these studies generally used separate interviews, resulting in two distinct accounts, or interviewed one couple member (for example, O'Shaughnessy, Lee, & Lintern, 2010). One IPA study conducted by Harris et al. (2006) interviewed couples together (twice) to examine support processes in depression. Separate themes for each couple member were not identified in the analysis, as conjoint interviews were considered to lead to obvious separate narratives being unidentifiable. An email to Jonathan Smith sent by a university research supervisor (personal communication, March 9, 2011) and the email correspondence and telephone conversation I had with an author of the study, T. Harris (personal communication, July 17, 2012) confirmed the current study was a novel IPA idea, and potentially useful in gaining a couple perspective. Thus, the benefits of interviewing couples jointly, argued by several other non-IPA researchers (for example, Tecimer et al., 2011) seemed to outweigh the disadvantages.

Joint interviews have been argued as providing a more “reliable” and “comprehensive” picture than either member’s individual story (Racher, Kaufert, & Havens, 2000). Although this is not within the remit of a qualitative approach and IPA research, it does raise important epistemological questions: what is the “true” story of an experience? Is one account more valid than the other? Is there one true account? What if the couple’s accounts differ? The challenge of eliciting “‘truth’ is an issue raised in relation to IPA and focus groups, with some researchers contending participant responses may be inconsistent, some participants possibly fearing disapproval from other group members (for example, Barbour, 2007; Warr, 2005). An interest in accessing the truth in couple data seems to be more in line with a positivist approach: in the context of a qualitative approach, the ‘truth’ is perceived as relative, with no conclusive view. The aim of this study is not to find a description of the truth about

being in the “real world”; therefore, conducting couple interviews seems to be relevant to the research aims.

Ethical issues. I considered the ethical issues regarding interviewing couples together. For example, unanticipated tension arising between the couple during the interview may continue after its conclusion (Valentine, 1999). As Bailey (2001) advises, if interviewing couples together, risks of creating tension should be addressed in the informed consent process. In the current study I reminded participants that unexpected feelings may arise in interviews; thus, they could stop the interview at any time. In hindsight, the informed consent process could have included a specific point about a potential risk of being interviewed together. Further, one couple member may feel uncomfortable in the presence of their partner; thus, they might not offer certain details, or adjust their accounts to avoid presenting negative perceptions of their relationship (Valentine, 1999). With regard to focus groups, it has been suggested that the dynamic between participants possibly influences the data, with certain members dominating discussions, thereby compromising an equal representation of views (Barbour, 2007). This was seen as important for the current study, as in all but one of the cases it seemed that the men had participated at the request of their partners. This is likely to be due to the placement of participant advertisements in more “female” domains, the possible impact of which I will discuss further in the “Methods” section.

Another issue was whether the couple interview would be less conducive to discussing the sensitive topic of PMS than an individual interview. In terms of focus groups, it has been suggested that the social context of the group may either encourage support and disclosure, or create barriers to facilitating discovery (Willig, 2008). In the current study, these issues could have been more explicitly raised with couples, making it clear in participant information and the informed consent process that if they did not wish to discuss particular topics in a joint interview, couples should consider whether or not participation was appropriate. In any case, the supportive nature of the couple was actually viewed as an interesting and important dynamic for the analysis, potentially helping to illuminate couples’ experiences of PMS.

Rationale for joint interviews. My decision to use joint interviews was also influenced by the increasing number of research studies employing this method, including studies examining partners’ or spouses’ experiences of illness in the family, which focused on understanding more about living and coping with illness when a

partner is affected by physical or cognitive impairments (for example, Clipp & George, 1992; Lu & Haase, 2009). As these studies demonstrate, the advantages of this interview method include couples' ability to fill in each other's gaps and use each other to recall stories, triggering spontaneous discussion and permitting exploration of further information.

Furthermore, observing that heterosexual couples' voices were missing from the literature instilled my desire to raise awareness of this group's experiences of PMS. Couple interviews potentially offered a chance to observe and, therefore, gain insight into, the dynamics occurring between couples during the premenstrual time, such as how they view PMS and cope with it (or not), which remains largely unexplored in existing literature. My examination of the benefits and shortcomings of couple interviews led to a decision of this being the most appropriate form of data collection for this study.

2.2.7 Epistemological standpoint

According to Willig, "it is important that researchers are aware of, clear about and prepared to acknowledge and 'own' their epistemological position" (Willig, 2012 p. 14). The unspoken nature of assumptions made about the world can, however, make this a complicated process. IPA was developed from theoretical influences, including phenomenology (see Moran, 2000), symbolic interactionism (see Blumer, 1969), social cognition (Smith, 1996) and social constructionism (see Burr, 2003). I will outline some of these positions as I discuss the epistemological position of the current study.

As this research focuses on the phenomenon of PMS, which is viewed as a female body/health issue, I will discuss the feminist epistemological position. The feminist position aims to identify ways in which the dominant conceptions and practices of knowledge disadvantage women and other subordinated groups, such as those based on race, class, culture, sexuality or age, and tries to reform these to serve the interests of these groups (Alcoff & Potter, 1993). Aligned with the feminist stance, I believe that gender influences ideas about knowledge and investigation practices. The assumption that PMS creates distress could, however, be argued as misaligned with a feminist standpoint. By interviewing heterosexual couples, a central aim of the research is not to alter principal theories that disadvantage women, but to give both genders (male and female) a voice to help the couple to deal with PMS.

The intention of this study is not to investigate whether participants are describing a truth about being in the real world. It could be said, therefore, that this

study takes on a relativist ontological position by assuming that reality as we know it is constructed intersubjectively through the meanings and understandings developed socially and experientially. This standpoint emphasises the diversity of interpretations that can be applied (Willig, 2001). Therefore, it is argued that the social context in which a person operates is important to their experience. This is aligned with Eatough and Smith's (2008) idea that socio-cultural and historical processes are central to the way in which people experience the world and are linked with the understanding and reporting of such experiences. In my view, language is significant to how people experience their social world; therefore, this research has taken the standpoint that an individual's sense of self partly emerges from the processes of relations between people. This approach to IPA could be described as social constructionist by stressing that an individual's experience is mediated linguistically, culturally and historically (Willig, 2001). As Smith et al. (2009) propose, IPA subscribes to a less robust form of social constructionism than DP and FDA. The approach could, therefore, be described as lightly social constructionist due to its assumption that reality is not completely constructed through conversations and social interactions. Instead, while assuming that a real world exists, each person constructs their own version of it through observation and communication (Eatough & Smith, 2008). As Willig (2012) suggests, by not assuming that the individual's version of their experience directly reflects reality, this may be expressed as being aligned with a critical realist position; thus, the position gives a role to the particular context within which the individual is trying to understand their experience. This is still within the phenomenological position, as the experience is viewed as occurring in a particular situation, at a particular time and in a particular cultural context (Clifton, Watts, & Larkin, 2006).

IPA emphasises subjective meaning-making and considers the individual as being caught in a reality they are experiencing. This is the view of the current study and is aligned with symbolic interactionism. This perspective sees the individual as constructing their social worlds and developing their sense of self through intersubjective interpretative activity (Eatough & Smith, 2008). IPA goes beyond description, as it attempts to step outside the account and reflect upon its wider social, cultural and psychological meanings (Willig, 2012). Clifton, Watts and Larkin (2006) assert that this interpretative position allows for the meaning of the participants' experience to be drawn out for the participant and researcher. I intend to align myself with this interpretative position, aiming to stay close to the couples' accounts. I believe an interpretative position is practised by counselling psychologists and, thus, it is useful

to represent this within the current research by attending to the person-in-context. The aim is to illuminate how participants understand and make sense of their experience in the context of their history, culture and environment.

2.2.8 Ethical considerations

During the development stages, I carefully considered the ethical implications of the study. I adhered to the British Psychological Society's (BPS) Ethical Principles for conducting Research with Human Participants, as outlined in the BPS Code of Ethics and Conduct (BPS, 2006) and the Health Professions Council (HPC) standards, outlined in the Standards of Conduct, Performance and Ethics policy (HPC, 2008). The study was also granted ethical approval by the Department of Psychology of City University (see Appendix A). The issues I considered to ensure the risk of physical and psychological harm to the participants was no greater than the risk they would be exposed to in the course of their lives included informed consent; confidentiality and protection of privacy; managing potential distress; debriefing; and the dual roles of the counselling psychologist and researcher.

Informed consent. This was obtained once I had established in person with each participant that they understood the information provided. A consent form (see Appendix B) was used, expressed verbally and in writing, and was signed by participants before beginning interviews. This form explained and reiterated all the information regarding the study's purpose, what to expect in the interview, the participant's rights (the right to withdraw at any time) and the supervisor's and researcher's contact details. I assured the participants that they had the right to refuse to answer any questions.

Confidentiality and protection of privacy. This was adhered to throughout the study. All signed material, such as consent forms, and participant material, such as demographic forms, was kept securely in a locked cabinet at my home and will be destroyed once the research and assessment is complete. All participants' names and identifying details were changed during the transcription process, and the questionnaires were numbered. The consent forms containing participants' names and relating pseudonyms were kept separately from the data. All computer files with identifying details (the digital recordings of interviews) were password protected.

Managing potential distress. During the interview, participants' welfare was considered. It was particularly important that I established rapport by putting participants at ease. Prior to the interview I introduced myself, outlined the study and its

purpose and reminded couples the interview would be recorded. Confidentiality issues were covered and I explained that they could withdraw at any time or have a break if and when required. At the end of the interview I initiated a verbal debriefing to discuss the participation experience, to comprehend how participants felt and to deal with any anxieties or useful outcomes. One couple raised anxiety about the impact that PMS was having on their relationship and said that they were considering additional relationship support. I provided additional private psychological counselling contacts to the couple. I also informed the couple about contacting their GP (either individually or as a couple). I was aware that many couples had not openly discussed their experiences in depth before this time. I remained aware of any potential anxiety or stress that was created and reassured couples of the support available from the contacts given and that they could contact me after the interview if needed.

Debriefing. Participants received a written debriefing (see Appendix C) at the end of the interview; this contained information about the study and details of relevant counselling and PMS resources in the event that they required support following the interview. The debriefing also contained the research supervisor's contact details and my own contact details for participants to use if they decided to withdraw from the study or wanted to raise any other issues regarding the interview process. I advised participants that they could decline to participate, that they could withdraw consent or participation at any point and that all relevant participant data and recordings would be destroyed.

Ethical dilemmas. I also addressed particular ethical dilemmas arising due to a potential overlap between my roles as a counselling psychologist and a qualitative researcher (Brinkmann & Kvale, 2005, 2008; Russo & Thompson, 2012). As Russo and Thompson (2012) suggest, I was aware of distinguishing between my work as a counselling psychologist, which aims to build a working relationship with a client in order to help facilitate change, and that of a qualitative researcher, who aims to gather information. I was aware that I was not offering therapy and that I needed to manage any expectations that I would provide it by describing my role to potential participants as a counselling psychologist who was conducting research as part of her training. This was outlined in the recruitment advertisements, on meeting participants and during the debriefing. I was also aware of what Yanos and Ziedonis (2006) have termed as a possible "internal" and "external" blurring of roles that may occur, and the importance

of supervision to enable the discussion of any possible confusion and any ethical or practical dilemmas.

2.2.9 Reflexivity

Willig (2001) has identified the importance of personal and epistemological reflexivity. Personal reflexivity involves reflecting on how “our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research” (Willig, 2001, p.10). Epistemological reflexivity requires the researcher to reflect upon assumptions about knowledge and what we can know (epistemology), as well as assumptions about the world (ontology), that have been made during the research process. Furthermore, how these might have influenced the research and its findings. I understand that my own view of the world and the nature of my interaction with participants will have influenced the data collection and analysis. A discussion of my assumptions and their impact is included here and is explored further in section 4.6 in Chapter 4.

As a woman in my late 30s with a personal experience of mild PMS, I have an understanding of some premenstrual symptoms. Being in a happily committed marriage with two young children, I am also mindful of some of the relationship and familial difficulties that may arise and become exacerbated during the premenstrual time. As a young woman in my 20s I had suffered mild PMS, which I tried to alleviate with the contraceptive pill, unsuccessfully. When getting married and contemplating starting a family, I became focused on my menstrual cycle, which led to an increased awareness of other women’s fertility health issues, including friends and clients I was working with who suffered with PMS and polycystic ovary syndrome (PCOS). An interest in women’s health issues also led me to take a clinical placement in a women’s health counselling service. When I thought about conducting research in the field of PMS, my curiosity around relationships was also ignited by the lack of research in this area. My desire to research the experiences of couples and PMS was partly driven by a belief that there is a lack of general understanding (academic, medical and social) of PMS and a lack of existing support available.

I am aware of my potential influence on the research, including that of being a menstruating woman who experiences mild PMS as a mother and wife. During the interviewing process, I did not disclose my PMS or any other personal details; however, being a woman may have led the women to feel I might relate to what they were going through, possibly making them feel relaxed and able to open up. Alternatively, it may

have made them less comfortable and led to them fearing judgement. Being a woman may have contributed to the male participants feeling outnumbered; thus, less willing to talk openly. In the interview the women may have felt more comfortable talking, or the men may have felt a need to assert dominance, as Payne (2010) suggests can potentially occur in a couples counselling setting. I knew when going into the interviews that most of the men were likely to be taking part at their partner's request (except one participant, Douglas). It seemed that the men, however, had a great deal to discuss. Perhaps they felt safer in the context of the interview, talking to a third person rather than directly to their partner.

Previous studies, in particular the debates surrounding PMS and research conducted from a feminist perspective, may also have influenced the current research. It is possible that my own aims not to contribute to the negative socio-cultural perceptions of PMS and stigma may have influenced my interview behaviour, the schedule and the research outcomes. Although I made efforts to give minimal input throughout the interviews, it is likely that my responses to certain information, including prompts and material chosen to follow-up on, shaped the research, as suggested by Finlay (2002). Both couple members, but especially the women, might have assumed that I understood certain things and, therefore, skipped over details. In addition, as individuals and as a couple, the participants may have felt compelled to respond according to cultural norms, perhaps trying not to present negative views of their relationship. I may have heard couples report on something that resonated with my own experiences and, without realising, merged my thoughts with my understanding of the participants' information.

2.3 Research Method

2.3.1 Research aims and questions

The aim of this study is to investigate the experiences of heterosexual couples when the woman suffers from PMS. This includes the meaning of this experience to the couple, incorporating the potential effect on relationship dynamics, such as communication, coping and support. The aim is to gain a deeper insight into the PMS experiences of heterosexual couples; therefore, this study was driven by the research questions:

- What does PMS mean for the couple?
- How do couples make sense of their PMS experience?
- How does PMS impact on the couple relationship?

2.3.2 Sampling and participants

Inclusion criteria. Participants included in the study were women who self-identified, or were identified by their partners, as experiencing PMS. It was not intended that participants should have a diagnosis of PMS, so a definition of PMS was not provided. Some common symptoms, however, were presented in the advertisement as prompts such as: “Do you or your partner experience PMS?”, “Do you feel agitated and restless?” and “Do you get angry and feel out of control?” (see Appendix D). These descriptions may have influenced the self-selection. To gain informed consent, the criteria for inclusion also encompassed both participants being at least 18 years old. An upper age limit for the women was originally set at 35 years (women in the typical child-bearing age range, who have not yet entered into perimenopause). I later changed this to include women over 35 years, as I considered the original age limit to be too restrictive in terms of self-selection and not consistent with the study’s aims.

Regular menstruation cycles. To help verify the phenomenon of PMS under investigation, further inclusion criteria for the women were that they had had regular menstruation cycles (between 25 to 35 days, + or – 3 days) for the last 12 months. Women were also asked to complete a shortened version of the Premenstrual Assessment Form (PAF) (Allen, McBride, & Pirie, 1991) (Appendix E) by email prior to an interview to determine the severity of their experienced symptoms. The PAF is a 10-item retrospective measure in which the intensity of PMS symptoms is rated by the women on a scale from 1 (not present or no change from usual) to 6 (extreme change, perhaps noticeable even to casual acquaintances) during the premenstrual phase of their last cycle. The shortened PAF allows for the assessment of three PMS constructs (change in affect, water retention and pain) occurring in the seven days leading up to the onset of menses compared with the non-premenstrual period. A score of more than 30 indicates moderate PMS symptoms; the more severe the symptoms, the higher the score. This measure has been shown to be reliable, although its validity (content and criterion) has been questioned (for example, Haywood, Slade, & King, 2002). All participants recruited for the study gained a moderate to high score on the PAF measure. If this had not been the case but the participants had still identified as experiencing PMS, they would not have been excluded. The PAF measure was used to gauge the main reported premenstrual symptoms and their perceived severity in order to understand their apparent impact.

The use of a medical model questionnaire may be considered as inconsistent with the study's epistemological position. The purpose of collecting this data, however, was not to diagnose, but to be used as an additional source of information in order to understand the nature of PMS in the group being researched. It also acted as an introduction to the topic area for the participants and, in some cases, helped to establish participant rapport. On reflection, it was perhaps a combination of my inexperience as a qualitative researcher, along with my research supervisor's expertise and advice at the time that led to my inclusion of the questionnaire. Having gained more insight into and experience of the qualitative research process, I am more confident in this approach and, on reflection, I would not have included this measure and instead would have relied on the participants' self-identification.

Married or cohabiting couples. A further inclusion criterion was that couples must have been married or living together for at least one year. There were no inclusion or exclusion criteria in relation to participants having children. When developing the study, I did not consider that children would greatly influence couples' experiences. On reflection, this was a naïve view; I will discuss this further in section 4.5 in Chapter 4.

Heterosexual couples. The decision to interview heterosexual couples rather than individuals in a heterosexual relationship is supported by evidence that indicates that PMS is a relational issue (Ussher & Perz, 2008, 2013). Such research suggests that intimate partners (male or female) can influence women's ways of experiencing and understanding premenstrual change, with partners' responses contributing to the betterment or exacerbation of women's premenstrual distress (Jones et al., 2000; Mooney-Somers et al., 2008; Rundle, 2005; Ussher & Perz, 2008, 2013). A limited number of studies have proposed that changes in relationship dynamics during the premenstrual time may also affect men (King, 2013; Rundle, 2005). As male partners are likely to have a role in women's premenstrual experiences, as many women who experience PMS have a partner or spouse, I considered it to be important for the current study to take into account men's as well as women's experiences of PMS. As such, contextual evidence of couples' experiences would be brought into focus and it is hoped that the study's findings will contribute to the development of clinical interventions with this group.

The inclusion of heterosexual couples was also driven by the lack of studies examining experiences of PMS from the perspective of heterosexual couples. Although some qualitative studies have studied heterosexual women's relational experiences of

PMS (for example, Ussher, 2003), this has largely been from the woman's perspective. While this research undoubtedly does provide an insight into the heterosexual relational experience of PMS, it has not focused on examining both members of the couple together and their reflections on each other. Interviewing the heterosexual couple side by side is considered to potentially lead to an exploration of overlooked aspects of the experience of living with PMS within a heterosexual relationship; aspects that are not easily identified in individual interviews. For example, joint interviews may provide a shared reflective space contributing to producing rich data in terms of extensions, observations of couples' behaviour as well as highlighting disagreements (Bjornholt and Farstad, 2012). Furthermore, some IPA researchers suggest that exploring a phenomenon from multiple perspectives can help to develop a more detailed and multifaceted account of that phenomenon, which, in addition, is a form of 'triangulation' (Reid, Flowers, & Larkin, 2005). The perceived benefits and difficulties of conducting joint couple interviews in relation to this study are further explored earlier in this chapter in the section "Deciding to interview couples together". In summary, my decision to interview heterosexual couples was based on the limited available qualitative research in this area, which has tended not to use the joint accounts of couples, or has used a mixture of individual and couple accounts (for example, Rundle, 2005) to obtain a couple perspective. Other research has focused only on individual accounts of the heterosexual relational experience of PMS; for example, King's (2013) study on men's experiences of PMS.

As Smith et al. (2009) argue, samples in IPA must be selected purposively. Thus, my intention to focus on this group of heterosexual couples was not to privilege this sample as the only one that is interesting. Instead, it was based on the premise that it may add a particular perspective to the phenomenon of PMS defined in relation to previous research in the topic area. Therefore, my decision was further based on existing research examining gender differences in the experience of PMS, particularly the experiences of PMS within the context of lesbian relationships (Ussher & Perz, 2008, 2013). Such research has found that women experiencing PMS who are in lesbian relationships tend to report greater support and understanding from their partners than women in heterosexual relationships do. These findings are in line with broader research indicating that, compared with heterosexual relationships, lesbian relationships are experienced as more satisfying (Kurdek, 2003), more egalitarian (Reilly & Lynch, 1990; Shechory & Ziv, 2007) and involving more effective conflict resolution (Gottman et al., 2003). These gender differences have been explained as being due to the female

gender role allowing women in lesbian relationships to be more mutually supportive and empathic (Metz et al., 1994). It has also been suggested that men in heterosexual relationships are inclined to follow patriarchal ideologies, which serve to maintain inequality within relationships – for example, with regard to domestic responsibilities – as well as being emotionally and practically unsupportive (Clayton & Harris, 2004; Lamke, Sollie, Durbin, & Fitzpatrick, 1994). It is suggested, therefore, that there are differences in the way in which PMS is experienced in heterosexual and in lesbian relationships, which could be explained by gender roles. However, it seems that little research has examined the PMS experience and gender roles in depth within the context of heterosexual relationships. Thus, research on the experience of PMS in heterosexual relationships that can be compared with studies on PMS experiences within lesbian relationships seems to be limited, existing only from the women's perspective, from separate accounts of the heterosexual relationship (see King, 2013; Ussher, 2003; 2011), or from individual and couple accounts (Rundle, 2005). As such, the majority of the PMS relational research has focused on women's experiences of their male partners as being unsupportive, which is reinforced by general depictions of men aggravating women's PMS distress. It is proposed, therefore, that further exploration of men's experiences alongside those of their partner within the heterosexual relational context could help to better understand the men's, women's and couples' experience.

A further reason for choosing a heterosexual sample in this study was based on the lack of qualitative exploration of PMS experiences within this group and, to the best of my knowledge, specifically no IPA studies having been undertaken to date. As previously mentioned, and as Ussher (2011) has suggested, the majority of existing research on premenstrual distress has focused on heterosexual women (due to deliberate omission or a lack of consideration of the gender of the women's partners) (Ussher & Perz, 2008); thus, it has focused on PMS in heterosexual relationships. As the literature review revealed, the majority of these studies have applied a quantitative approach and have tended to concentrate on the association between relationship tension and PMS, as well as objective reports of marital relationship dissatisfaction or difficulty (Coughlin, 1990; Frank et al., 1993; Ryser & Feinauer, 1992). While this type of research is undeniably informative, the data gained does not provide any in-depth insight into the meaning of the experience of PMS for heterosexual couples. This is mainly because quantitative methodology, by its nature, cannot reveal the subjective perspectives of the woman with PMS, her partner, or the couple. Therefore, my decision to interview

heterosexual couples was also based on the dearth of qualitative studies in this area and a desire to understand the lived experiences of these couples in more detail.

A further reason for including this particular sample was that the literature review revealed no existing studies from heterosexual couples in a UK context, with the majority of studies conducted with samples from North America (Rundle, 2005) and Australia (King, 2013; Ussher, 2011). Some evidence suggests that there are cultural variances in women's reports of PMS experiences (Chandra & Chaturvedi, 1989; Johnson, 1987). It could, therefore, be suggested that an examination of the current sample of couples living in Britain may offer important insights into their lived experiences, which I hope will, in turn, inform clinical practice in the UK.

Exclusion criteria. Exclusion criteria included participants having a diagnosis of a clinical mental illness (for example, depression or schizophrenia) and the use of psychiatric medication (for example, anti-depressants) concurrent to the study. Women receiving treatment for PMS (for example, psychological or medical) were not excluded from the study. Although it could be argued that treatment may reduce or stop symptoms, lessening any relational effects, I believed that due to the lack of general knowledge and research in this area, along with the dearth of available effective treatments for women, this would not have a strong impact on women identifying as experiencing PMS or their partners. However, women were excluded if they were breastfeeding or pregnant within the last six months. This is based on research indicating that pregnant or lactating women usually do not have PMS symptoms (Coughlin, 1990).

Initially it was proposed that women participants would be asked to complete the Calendar of Premenstrual Experiences (COPE) (Mortola et al., 1990) (Appendix F), a prospective measure used to diagnose PMS from two recorded consecutive cycles. These results were to be used as additional information for the study and participants would not be excluded if they did not meet the diagnosis of PMS. COPE is considered to be one of the easiest prospective PMS measures to monitor symptoms; however, the majority of women were reluctant to use it. The low take-up rate (one participant) is likely to have been due to the commitment involved. Therefore, this information was not included, as it was not considered significant to the research aims. The low take-up rate of COPE and the lack of desire to monitor symptoms may reflect a lack of concern about PMS as a medical or health condition, as revealed by the women's accounts (for

example, Elaine and Denise). Women were not directly asked why they did not complete the COPE, which is a line of inquiry that may be followed up in future studies.

2.3.3 Recruitment of participants

To recruit participants, advertisements were placed on several websites: the National Association of Premenstrual Syndrome (NAPS) (www.pms.org.uk), Mumsnet (www.mumsnet.com) and PMS Warrior (www.pms.warrior.com). Advertisements were also placed on a severe PMS/PMDD internet support group on Facebook (<https://www.facebook.com/PMDDWorldwideCommunity>). The exact wording of the advertisements differed slightly depending on the website or internet support group; an example can be found in Appendix G.

Seven participant couples were recruited and interviewed based on Smith et al.'s (2009) suggestion that professional doctorate IPA research typically includes between four and ten interviews. One couple was recruited through the Mumsnet website, two through the NAPS website, two through the PMS Warrior website and two through word of mouth. The participants were aged between 28 and 44. Short case studies for each couple are included in Appendix H and are intended to be read before the analysis (Chapter 3) to provide the context of the couples' backgrounds. Demographic details of the participants considered relevant to the study can be found in Table 2, presented on the page following. I considered that the inclusion of participants' occupations may enable their identification; thus, these details were excluded.

Table 2. *Participant characteristics*

Participant Couple	Gender and Pseudonym	Age (yrs.)	Relationship status	Further details, if provided	No. of children	PAF score and level of PMS
1	M Mark F Elaine	43 39	Married	In relationship for 19 years	2	58 – severe
2	M Bob F Margs	28 29	Married		0	39 – moderate to severe
3	M James F Mary	37 36	Married		2	37 – moderate
4	M Joe F Olivia	33 33	Cohabiting	In relationship for 2 years	2 (Joe’s from a previous relationship)	28 – moderate
5	M Douglas F Samantha	44 38	Married	In relationship for 3 years	0	50 – severe
6	M Maxwell R Rita	32 34	Married	In relationship for 9.5 years	3	29 – moderate
7	M Dave F Denise	28 34	Married	In relationship for 3 years	2 (Denise’s from a previous relationship)	40 – severe

Pre-interview screening. Interested participants contacted me by phone or email, whereupon I outlined the study and answered initial queries. All the interested participants, apart from one, were women. The majority of male partners had not volunteered to participate, agreeing at their partners’ requests. They learnt about the study from their partner before the interview or from me during the interview introduction. More male interest may have been attained if advertisements had been placed in more “male” domains, which may (or may not) have influenced the data collection. I am aware that this dynamic may have an impact upon the findings.

Participants were informed that they needed to meet certain criteria in order to participate and complete a screening interview by return email (see Appendix I). Eight participants (four couples) did not meet the inclusion criteria. This was because two couples had not been in a relationship for longer than 12 months, and two couples were not cohabiting. I informed these participants that they did not meet the study’s criteria.

I then thanked them for their interest and gave them specific and general PMS support contact details.

I emailed study information (Appendix J) to those participants who met the inclusion criteria. I also asked the women participants to complete the COPE (see Appendix F). I notified them that this was not to confirm a diagnosis of PMS and, if a diagnosis was wanted, the COPE results could be presented to a GP for analysing. I also informed the women that the completion of the COPE was optional and was not a requirement to participate. When the screening questionnaire was returned by participants and I had decided that they met the inclusion criteria, I arranged a suitable time and place to conduct the interview by email or phone.

Thirty-five people (34 females and one male) emailed me regarding the research study, many of them outlining details about PMS and their relationship issues. As mentioned, the gender difference in responses is likely to be due to advertisement positioning, along with possible perceptions of PMS as a women's health issue. Interestingly, two people emailed who did not wish to participate but who wanted to communicate their views on the usefulness of the research as an under-researched area. Several women who emailed expressing interest in the research failed to meet the relationship criteria (they were in long-distance relationships, divorced or separated; some specifically due to the impact of PMS on their relationships). It could be argued that these couples were struggling significantly with the relational impact of PMS; therefore, the research overlooks these couples. This possible limitation of the study is discussed further in section 4.5. Despite this, the overwhelming interest and enthusiasm for the study suggests the prevalence of PMS distress experienced by women and couples and the need for greater support.

After initial contact, five participants were sent the screening email but did not respond and did not explain why, two participants completed the screening email but did not reply to the invitation to be interviewed, four participants did not meet the study's inclusion criteria (one in a lesbian relationship; one divorcing; one not in a relationship at the time; and one whose male partner did not want to participate). Fourteen people interested in participation emailed after the deadline; this was due to website advertisements being revisited by interested people, despite notices indicating recruitment had ended. Of the seven participant couples interviewed, none withdrew from the study.

2.3.4 Interview procedure

Semi-structured interviews. These were conducted with each participant couple together. According to Smith and Eatough (2006), semi-structured interviews allow a flexible approach to data gathering and allow for understanding the individual's experiences and meanings while maintaining an awareness of contextual factors. Participants were presented with a choice of interview location, date and time; either at a neutral location (City University), their home, or another place considered to be suitable. All the interviews took place in couples' homes and lasted between 90 and 120 minutes. Safety precautions ensured I was protected should anything problematic occur during the interviews, including initial telephone contact with each participant, followed by a close contact of mine being notified of participants' details and contact by telephone before entering and after departing the address at the end of the interview.

Demographics. Basic demographic information (age, education, employment, marital status and number of children) was collected from both couple members using the form in Appendix K. I obtained informed consent from all participants before participation. I modified the initial interview questions depending on participants' responses, which provided flexibility to explore any potential interesting or unexpected issues. The framework for the semi-structured interviews can be found in Appendix L. Consistent with IPA, I developed the interview schedule to facilitate a comfortable interaction with participants, allowing them to provide a detailed account of their experience, rather than dictate the interview direction (Smith et al., 2009). The questions were not designed to be leading and were open-ended to elicit participants' own process of meaning-making. The interview schedule was constructed to cover a range of issues. I derived inspiration for the interview questions and the structure of the schedule from a review of the relevant literature, including theoretical knowledge and corresponding standpoints.

The interview schedule. Interviews started with a question about the meaning of PMS, which intended to encourage any material that first came to the participants' minds and to help them feel comfortable with the topic. This was followed by questions and prompts relating to PMS and the influence of PMS experiences on their lives, including relationships, communication, coping skills and support experiences, as well as examples of a "typical" PMS experience. These questions aimed to elicit a detailed picture of what PMS meant to the couple. The specific questions aimed to stimulate material that stayed close to the phenomenon, but also allowed participants to share

idiosyncratic experiences. I altered the interview according to the participants, with the schedule being used as a framework. I constructed the schedule early in the research process and it somewhat reflects my inexperience as a qualitative researcher. With a greater understanding of qualitative interviewing, I would have created a different schedule that aimed for a more mutual exploratory journey and an initial description of the interview that described this. I would have been more open about my desire for participants to consider themselves the “experts” when describing their experiences. I would also have attempted to dispel any preconceptions about the interview or about me, as the interviewer, being an authority. On reflection, participating couples were very thoughtful and open overall, articulated their thoughts and feelings and reflected during the interview with minimal encouragement from me.

Debriefing. At the end of the interviews, participants were verbally debriefed and provided with written debriefing information (Appendix B). The interview recordings were transferred to a password-protected PC and a removable hard drive stored in a locked cabinet at my home. I informed participants that the recordings would be destroyed when the research and assessment were completed.

Pilot interview. I initially tested the interview schedule in a pilot interview with a couple who did not meet the study’s criteria. They were engaged to be married and had been in a non-cohabiting relationship for 18 months. Due to this couple not fitting the criteria, I did not include their data in the final analysis; the data may have affected the homogeneity of the sample, which Smith et al. (2009) state as important to IPA. This pilot interview, however, provided me with an opportunity to pre-test the interview schedule and focus on the organisation and wording of questions. It allowed me to consider participants’ responses and to rehearse. Being inexperienced in conducting qualitative IPA research, I found this useful for the research process.

2.3.5 Transcription

All interviews were recorded on a digital recorder and transcribed verbatim by a professional transcriber instructed to transcribe line by line and include non-verbal information, such as broken words and sentences, laughter, crying and behavioural occurrences (for example, leaving the room), so as to create text as close to participants’ accounts as possible. To maintain anonymity, all identifying details were changed after transcription while re-listening to the interviews. These details included names (of participants and other individuals they referred to), location names and other identifying details as far as possible to protect privacy. Closely re-listening to the interviews while

following the transcribed text ensured no details were excluded and any small changes could be made.

2.3.6 Analytic strategy

The IPA approach is committed to examining how people make sense of their experiences and is concerned with exploring that experience on its own terms (Smith et al., 2009). IPA uses a set of common processes and principles that are applied flexibly according to the task. IPA analysis has been described as an iterative and inductive cycle, moving from interpretation of “part” to “whole” (Smith et al., 2009). Before beginning my analysis of the transcripts, I attended an IPA workshop led by Pnina Shinebourne, an experienced IPA researcher. It recommended a thorough analysis as being highly important for novice IPA researchers and advised reading a peer-reviewed article by Gee (2011), which inspired the A3 format of the analysis.

As suggested by Smith et al. (2010), each interview was analysed separately. The first stage involved listening to the interview several times while reading and re-reading the transcript. This allowed for the creation of a mental picture of the couples talking while reading the narrative, which helped begin the process of entering into their worlds. While listening and reading, my first impressions were recorded and I highlighted anything that stood out within the accounts. I made notes of any recollections and observations of the interview experience and recorded them throughout the transcript. Willig (2008) suggests such notes allow for the documenting of initial significant observations and could include associations, questions, summaries, comments on the language used, and absences. I found that my counselling psychology training was helpful at this stage, with comments being made on processes in the interview; for example, emotional reactions and tone.

The next stage involved recording exploratory commentary, including descriptive, linguistic and conceptual comments. Descriptive comments focused on describing the content of participants’ accounts (specific words, phrases and terms); linguistic comments concentrated on exploring the specific use of language, including non-verbal language (for example, pauses, laughter and metaphors); and conceptual comments focused on getting to the underlying meaning of accounts, thereby using more psychological terminology. I noted these in the right-hand column of the transcript and I colour coded them for easier identification.

I then identified and developed the emergent themes from the initial exploratory notes and recorded these on the left-hand side of the transcript. I aimed to transform the

initial notes into more specific themes and phrases by focusing on the psychological content of the couples' accounts. Initially it was difficult to devise theme names that succinctly depicted the couples' experiences; this became easier as I realised these were not definitive and could change. Throughout this process I re-read each transcript several times to ensure the emergent themes represented participant couples' narratives.

I chronologically entered the emergent themes recorded on the transcript into a table. I printed this list to help me to connect the themes with the cluster themes according to apparent links and similarities. I then gave these clusters tentative labels. This clustering of themes involved an iterative process of continually checking the theme labels against the transcript to ensure connections between the identified quote and theme labels.

I created a summary table of the cluster theme labels and the themes emerging from the transcript with their corresponding line numbers and relevant key quotes. This allowed me to link each emergent theme and cluster theme to the original text for easy tracking throughout the analytic process, ensuring the study's validity. Where I considered that an emergent theme represented the "spirit" of the cluster, I used it to label the cluster theme.

I conducted the above stages separately for each transcript. During this process I was aware of remaining open to new themes evolving in subsequent transcripts and of trying to bracket ideas emerging from the analysis of previous cases. I did this by attempting to treat each case on its own merits, giving myself space before moving on to the next case, and systematically following the steps in the analysis process for each case (Smith et al., 2009). This process also helped me to keep in mind the importance of allowing myself to be curious and interested in each couple's subjective experience. Taking such measures during the analysis stages to, at best, recognise any held preconceptions is considered by Smith et al. (2009) as important to the research process. This is because it allows for an opportunity to examine and reflect upon any assumptions and judgements taken for granted so as to be open to the participant's experience. While following these steps, however, I also realised that my previous experiences would inevitably influence the interpretative analysis. I was also aware that the notion of bracketing, or putting to one side taken-for-granted ways of living in the world of objects, as originally described by Husserl (1927), is a controversial aspect of IPA. As such, IPA takes on a Heideggerian perspective to bracketing, in which the researcher attempts to identify their basic understanding of a particular phenomenon,

but also acknowledges that an awareness of these “fore-conceptions” may not become evident until work has started on the interview or the analysis; that is, until the phenomenon has started to emerge (Smith et al., 2009). A “sensitive and responsive” approach to data collection and analysis by the IPA researcher is attempted that allows any preconceptions to be prodded and adjusted by the data (Larkin et al., 2006, p. 108). In this form of bracketing, Smith et al. (2009) stress the need for the IPA researcher to pay careful attention, to empathise, and to engage with the participant: in doing so, a dynamic or cyclical form of bracketing occurs and the researcher enters a hermeneutic circle as they engage in self-reflective practice. For example, while the researcher may attempt to bracket their scientific and theoretical assumptions about the research topic, these may only be discovered once they start to engage with the data. Thus, IPA recognises the importance of the researcher’s presuppositions and that they can enhance as well as impede interpretation.

During the research process, I was aware of attempting to bracket my pre-understandings, but also trying to use them as a source of insight when interpreting the participant couples’ lived experiences. I tried to take on the research position Finlay describes as being “distanced and detached, but at the same time open and fully involved” (Finlay, 2008). This included engaging with what Finlay describes as hermeneutic reflection, by being proactively self-reflective; that is, being reflexive, or attempting to facilitate an awareness of my relationship with the participant’s data. For example, as part of my reflexive practice, before conducting the interviews and throughout the research process, I asked myself questions included in the research interview, such as: What does PMS mean to me and to my own relationship with my partner? This enhanced my self-awareness of the influence of my own experiences of PMS within a couple relationship, which, in turn, helped me to empathise with many of the experiences expressed by the participant couples, enhancing the level of my engagement with them during the interview and analysis stages.

Once I had conducted an initial analysis of all the transcripts, I reviewed each table of themes. I re-read the transcripts and checked the quotes, ensuring that they represented emerging themes. During this process, I put aside any quotes that I did not consider to be representative of the emerging themes and reordered the clustering.

I then performed the analysis across cases. I compared and contrasted each cluster of themes across the participant couples and examined connections between participant couples’ theme tables. I constructed a master table of themes for the group. I

grouped clusters of themes together to form superordinate themes that aimed to capture the majority of the participant couples' data. To this table I then added themes, participant references and line references for quotes. Examples of the audit trail can be found in Appendices M, N, O, and P. During this stage I sifted through the data set and put aside any quotes and themes that I considered to be less relevant. This led to a final paring down of the data to prepare for the write-up.

Once the analytical process was complete, I began the writing up. During this process I constantly re-evaluated and re-worked the theme labels and continued to reference the transcripts. I also edited some quotes to improve readability. I omitted words that I considered to be unimportant for understanding the main idea of the quote, taking care not to alter the meaning. My final selection of themes and quotes reflects an immersion in the data and my consideration of the relationships between the quotes, themes, and transcripts. I translated these themes into a narrative, which is reported in the following analysis section (Chapter 3).

Chapter 3: Analysis

3.1 Introduction

This chapter presents the superordinate and related subordinate themes derived from IPA. My interpretation of the lived experiences of the participant couples is also presented. As such, the analysis incorporates the similarities and differences among the couples, as well as the relevant interactional processes. Furthermore, intersubjective experiences are explored, including the couples' emotional impact on me as the researcher and how this influenced the interview. These reflections are presented in ***bold italics***. The findings presented are based on interpretation; thus there is an element of subjectivity throughout the analysis. To contextualise the couples' experiences, background information about each couple is provided in Appendix H. The following three superordinate themes emerged from the data:

- (1) The “curse” of PMS
- (2) Connection and disconnection: the importance of communication and intimacy
- (3) Beyond the couple: social influences on the relationship.

These superordinate themes depict the complexity of the couples' experiences and highlight some of the most meaningful extracts emerging from the research. The themes are not necessarily distinct, as there are overlaps between and within them. Participants' quotations are marked with their pseudonyms and with transcript line reference numbers and are presented in *italics*. A summary of the superordinate themes is presented in Figure 1.

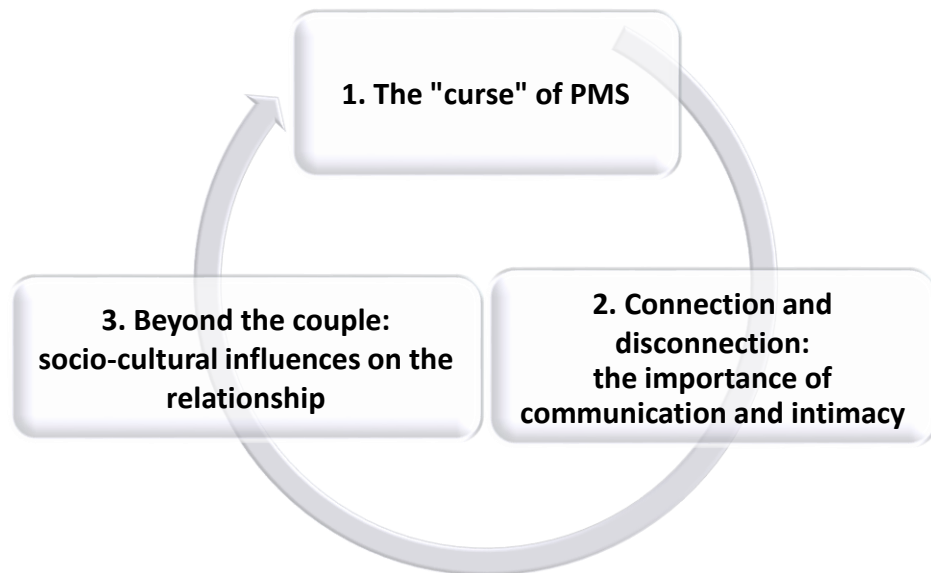


Figure 1. The three superordinate themes and their relation to each other

As the diagram shows, the couples’ perception and experience of PMS as a “curse” has an impact on communication and intimacy. This affects how the couples are able to cope with PMS within the relationship. Further influencing the couples’ PMS experiences are social and cultural norms and expectations, as well as the stigma attached to the PMS experience. Attention will now be focused on each superordinate theme and its subordinate themes.

3.2 The “Curse” of PMS

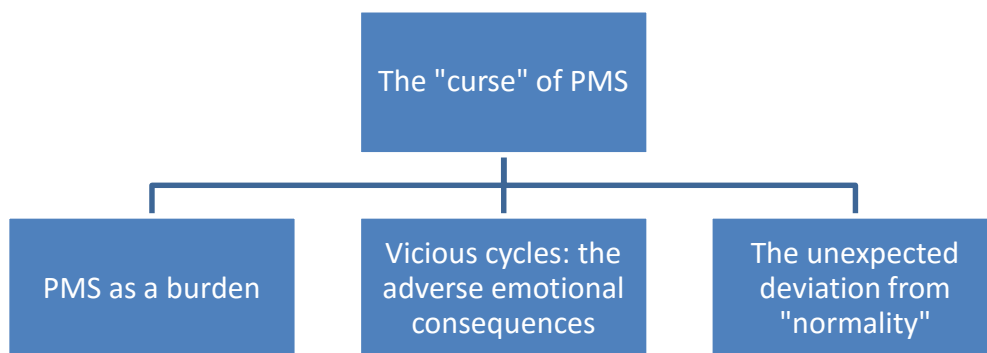


Figure 2. Superordinate theme (1): The “curse” of PMS and related subordinate themes

This superordinate theme describes the couples’ attempts to make sense of PMS in the context of their relationships. The label “*the curse*” was mentioned by one of the participants (Mary, 307–308) and encapsulates the majority of the couples’ shared

experiences of PMS. Mary reports that her mother referred to PMS as “*the curse*”, inferring a generational influence on negative constructions of PMS. Mary also uses this term to describe her experience of PMS within her relationship as a form of adversity or misfortune. Additionally, a curse can refer to harm inflicted by supernatural or magical powers (such as witchcraft). Such a view of PMS can maintain or emphasise the mysticism that surrounds it. For the couples in this study, it reinforces the position of PMS as “bad” and difficult to control: a curse.

As Figure 2 shows, this superordinate theme contains three subordinate themes. The first, ‘PMS as a burden’, demonstrates how PMS is regarded by the couples a highly negative and problematic experience that adds to the hassle of their lives. The second, ‘Vicious cycles: the adverse emotional consequences’, describes the negative emotional effects of PMS; most notably, anxiety and depression. The third subordinate theme, ‘The unexpected deviation from “normality”’, explores how the couples describe PMS as an unexpected phenomenon. PMS leads to a change in how the couples usually relate to each other outside of the premenstrual time.

3.2.1 PMS as a burden

Among the couples there is an overwhelming sense of PMS experienced as a negative, unwanted, and disliked experience creating disturbance. All the couples describe a pervasive and entrenched negative perception of PMS. The majority also struggle to identify anything positive about their experience. The couples use such descriptions as “*negative*” (Dave, 908–918) “*loads of stress*” (Denise, 33–34); “*a grey cloud*” (Douglas, 35); and “*an extra thing to have to deal with*” (Mary, 72). This language portrays a heavy, problematic and an undesirable experience.

The majority of the couples express difficulty being able to consider anything positive about PMS. For example, Rita conveys disbelief at this possibility: “*Is there anything positive, has anybody ever said anything positive? I can’t think of anything positive*” (Rita, 276–278). Rita’s doubt is inferred by her repeated questioning. She seems curious about how her experience of PMS compares with that of others. Rita may have been seeking validation for her own negative experience, either from me or through others (research participants), as inferred by her use of “*anybody*”. *In our meeting, I sensed Rita’s feelings of hopelessness and scepticism, highlighting the sense of PMS as a burden. This may have been reinforced by her previous experience of postnatal depression. I responded in a way that encouraged a sense of hope by letting her know that, although it was not necessarily usual to consider PMS in a*

positive light, it was possible. Rita paused, perhaps indicating further reflection. However, she may actually have been communicating a sense of failure or inadequacy for not considering PMS a positive experience when others may do so. My reflection, therefore, may have led to reinforcing her sense of hopelessness and, thus, the sense of PMS as a burden.

In contrast, some of the couples report positive aspects of PMS. These include the opportunity to strive for greater self-compassion and self-acceptance. In this sense, PMS is not depicted as a burdening experience. PMS is also perceived as providing a legitimate space within the relationship to express internalised frustration, anger, and sadness. Nevertheless, these responses are not immediate or “natural”. For example, it is evident that some couples need time to ponder this and most struggle to reflect on this alternative possibility. This indicates that PMS is more typically perceived as burdensome and seems to answer Rita’s earlier question of whether “*anybody has said anything positive?*” (about PMS). This perhaps demonstrates the power of negative social and cultural influences on the couples’ perceptions of PMS. Thus, there is a tendency to focus on associated unfavourable PMS responses, reinforcing the sense of PMS as a curse. This is captured in the following excerpt from Mary and James. Earlier in the couples’ account, James reflects upon and then challenges the idea of the PMS experience as being a wholly ‘negative’ one. Here Mary expresses her “*surprise*” at James’ perspective:

Mary: I don’t think I’ve ever heard you wonder if it was a positive thing; that surprised me.

James: [...] I mean we’ve never sat down and talked about it like this, but I just wonder, I don’t know, it’s just a wonder of whether, I mean it’s just ... maybe what we do, maybe how we deal and what we do with it, you know, like everything it can be improved but maybe it brings something to us that we’ve never quite, we’ve never really realised. Or maybe it doesn’t [laughs], maybe.

Mary: I don’t think we’ve really talked about it much when we’re, I’m in a positive stage of the cycle rather than when we talk about it probably in, negatively when it’s affected us but it may not. If you come in two weeks’ time, it might be a bit different [laughs]. (Mary and James, 342–349)

This extract demonstrates the extent to which PMS is viewed negatively and is possibly embedded as an adverse relational experience. It also shows that James may

value this particular opportunity to deliberate further with Mary, as indicated by his comment: “*we’ve never sat down and talked about it like this*”. This is considered to be a strength of this research, as the interview perhaps provides a space for the couple to be able to communicate their inner thoughts. This is something they may not be able to do easily in their everyday lives. The integration of my skills as a clinician (for example, empathy and active listening) and as a researcher (for example, interest in the topic) may have helped to facilitate this process.

The idea of PMS as a burden or curse on the relationship is further expressed by the couples in their common perception of PMS as a “no-win” situation, creating a mutual sense of defeat and hopelessness. This is captured by Dave and Denise:

Dave: To me it [PMS] means losing a bloody battle, that’s how it feels; it’s a burden that I can’t shake for me personally. The same as you, I feel like I’m always on edge even at the times where you’re not displaying symptoms because I find I just, you know, look forward to it with that trepidation or, you know, eggshells all the time even at the good times sometimes. Yeah, PMS means many things.

Denise: None of them great.

Dave: No, not in that sense. PMS means locking your doors.

Denise: Yeah it does, it means kind of like battening down the hatches.

(Dave and Denise, 27–34)

Here, Dave graphically expresses the sense that PMS drains the life (blood) from him and the relationship; he refers to it as “*losing a bloody battle*”, highlighting its burdensome nature. His use of “bloody” has several connotations. First, as a profanity, it directs a sense of dislike and anger toward PMS and, potentially, Denise. This is reinforced by the perception expressed by the majority of the couples that PMS is part of, rather than external to, the woman. Furthermore, “bloody” may also refer to menstrual bleeding; the outcome of the premenstrual phase. It also refers to the goriness and injury that a ‘battle’ may entail. There is a sense that this couple views PMS as a time of immense difficulty and struggle. Their shared use of terms indicates a need to protect themselves from the many dangers that PMS creates for their relationship. For example, Dave’s expression of “*locking your doors*” and Denise’s phrase “*battening down the hatches*” indicates a shared perception of the need to prepare for a crisis. This relationship crisis could be an unspoken sexual, physical and

emotional distance between the couple. The terms they use can be regarded as metaphors for their physical and emotional “shutdown” during the premenstrual time. For example, Denise may be indicating that she is “*battened down*”. At the same time, perhaps for Dave, PMS feels like being “*locked*” out of the relationship sexually, physically and emotionally.

The majority of couples express views of the premenstrual time as difficult and PMS as a problem. As such, couples express a mutual desire to reduce or “*eradicate*” PMS. For example, Elaine describes considering the option of a hysterectomy (Elaine, 941–943). The following excerpt from Elaine and Mark communicates their desire to treat PMS like a physical illness:

Mark: *Well, I mean it's always been a negative thing in my mind. I mean it's hard for it not to be ... and certainly I think, clearly, if someone was to invent something tomorrow that had no side effects that would moderate it, you know, I think we'd regard that as a very good thing, wouldn't it ... and just take, it would take the edge off ... it would certainly be very welcome.*

Elaine: *[...] the fact that it's there every single month, it's just an added hassle and pressure on sort of what is already a life that is filled with sort of added pressures and it's just like one more thing that you have to sort of cope with and, yeah, if I could take something tomorrow that would completely eradicate everything and would be safe, then I would do. I mean, yeah, it's just a constant annoyance.* (Mark and Elaine, 925–938)

Mark considers PMS as undesirable. This is further emphasised by his use of the word “*hard*”, suggesting his negative perceptions are inflexible. The phrase “*take the edge off*” conveys a sense of anxiety about being able to find a solution that reduces uncomfortable feelings. It is reminiscent of the language of a drug addict who is looking for a “quick fix” to relieve discomfort. Mark and Elaine communicate a shared wish to eliminate PMS by taking “*something*” that has no “*side effects*” and is “*safe*”. Mark’s reference to “*someone*” who was to “*invent something tomorrow*” reiterates a perceived mysticism around PMS, which is echoed in Elaine’s description of an imaginary cure that would safely “*eradicate*” everything. The couple seem to be searching for a magical cure prescribed by someone who does not exist within Western medicine (for example, a magician or shaman). This resonates with the sense of PMS as an unnatural curse. However, the couple’s joint wish may never be realised, again emphasising PMS’s burdensome nature. This excerpt is taken from the end of the couple’s account. It

demonstrates just how fixed the negative view of PMS is for this particular couple: a perception that is commonly expressed across the participant couples.

Overall, Mark and Elaine appear to manage the “problem” of PMS and its negative impact together. The majority of partners support the women’s desires to reduce their distress (for example, medically). However, there are discrepancies in the couples’ accounts of the reasons for trying to manage PMS in the relationship. This is evident in the majority of men reporting that their partners’ feelings of guilt and regret about their PMS behaviour are unnecessary. They express a view of premenstrual responses as being an unchangeable part of their partner, reflecting the discourse that PMS is part of a woman, intertwined with her personality.

Many of the male partners express a desire to actively support the women, discouraging self-blame. These partners express a sense of empathy; thus, perhaps there is also a greater acceptance of vulnerability. In particular, Douglas and James empathise with their partners’ feelings of guilt and perception of PMS as a personal failure. The two men also appear to disagree with their partners’ self-blaming tendencies, as illustrated by James’ comment to Mary:

... that’s just the way you are... I can’t change it [PMS], I might not like it but I can’t change it...you’re just a human being, you know, just a human. (James, 316–319)

James describes PMS as an unlikable part of Mary’s character that cannot be easily changed. James perceives Mary as “human” and, therefore, fallible. His use of the first person throughout this excerpt may also be a reference to his own imperfections as a recovering drug addict. For Douglas as well as James, the empathy they each have for their partner’s PMS responses may be influenced by ideas about their own vulnerabilities. During the interviews, however, it appears that the couples might not have discussed this openly or at length before; in particular, feelings of guilt and self-blame. *Slowing the interview down in order give the couples space to explore such issues in depth seemed to lead them to experience some relief (through crying, consoling, and affection) from feelings of guilt and responsibility related to PMS. Therefore, this may represent another way for PMS to be viewed more positively in the relationship – as a problem that can be worked through together, lifting the curse and lessening the burden.*

3.2.2 Vicious cycles: the adverse emotional consequences

Across the couples' accounts, the adverse psychological impact of PMS on the relationship contributes to their expressed perception of it being a burden. The adverse emotional consequences that surface between the couples during the premenstrual time include anxiety, depression and anger, usually followed by anticipatory anxiety about the next cycle. There is a sense of PMS as a vicious cycle, reinforcing the idea of the curse. Denise and Dave summarise their experience:

Denise: So I just feel like we're in a continuous cycle of I go down, you come down with me, the kids get caught in the middle and we are trying to scramble our way out the top and then just as we do, it all kind of goes down again and that, for me, makes me feel very "well what's the point then, because it's only going to be same next month?" So it feels like a never-ending cycle ...

Dave: It does, doesn't it ...?

Denise: Of stuff that I'm never going to climb out of.

Dave: It does feel very difficult, doesn't it, to...?

Denise: It's very overwhelming. (Denise and Dave, 128–136)

As Denise talks, there is a sense of despair and hopelessness. The feeling is that she is falling into a deep hole, followed closely by Dave. The children are left with the impact of the withdrawal of their parents. There is an effort to “scramble” out of the hole, however their attempts are hindered and they are left in a “continuous” and “never-ending cycle”. Although Denise refers to Dave and the children, there is a sense of loneliness, as she moves from using “we” to “I”. It seems that Denise feels alone in her experience, despite Dave’s recognition of the difficulty of the experience. This is highlighted by Dave’s responses, which Denise appears not to acknowledge. The scene Denise and Dave describe is reminiscent of the story of *Alice in Wonderland*, where Alice stumbles into a strange and disorientating alternate reality. This resonates with the mysticism surrounding the PMS experience.

The notion of PMS as an unbreakable negative cycle is further captured in the sense of anxiety the couples express. This is evident in their anticipation of the negative effects of the next menstrual cycle and its potential relational impact. The couples’ fears are mainly based on past negative experiences and imagined future events. For example, Rita and Maxwell’s worries are based on a previous experience of postnatal depression after the birth of their third child. Rita’s premenstrual low mood is a reminder of the

experience of depression and its negative impact on her, Maxwell and the rest of the family. In contrast, other couples express worries about problematic PMS symptoms creating potential future difficulties in their relationships. For example, for Elaine and Mary, particular PMS responses trigger fears about menopause and how this may negatively affect their relationships (Elaine, 625–634; Mary, 323–324). Similarly, Douglas and Samantha discuss PMS-related anxiety as triggering worries about the future of their relationship. Douglas fears that the current difficulties in his relationship with Samantha at the premenstrual time are a “*sign*” of more serious problems between them (Douglas, 193–194). The use of this word emphasises PMS as a potential relational “*curse*”, reiterating the mysticism around it. In support of this, Douglas is the only male participant who approached me to be interviewed. This may reflect the strength of his concerns. The couple’s anxiety is illustrated again later in their accounts when describing particular relational fears related to PMS:

***Samantha:** For me it’s feeling on edge and not feeling relaxed. I always feel like it’s there and something could go ... wrong. You know, you don’t ever feel stable because you, you worry, you know, about what it’s going to do that I, it’s going to, you know, make me impossible and you’re just going to get sick of it, or that I’m making demands on you that are not reasonable and you’re not getting what you need and, yeah.*

***Douglas:** Yeah, for me it pretty much parallels that. There’s always somewhere deep down the worry, that feeling I can’t do much to make her, like, let’s see, happier and it’s just going to drag me down with it until the point eventually she’ll sort of get sick and want to move on. I’m not saying that I actually think that of you but ... (Samantha and Douglas, 999–1011).*

Samantha suggests that her unreasonable demands of Douglas may lead him to become “*sick of it*”; thus, sick of her. She may also be describing her dislike of particular self-aspects, perceived as “*demanding*” and “*unreasonable*”. Also evident in this excerpt is a sense of miscommunication between the couple, reflected in Douglas’ description of his experience as not entirely but “*pretty much*” paralleling Samantha’s. Miscommunication is further revealed in the different ways in which Samantha and Douglas use the term “*sick*”. The word could be understood as meaning boredom or feeling fed up with each other and the relational impact of PMS. It may also be interpreted as illness. This is reflected in Douglas’ suggestion that he will be ultimately “*dragged down*” and negatively affected by PMS, perhaps indicating that he will be

cursed in some way (for example, by becoming depressed). This would lead Samantha to “*move on*”. Here Douglas may also be referring to himself moving on from Samantha. This is demonstrated in his self-justification at the end of his comment. He may be alluding to potential unexpressed negative feelings about Samantha and his relationship.

The couple’s miscommunication could be due to the different ways in which men and women tend to behave when faced with a problem. For example, men have a natural tendency to be solution-focused. Perhaps Douglas feels helpless about his inability to “fix” Samantha, as indicated by the comment: “*I can’t do much to make her [...] happier*”. Douglas’ worries about being unable to help Samantha lead to doubts about whether she will get sick of his inability to help her (and him) and “*move on*”. This indicates that they are both unhappy in their relationship, illuminating the adverse relational impact of PMS. In this excerpt there is a sense that due to the chronic impact of PMS, Douglas and Samantha are finding it difficult to experience the positive feelings toward each other that perhaps they once did.

The vicious cycle of PMS and its adverse emotional consequences are further encapsulated in the negative relational outlook the couples report as occurring during the premenstrual time. This could be interpreted as consistent with the emotional and cognitive experiences of depression. No couples were receiving treatment for depression; however, several describe a history of various presentations and diagnoses of depression (for example, Rita, Elaine, and both Denise and Dave). This indicates a potential for these couples to experience depressive responses during the premenstrual time. For example, through metaphors the majority of the couples report that PMS signifies depression. Douglas describes PMS as “*like a grey cloud has descended for a period of time ... a sort of grey cloud of tension and depression*” (35–37). Similarly, Elaine says it is “*like a black cloud coming over every month*” (18), while Denise describes the premenstrual phase as “*black*” (2273). The couples also express a variety of depressive thoughts and behaviours occurring between them during the premenstrual time. These include negative appraisals (both self and partner directed – as irritable, unresponsive, and attacking), negative predictions about the future, and withdrawal from each other (as a form of self-protection).

Although most of the depressive cognitions and behaviours appear to come from the women, depression affects both members of the couple because the dyad consists of two individuals. Depression leads the couple members to feel distant and isolated. This

is most evident in the common reporting of behavioural and emotional withdrawal. For example, Elaine describes withdrawing from Mark, her children and her responsibilities during the premenstrual time (165–166). Dave describes Denise as retreating into a “*bubble*”, leaving him feeling isolated and annoyed about having to take on more responsibility in the relationship (for example, financial decisions).

Depressive cognitions were also evident in the many negative self-statements and beliefs the women report about the body and physical appearance during the premenstrual time. For example, several participants describe their premenstrual self as “*ugly*”, “*fat*”, or “*horrible*” (Olivia, 191–192; Margs, 380). The different ways in which these statements were noticed and responded to in the relationship may contribute to how PMS-related distress and negative self-evaluations in general are perceived and experienced within the relationship. For example, Joe notices Olivia’s bodily changes, including becoming “*bloated*”; however, it seems that he does not try to alleviate her distress by making more positive statements. Such a response may be interpreted as a lack of Joe’s awareness or supportiveness to Olivia. In contrast, Bob responds to Margs’ self-critical thoughts, feelings, and low self-esteem in a supportive and positive way (Margs and Bob, 197–200). Margs reports that Bob is “*very loving*”, “*patient*”, and that he lets her know she is “*beautiful*” (520). These more helpful responses may help Margs feel more supported by Bob while experiencing PMS. Interestingly, these two couples share similarities: they are the youngest of the participant couples and do not yet have any children. Perhaps this indicates that these couples focus more on bodily changes and the related ideas of attractiveness and value. This is not as prominent in the accounts of the other couples.

As this subordinate theme has shown, overall the majority of the couples struggled with the adverse emotional consequences of PMS, including experiences of anxiety and depression.

3.2.3 The unexpected deviation from “normality”

This subordinate theme entails the sense of PMS as unexpected. This is reported by the couples as the experience of being surprised by the arrival of PMS each month. For example, Mary says to James: “*it still each month seems to surprise you, it surprises me sometimes*” (107). I found this particularly striking considering that the couples also reported their PMS experience as highly burdensome, negative, and problematic. The fact that it creeps up unannounced reiterates the sense of PMS as a curse on the relationship. This is reinforced by the couples’ lack of preparation; for example, not

diarising the menstrual cycle. The majority of the couples attribute this to the irregularity of presenting PMS symptoms (for example, Samantha and Douglas, 946–953; James and Mary, 452–458). The common expressed absence of preparation and thinking about PMS leads to a delayed reaction. This results in a range of emotional reactions, including fear and confusion. For example, Elaine explains her experience and some related consequences:

... it's the times when I've not been aware at all and I've not given it [PMS] a second thought and then it's come upon me that I've felt frightened ... because I didn't know what was happening. (Elaine, 291–293)

Joe also describes a lack of recognition of Olivia's cycle:

... it's like the penny dropping, it's like, "Oh I see, but why is, why is she being so unpredictable?" or not unpredictable but just like not letting things go and then suddenly I think "Oh maybe, maybe it's that, maybe it's PMS"... And it just suddenly sort of clicks that "Ah", because you're not looking for it or thinking about it. (Joe, 31–35)

These extracts from different couples demonstrate the common experience of a delayed realisation, or unawareness, affecting both members of the couple in different ways. Elaine's excerpt highlights that many of the women experience PMS as an internal change: a part of themselves that is usually feared. Joe's excerpt highlights that the majority of male partners perceive PMS as something external that creates confusion and unpredictability due to its impact on their partner's ways of relating. Both of these experiences ultimately contribute to a sense of confusion. The participant couples' delayed realisation or unawareness could be interpreted as a denial of the impending consequences of PMS for the relationship. It could also reveal the coping strategies these particular couples use to manage stress (for example, avoidance) or the consequences of PMS as a traumatic experience (for example, memory loss). A deviation from "normality" implies the existence of an "abnormal"; thus, a polarisation or split occurs between the PMS and non-PMS time. Many couples report underlying expectations of the woman (both self- and partner-directed) to be emotionally and behaviourally stable in the relationship. For example, several women report that PMS leaves them feeling incapable of doing things they are usually competent at, such as being organised or sociable; Margs expresses this change as loss of "*progress*" or "*consistency*" (208–209). Margs is annoyed about this, indicated in her tone and in her description of feeling "*really resentful even talking about it*" (208–209). Perhaps

underlying Margs' resentment is the socio-cultural expectation that women should remain in full control of themselves at all times: an experience reported by all the women.

For some couples, a change in normality leads to not feeling understood, which creates distance in the relationship. For others, it means a temporary shifting of relationship roles. For example, Margs' deviation from her "normal" trait of being organised is positively handled by Bob through problem-solving and breaking down important issues into more manageable tasks (Bob, 310–312, 334–340). This sense of joint coping in times of stress is indicated throughout their account, particularly in their use of "we". Several other couples report experiencing a sense of togetherness during the temporary shifting of "normal" relational roles. Those couples with young children for the most part, share responsibility equally and are flexible about traditional relationship roles. This is evident in reports of men engaging in practical help around the home, such as housework, child-minding and cooking (James and Mary, 511–514; Rita and Maxwell, 399–405). It seems they are demonstrating effective co-parenting of young children.

In contrast, for some of the couples, such role shifts do not occur as readily, creating relationship tension. For example, Samantha describes remaining responsible for household tasks, such as cooking meals, during the premenstrual time. Samantha reports preferring increased practical help from Douglas, rather than the emotional support he offers (710–719, 740–753). This creates conflict in their relationship; therefore, they consider the deviation from normality that occurs during the premenstrual time as being more difficult to manage.

Similarly, Joe and Olivia, find the changes occurring in the premenstrual time as unsettling. In particular, Joe perceives Olivia's premenstrual change as a time when she is unable to "control" herself. For Joe, this leads to feelings of intensified anger, confusion, and a lack of empathy, as evident in the following excerpt:

***Joe:** [...] I don't understand why you can't control yourself and like, "why, why are you being like this?" It's, it makes me really angry and it makes me just not want to talk to you at all or be in contact with you whatsoever. And I guess that's why in X, when I was in X on those weekends at the time that you did have PMS, then I just didn't talk to you okay, because I was so enraged and I felt like it affected the time with the children to the point where I couldn't enjoy my, the little time that I do have with them, that I couldn't enjoy that time. So I felt angry*

that your situation affected my relationship with them because I couldn't enjoy my time with them to the full, and give them "me in my best self" either because I was so affected by you.

Olivia: *That's fair enough. It's true and I know it's true but it's just that I don't know how, I don't know, maybe I need to learn coping.* (Olivia and Joe, 391–402)

Joe recalls an occasion when he was visiting his children during Olivia's premenstrual period. He blames Olivia and her premenstrual responses for his inability to enjoy himself. Joe becomes "*enraged*", which is reinforced by his angry tone. This may be interpreted as a projection of these denied aspects of himself. Underlying Joe's blame and anger may be feelings related to his own inadequacies as a father, as reflected in his comment about not being able to "*give them 'me in my best self'*". A distance is created between the couple in the form of a lack of communication, resulting in feelings of guilt and anger. This may explain why Joe and Olivia, later in their account, tend to place great importance on reconnecting with each other by enthusiastically reporting on their many shared activities. For example, Olivia and Joe stand out from the other participant couples as a couple who engage in and enjoy a great number of activities together, such as cooking, socialising and particularly sex. ***During the interview, I sensed the couple's sense of fun and their enjoyment of each other's company, as reflected in their animated tone and laughter, touching, and eye contact with each other while recounting the many activities they shared. I became more curious about this, which helped them to reflect further on the more positive aspects of their relationship, which, up until this point, they had found it difficult to do.***

Joe's view that Olivia's lack of emotional control due to PMS is an unacceptable deviation from normality is one that is shared by the majority of the couples. This demonstrates a sense of "splitting". For example, Margs describes becoming "*a demon*" (240) and Mary explains her PMS self as a "*stupid witch*" (466–469). Both of these labels depict typically "bad" or evil characters who are generally frightening and feared. This emphasises the idea of PMS as a curse and may reveal difficulties in acknowledging PMS-related distressing emotional and behavioural changes. Several women report PMS as a part of themselves that they find difficult to acknowledge. For example, Elaine describes PMS as "*the negative bits of me that I don't like very much*" (953–956). The women's tendency to identify themselves as "bad" influences their partners' views: many of the partners use the same labels that the women assign to

themselves. For example, Dave refers to Denise's PMS as "*the evil twin*" (a name Denise employs). This proposes two sides to Denise's character, the "bad" side being borne out during the premenstrual time. Such labelling implies an aim to externalise and attribute the perceived "badness" of PMS to someone or something other than the self/partner. For example, James explains Mary's "abnormal" PMS behaviour as like getting a "*shot of a drug that makes her behave in a way in which she would not, in the cold light of day, normally*" (20–22). The metaphor of a drug to suggest that Mary has little behavioural control perhaps comes from James' own experience of addiction. The description of the "*cold light of day*" also suggests a darker, cursed side that exists due to PMS.

The sense of splitting or polarisation that occurs due to the unexpected deviation from normality leads the PMS self/partner to be considered as "bad" and hostile; thus, not tolerated. This contrasts with the non-PMS self/partner, who encompasses loving and socially acceptable traits and feelings. This polarisation could represent a way in which the couples manage PMS-related distress. Conversely, the separation of the PMS and non-PMS self/partner may lead to PMS being considered as something that should be controlled. Therefore, when the couples are unable to do this, they may experience a sense of failure. This is captured in many of the male partners' reports that they do not have a clear way of managing PMS, triggering feelings of hopelessness, confusion, and frustration. This reflects dominant social discourse and norms around men as "fixers". When they are unable to fulfil this role, they are left feeling hopeless. This is expressed by Maxwell:

I said it was confusing, I think it's just, you know, the rules of the game change every so often, you know, like ... you think you're playing all right, you're doing all right but, you know, then the rules change and suddenly it's not quite as good as it should be. (Maxwell, 816–820)

Maxwell's analogy of PMS as a game with changing rules indicates that it is a challenging experience. It also evidences a male discourse around PMS; that is, it is not possible to have a rational protocol to follow. Such confusion is expressed by most of the male partners. For example, as discussed earlier, Douglas describes a struggle due to not knowing how to make Samantha "*happier*" and understand her premenstrual moods (236–252). Similarly, James expresses puzzlement about the inconsistency of Mary's premenstrual "*reaction*" (452–458). For all the couples there is a struggle to understand PMS, regardless of the frequency and consistency of its presence.

A similar sense of failure pervades the women's accounts. Generally, this relates to a perceived inability to fulfil multiple roles and responsibilities as employees, mothers, wives, and girlfriends during the premenstrual time. Denise articulates this in her description of being "*responsible for the well-being of everybody in the house*" (110, 637). The women's sense of failure also relates to unwanted and unaccepted hostile premenstrual reactions, such as anger and irrationality, and the impact on their partners and children. Those who are mothers report that premenstrual anger and irrationality leads to feelings of incompetency as a parent, creating immense worry and guilt. For example, Elaine repeatedly describes heightened premenstrual feelings of ineffectiveness and guilt. This leads her to "*compensate*" outside of the premenstrual time to repair any "*damage*" caused to her children (957; 150–152). In contrast, the women who do not have children express similar feelings of guilt about the negative impact of PMS on others. These concerns are mostly directed toward their partners. Samantha, Margs, and Olivia all express a discourse of PMS as "*unfairly*" impacting their respective partners. Samantha attributes her perceived unfairness to unrealistic expectations of Douglas, including "*to stop expecting normality for a long period of time and to just sort of step back and tread around me*" (183–187). Such expectations emerge as leading to a mutual sense of failure.

A similar joint sense failure is apparent across the majority of the couples. This is most evident in unsuccessful attempts to control PMS together in the relationship. For example, only Rita and Maxwell discuss efforts to receive support for PMS-related issues via "*unofficial counselling*" from someone in their church. However, they report that the counselling was ineffective due to perceiving relational issues as important during the premenstrual time and less problematic at other times. This indicates the importance of timing in relationship counselling. It also suggests that couples do not allow time and space to talk about the relationship difficulties that surface during the premenstrual time and, thus, they do not have the opportunity to resolve them together. This potentially creates a risk of particular relationship issues re-emerging at other times. Additionally, as discussed at the beginning this section, perhaps reinforcing the sense of failure and the lack of control for all the couples is a tendency not to prepare for the premenstrual period.

3.2.4 Summary

The couples' accounts depicted PMS as a curse on their relationships. They described PMS as a burden that creates a deviation from their normal ways of relating.

PMS involves a variety of adverse emotional consequences, indicating the complexity of the phenomenon and the couples' everyday relational experiences of it. Attempts to manage PMS seem to lead to confusion and a sense of failure and hopelessness, adding to the perception of PMS as a burden. The next superordinate theme further explores the impact of PMS on couple interactions.

3.3 Connection and Disconnection: The Importance of Communication and Intimacy

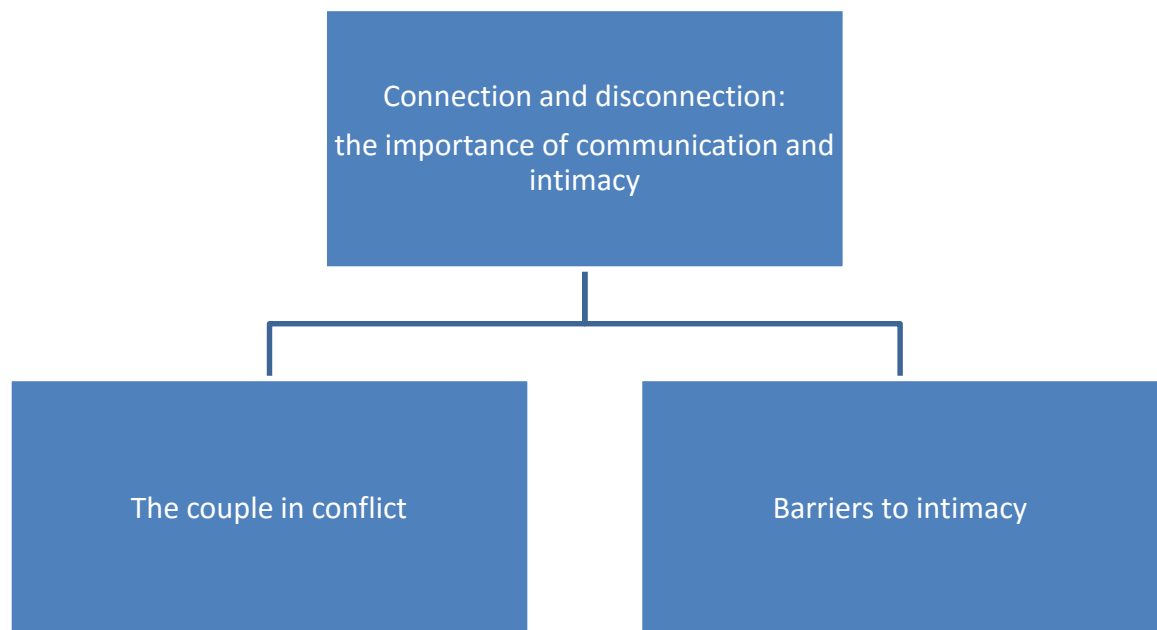


Figure 3. Superordinate theme (2): Connection and disconnection: the importance of communication and intimacy and related subordinate themes

This superordinate theme captures the couples' reported challenges of maintaining communication and intimacy during the premenstrual time. This either enables the couples to feel connected or leads to disconnection. The first subordinate theme describes the shared experience of increased conflict and tension in the couple relationship, leading to detachment and isolation. The second theme explores the many barriers to intimacy during the premenstrual time, including loss of attraction, communication problems, validation, and withdrawal.

3.3.1 The couple in conflict

As discussed, several barriers to intimacy surface during the premenstrual time. Underlying all of these is the experience of intensified and recurrent conflict between the couple. For many of the couples, conflict is expressed as defining the relational experience of PMS. Much of the conflict appears due to the unpredictable change in the

relationship created by PMS, which leads to anger, anxiety, and a sense of instability, and upsets the couples' predictable responses. This creates confusion and frustration, leaving couples struggling for a sense of power over PMS. Contributing to the tension is the resurfacing of unresolved conflict, along with the couples' lack of conflict-resolution skills and strategies. Conflict is also expressed as involving feelings of hurt and resentment, which serve to increase disconnection.

The PMS experience is marked by feelings of anger. While both partners describe these feelings, it is noticeable that all the women explain their angry outbursts as leading to guilt, self-blame, sadness, and shame. These women view their expressions of anger as a personal failing and report feelings of regret and guilt and many acts of apologising. For example, Elaine says:

I tend to just be irritable and you're annoyed and then I'll apologise to Mark later. (Elaine, 301–302).

Olivia also expresses a tendency to express regret:

[...] when it has subsided I'll often say "I'm sorry I've been a bit grumpy", or "I'm sorry for my irrational behaviour". (Olivia, 616–622)

This may reflect women's attempts to make peace with the object of their anger (usually their partner, friends, or children). It suggests that the experience of premenstrual anger highlights a sense of separateness from others, creating feelings of fear (perhaps of abandonment or rejection by their partners and children) and loss, and activating a desire to reconnect. In the couple relationship, it is suggested that this pattern creates a barrier to intimacy by keeping the issues that are the source of the women's anger unexplored and unexpressed. This process is also considered to contribute to maintaining the debilitating shame of PMS. Added to this is a social gender discourse of women not being allowed to express their anger.

During times of conflict the women tend to project unwanted feelings of frustration and anger on to their partners, making them scapegoats. The women's "attacks" on their partners could also be interpreted as a way of directing hurt toward themselves; for example, blaming their partners for things that are not their fault, while simultaneously feeling highly "*persecuted*", "*accused*" and "*attacked*" by their partners. This leads to a sense of mutual attack. Denise and Dave explain their experience:

Denise: I blame Dave for loads of stuff that isn't his fault, I shout and yell and accuse him of being accusatory, I think that's probably the big thing I feel from Dave when I am in my worst times, I feel like I'm being persecuted and accused of things and I always go on at Dave about his tone of voice when it's probably no different than it ever is, but I see things so differently and I kind of, I don't know, I just give him hell.

Dave: You always describe it to me as attacking you ... I could say anything in any way and you'd find some way of making it an attack. (Denise and Dave, 116–123)

Here the couple communicate feeling unfairly “persecuted” by each other. Denise might not be able to tolerate her difficult feelings (shame, anger, and imperfection); therefore, she tries to rid herself of them, rather than understand them and communicate her suffering to Dave. This is indicated in the description “*I just give him hell*”. The word “hell” suggests torture and misery and reflects the sense of a deep dark hole that the couple describe earlier in their account. Denise construes Dave’s “*tone of voice*” as highly critical and attacking. It is possible that the “voice” Denise is referring to is her internal critical dialogue. Denise’s self-critical manner and her struggle for perfection is highlighted throughout her account. For example, she describes trying to maintain her roles as a mother, employee, and partner, but falls short in her attempts to maintain this “superwoman” mode.

The experience of the partner becoming a scapegoat during the premenstrual time is expressed by several other couples. For example, Douglas describes experiencing indirect negative psychological consequences due to Samantha’s “*projection*” of undesired feelings and thoughts onto him (373–375). It could be interpreted that blaming partners allows the women to detach themselves from painful feelings. This may be considered a more acceptable and safer way to express their anger. As Mary explains:

I don't take it out on the children but I will take it out on James when he comes home... (Mary, 46–47)

Later, she explains further:

[...] it's [the PMS] never worried me around the kids, it just makes me a bit more snappy probably and a bit more tired, but then I'll take it out on James. I think that's the thing, it's as a mum you sort of, you know, you're at your best for your children in a way, aren't you, and then you probably take it out on your husband when they come home. So I will try and put a sort of brave face on it and, you know, try and be at my best all day but then probably snap more at James because of that. (Mary, 199–203)

Mary's attempts to be at her “best” for her children may be understood as a reaction to the socio-cultural expectations of women. Mothers may be expected not to be emotionally reactive toward their children. This is reinforced by Mary's admission that she considers herself “*like a role model*” to her daughters (226).

A further way in which conflict emerges during the premenstrual time is through disequilibrium, as discussed in the preceding section 3.2.3. Many couples express a sense of confusion and frustration; thus, a struggle to gain power. The majority of the male partners express a desire to know about the timings of their partner's cycle in order to help them prepare for the premenstrual period. Douglas, Bob, and Maxwell seem most concerned about this. These partners express that knowing their partners' cycles would help to relieve them of their concerns about being responsible for any relationship tension created between the couple. This could be interpreted as a way to attribute difficult relationship changes to PMS instead of recognising their own role in the conflicts that occur. It could also be interpreted as a way to gain a sense of control in a perceived “out of control” period. For example, Maxwell suggests that not having a set strategy due to the unpredictability of Rita's premenstrual mood symptoms is difficult. Similarly, Bob expresses a sense of powerlessness due to not knowing where he stands with Margs; he refers to “*tiptoeing around the mines*”, indicating a worry that any response may lead to an explosion (324–330). Douglas also explains a difficulty with knowing whether to “*empathise [...] with the feelings*” or “*try and stay firm and a bit aloof*” (236–252).

The majority of the women, however, seem unwilling to communicate the timings of the premenstrual period to their partners. Consequently, most of the men do not have this knowledge available to them. This may be interpreted as a way for the women to conceal their own feelings of powerlessness or lack of control over PMS and the bodily/hormonal responses. For the couples, this leads to a conflict of expectations related to achieving a mutual goal – a sense of safety within the relationship. It could be

understood that fear gives both couple members a need for a sense of power (and, thus, safety) over PMS; for example, a fear of failure, attack, abandonment, rejection, or inadequacy as an individual and a partner.

Another pattern of conflict repeatedly reported by the couples is a tendency for the woman to become angry with her partner over “trivial” matters. However, many of the women describe themselves as being unable to disengage from arguments. For example, Olivia describes herself as “*a bit like a bull at a gate*” who “*won’t let things go*” (93–94). Similarly, Mary proposes that she has difficulty “*letting go*” of convictions, which James explains as “*getting the bit between your teeth*”. Both of these descriptions evoke a sense of a wild animal (a bull and a horse) that is determined and out of control. It could be argued the inability to “let go” that Mary describes relates to unresolved unconscious feelings; in particular, resentment associated with her role as a stay-at-home mother:

Yeah, that’s been much harder the last few years, it doesn’t feel like it’s my day job, it feels like, you know, I’m, I’m always the parent on call and if you’re around that’s great but I never have a clock-off time because I never know when you’re going to be home ... So I don’t think, “oh I’m having a bad day, but that’s okay I’ll go to yoga tonight or I’ll go for a walk when James gets home”, because he might not be home till eleven o’clock, so I think that, that’s probably, we probably argue more about that as well when I’m in. I mean we’d be likely to bicker about that anyway but probably when I’ve got PMS that’s worse, isn’t it, that I’ve lost my evenings?” (Mary, 411–418)

Mary describes finding it difficult to have a break because of James’ work hours and her parental responsibilities. She expresses a sense of loss of personal time, which feels worse during the premenstrual time. This is highlighted by the fact that at this point in the interview, the children interrupt and Mary leaves the room to attend to them – perhaps supporting the perception and related self-beliefs in relation to a lack of time for self-care. Mary’s experience of exacerbated frustration during the premenstrual time, shared by many of the other women, may be due to PMS allowing the expression of such frustration and distress that they otherwise feel unable to acknowledge.

Particular issues that are a source of anger remain unresolved within the relationship. This may be due to the couples having ineffective conflict-resolution skills. When grievances are raised by the women during the premenstrual time, this is usually done in an exaggerated manner (screaming – for example, Elaine and Denise) or

ineffectively (aggression – Elaine). As such, the women’s anger is generally disapproved of by her partner (for example, Dave and Joe). It seems the woman’s anger is dismissed by the couple as being due to PMS. This is highlighted by many women reporting how they do not want to consider PMS as an “excuse” for their behaviour. For example, several couples consider the issues they argue about as “trivial”, “petty” or “not important”, which is contrary to what is felt at the time, particularly by the women (for example, Maxwell and Rita, 315–322; Margs, 472–465). This is illustrated by Elaine and Mark as well as Denise and Dave, who coincidentally discuss a typical premenstrual argument centred on the topic of cheese (Elaine, 330–336; Dave and Denise, 1154–1179). In these accounts it could be considered that cheese (as an everyday food eaten by many families) is a trigger to the conflict about the responsibility for providing for the family. These arguments are, therefore, possibly more likely to be about the roles and responsibilities within the family – for example, childcare and food provision. It may be interpreted that because Denise and Elaine both have young children, the responsibility to care for the family is experienced as over-responsibility during the PMS time. This is captured in Dave and Denise’s account of a typical premenstrual argument:

***Dave:** I could go to the fridge and say “Denise, have we got any cheese?” because I can’t see any cheese in the fridge and she’ll be like, “Oh, I don’t buy enough cheese, that’s what you’re saying, you just said to me that I don’t buy enough cheese”... I’m just asking if we’ve got any cheese. It’s like that, a comical example but, you know, that is what it’s like and then you’ll just go on and on and on, and then I’ll try to explain that I was just was asking purely, simply to know if we had any cheese...*

***Denise:** Yeah, cheese.*

***Dave:** And meanwhile I still don’t know if we’ve got any cheese. But yeah, it does and it is, it’s usually something so petty, so petty and it’ll just come from like, nowhere, just come from a perfectly reasonable question, the one that I’ve gone into, I’ve entered into it expecting either a yes or a no answer: “No, we haven’t got any cheese” (Dave and Denise, 1154–1179).*

It is unclear whether this is a hypothetical or actual situation; however, Dave’s comment that it is “a comical example” perhaps indicates a presumed situation, which may be exaggerated for this reason. Dave’s tone while imitating Denise, however, indicates irritation and sarcasm. His apparent lack of empathy for Denise’s frustration

may also reflect an undermining of Denise's expressed premenstrual anger, which is underlined by a gendered position of the premenstrual woman as mad or irrational compared with the "rational" man. This is further reflected by Denise in her description of feeling "*very silly*" after premenstrual arguments with Dave (Denise, 1636–1646).

A similar pattern of dismissal and criticism of premenstrual anger is described by Olivia and Joe. It leads to tension within the relationship, which creates a barrier to intimacy. For this couple, premenstrual conflict centres on the unresolved issue of having a child together. This is highlighted for Olivia when Joe withdraws from her during the premenstrual time in order to be with his own children. A pattern of demand and withdrawal increases Olivia's sense of desperateness during the premenstrual time – the more Joe withdraws, the more Olivia becomes distressed:

Olivia: *...when he does back off I'm often like, "what the hell are you doing?" or, you know, just at you again, probably.*

Joe: *Yeah, probably, it probably makes it worse.*

Olivia: *But he wasn't going to win either way, that's the thing.*

Joe: *Well that's the thing; I'm never going to win in that situation I don't think.*

Olivia: *No you won't, because you back off, I'll just go "why, what's wrong with you?" and then keep digging.*

Joe: *Yeah actually that's right.*

Olivia: *And then when he doesn't back off, you know, it's "fuck you"*

(Olivia and Joe, 117–124)

Along with the dynamic of demand and withdrawal between Olivia and Joe, it seems that the couple's conflict-resolution style involves the use of power; thus, there are two possible outcomes: winning or losing. However, in this case it seems there is no "winner", as whatever Joe does, it does not fit with Olivia's expectations. These issues may remain unresolved between them due to the couple's tendency to blame each other.

In contrast with most of the other couples, Bob and Margs report having the most creative and effective conflict-resolution skills. These include listening to each other, repeating back what is heard to the other person, and physically expressing their frustration by locking hands. *During our meeting, while recalling previous disagreements, they apologised for things said, rather than being critical of each other, I sensed a particular sense of intimacy and connection between Bob and*

Margs. They both described that their effective conflict management was due to greater understanding of themselves through engaging in a mutual journey of personal development. There was a shared sense that they were working together toward a similar goal of greater self-awareness, mutual understanding, and security in their relationship.

3.3.2 Barriers to intimacy

The premenstrual experience leads to various communication difficulties and challenges for all the couples. This results in a disconnection, which contributes to feelings of isolation and abandonment and reduces the intimacy between the couple. Intimacy can be described as the need for each partner to feel closeness in the relationship. This can be experienced through affection, expressiveness, cohesion, and sexual expression. The couples express that PMS creates barriers to sexual intimacy. They also discuss problems with communicating and asserting their needs, wants, and desires; thus, their difficulties around feeling validated and their experiences of withdrawal.

The majority of the couples report an overall decrease in sexual intimacy during the premenstrual time. A major barrier to intimacy for several couples is a mutual loss of attraction. For example, Maxwell describes himself and Rita as usually “*tactile*”; however, during the premenstrual time there is a joint desire not to be intimate (708–711). Douglas and Samantha also report decreased intimacy. Douglas communicates this as being due to a perception of Samantha as “*fragile*”, while Samantha talks of not feeling “*sexy*” and finding it difficult to relax (Douglas and Samantha, 1713, 1682). Over time, this lack of intimacy may lead to decreased cohesion and increased disconnection.

In contrast, Olivia and Joe express that sexual intimacy is more important during the premenstrual time. They report sex as central to their relationship and discuss increased premenstrual sexual activity. Olivia suggests this is due to their tendency to engage in more conflict at this time. Perhaps sex allows Olivia and Joe to physically and emotionally connect with each other or to express their anger. Additionally, it may be that the desire to have a child, increases Olivia and Joe’s opportunities and motivation for sexual intimacy. This is in contrast with Elaine and Mark, who express that having two young children leads to much more problematic and limited couple “*quality time*”, including sexual intimacy (Elaine, 128–130).

For many of the couples, a major barrier to intimacy is a reported difficulty with communicating and expressing particular needs, emotions, thoughts, beliefs, and desires. *I was struck by how the majority of the couples seemed not to have discussed the issue of PMS before this interview and wondered why this was, considering he negative impact it had on their relationship every month. I was also surprised by some of the participants' abilities to disclose certain feelings and thoughts during the interview that their partners had been unaware of. At times this felt uncomfortable; however, I was aware that this might have been a reflection of how the couples themselves were feeling.* This is illustrated most powerfully in my meeting with Elaine and Mark. In contrast with the other couples, Elaine is very positive about the couple's ability to communicate openly and honestly. For example, she describes highly valuing the open conversations she has with Mark, which she says are particularly helpful when coping with stress related to parenting responsibilities (455; 895–896; 414–418). This excerpt demonstrates this:

... we've always talked to each other and we've always been very honest and open with each other so I feel very supported by Mark. I can tell him every day, you know, how I'm feeling or whether I've had a good day or a bad day and I always feel he sort of understands... (Elaine, 414–418).

During the interview with Elaine and Mark it was evident that certain issues had not been easily and openly discussed between them. Specifically, Mark mentioned his concerns about their lack of sexual intimacy and discussed thoughts about whether they might have benefited from couple counselling. Elaine seemed shocked. This led me to feel uncomfortable, possibly indicating the couple's unease. Perhaps Mark felt that this was an opportunity to open up to Elaine in the presence of a third person (me). Alternatively, he might have felt that starting the discussion would lead to further dialogue between them about such issues. As Mark's satisfaction with the couple's levels of intimacy did not appear to have been discussed, this suggests that, in some aspects of their lives, the couple relate to each other in a non-self-disclosing manner.

It appears that Mark's inability to communicate his needs has a negative impact on the couple's levels of sexual intimacy. Several of the women report similar difficulties with communication. They mention feeling that at times they could be more honest with their partners about their feelings, thoughts, and desires. However, many report that they usually feel embarrassed or uncomfortable about sharing such thoughts

and desires. This dynamic seems most obvious in Mary and James' account. Mary discusses difficulty with voicing any details of her menstrual cycle and of her PMS to James (449–450). She identifies her reasons as gender differences that mean James, as a man, cannot empathise with the PMS experience: a discourse echoed by many of the participant couples. Mary explains further:

... they [Mary's daughters] know to leave me alone better than James does actually because I can say to them, and I don't know if it's because I feel as a woman I don't want to talk to my husband about it, as a man, but the girls, when I say something about my hormone fairy, they instantly know in their sort of childlike innocence how to treat me...

...I don't think you've ever really sort of worked out to just sort of not fight me and just be loving and, you know, sort of don't feel like you can treat me with care at that time in a way, even though I know you care about me and love me ... like a friend, if you say to a girl "I've got PMT" they instantly go "Oh yeah" and of course they understand because they go through it. (Mary, 477–483)

Here, Mary explains a difficulty in expressing her needs to James. She suggests a view that only a woman is capable of understanding PMS because they “*go through it*”. This perhaps serves to reinforce the reification of a man/woman divide used by the couples to explain conflict. It could also be interpreted that Mary considers it to be difficult or even impossible for others to understand PMS and empathise. This is evidenced by Mary's contradictory description of her daughters “*instantly knowing*” about the cycle (the “*hormone fairy*”) in their “*childlike innocence*”. It seems that a naivety exists despite knowing about PMS and the menstrual cycle. The child-friendly name Mary uses with her daughters could also serve to reinforce the mystical and unknown nature of PMS and menstruation. This may strengthen the silence and shame connected with these experiences. Mary also suggests that the love and care James demonstrates does not compensate for this understanding. It is possible that she is also alluding to a desire for greater self-acceptance and self-understanding and that she finds it difficult not to “*fight*” herself.

Communication difficulties within the couples' relationships are further expressed in many of the women's perceptions that they should not have to tell their partners what they are expecting, thinking, or feeling; thus, that their partners should be “*telepathic*”. The women expect their partners to be aware of PMS and know how to respond. A psychodynamic interpretation of this may be that these women are wanting

their partner to respond to them like an adoring parent, responding to their needs in a one-way manner. The women may therefore feel angry with their partners for not responding (to them) appropriately. Another interpretation is that the women are indicating an unhelpful cognitive pattern, which in the CBT framework is termed ‘mind-reading’. For the most part, this pattern leads to the men feeling frustrated and inadequate and the women feeling unappreciated, unloved, and angry. For the couple, it leads to barriers to intimacy and a felt sense of disconnection. This is most commonly reported in the couples’ experiences of giving and receiving support. For example, Maxwell explains:

Rita doesn’t always want me to help, or no, sometimes she does want me to help but she doesn’t want to have to tell me that she wants me to help. (Maxwell, 361–363)

Later in the account, Rita describes a more helpful way of relating during the premenstrual time, which involves disclosing vulnerability:

...sometimes it’s more helpful just to kind of, it would be more helpful just to say “Actually I’m emotionally not able to cope with this”, no matter who’s right or wrong, but we don’t really do that... (Rita, 339–342)

Similarly, Dave and Denise describe their difficulties around self-disclosure:

Denise: *...I don’t delegate very well and therefore, when I’m unable to do things I kind of almost feel like telepathically you should be picking up on the fact that ... I’m sitting on the sofa really feeling depressed and then going “why isn’t he doing these things, why?” and getting really angry about it, but I won’t be able to say...*

Dave: *You don’t, you don’t speak to me a lot of the time and I, how many times do I sit there and say “I’m not in your head”?* (Denise and Dave, 1209–1219)

Denise’s and Rita’s tendency to avoid asking for support during the premenstrual time may imply a fear of needing help. Needing help perhaps confirms to them that they cannot cope on their own. These ways of interacting also indicate difficulties with the roles that each partner plays in the relationship in terms of seeking out and providing care. Rita and Denise may both find it difficult to voice their distress, convey their needs and connect with their partners. Denise seems particularly angry and disappointed that Dave cannot “telepathically” read her mind. Dave also communicates anger about Denise’s expectation that he should be able to mind-read. Neither Maxwell

nor Dave appear to be given the opportunity to meet their partners' needs or expectations. As a result, they appear to fail in their ability to demonstrate their own care-giving ability. This leaves both members of the couple feeling unheard and unappreciated.

On the other hand, for Bob and Margs, communicating their needs within their relationship is less of a problem. Instead, the disclosure of PMS to others outside of the relationship impacts the intimacy of the couple. Margs talks about a breaking of "confidentiality" as she powerfully explains that Bob's potential discussions with others is like having her "*personal life being exploded onto them*". Bob's expressed desire to be able to discuss PMS with others (for example, friends) creates anxiety for Margs, inhibiting Bob's ability to openly discuss his difficulties with others outside of their relationship. It could be interpreted that Margs, along with many of the other women, is deeply ashamed of her premenstrual behaviour. Revealing these personal aspects may lead others to make judgements about Bob and Margs as individuals (for example, there is something wrong with them) and as a couple (for example, they have relationship difficulties).

A desire for validation was evident during the couples' interviews, as most of them were interested to know about other participant couples' experiences when we met. I responded to their curiosity in a way that reassured them that they were not alone, without sharing details of other couples' interviews. This seemed to help them to share their experiences with me and with each other. This led to a sense of connection and also helped to normalise their PMS experiences. The desire for validation is openly expressed by Olivia: "*all I want is for my PMS to be validated*" (417). Although Olivia seems to refer to a wider socio-cultural confirmation of PMS, she may be offering PMS as a symbol of a deeper desire for validation of herself, including her own feelings and wishes. This desire for validation may also be related to a pattern emerging between Olivia and Joe – her upset and concerns around wanting a child with Joe are denied and brushed off as unimportant.

There seems to be a mutual invalidation of Denise's and Dave's feelings. This leads to them both feeling unheard, increasing barriers to intimacy. This is illustrated by Dave:

... you [Denise] say, "I feel unsupported and unheard", and I'm sitting there thinking "Have you not noticed that I've cooked dinner every night for the last five days and that I've hoovered the house and that I've done all the ironing

while you've been out today, even though I've got loads of stuff to do myself?"
(Dave, 1085–1088)

Dave feels his efforts go unnoticed and unappreciated by Denise. There is a sense of sadness in both their accounts, with Denise also expressing feeling “*unsupported and unheard*”. This demonstrates a lack of communication and a disparity in how they view events during (and also perhaps outside) the premenstrual time. This is indicated by Dave’s comment “*have you not noticed?*” in relation to the housework he has done. Perhaps Dave is also communicating a desire to be recognised for moving beyond the typically male domain to perform what could be considered an atypical male role within a heterosexual relationship (cooking, hoovering, and ironing). However, Dave’s description of “*thinking*” about what Denise has noticed, rather than discussing it, highlights the lack of communication and intimacy between them.

I was surprised how this seemed to contrast with the couple’s ability to openly express themselves when we met. Denise and Dave seemed to need very little prompting to express thoughts, feelings and opinions. At times I was overwhelmed by the detail of the information they were sharing. They perhaps sensed this, as they both often mentioned how much they had to say about the topic. The communication differences seen in Denise and Dave’s accounts may be an indication of how they, along with many of the other couples, cope with the stress and challenges of PMS. It they may revert to finding it difficult to communicate and solve problems together, preferring to manage (or not manage) individually. This leads to an emotional distance.

Barriers to intimacy were also evidenced by the couples’ reports of tending to withdraw from each other physically and emotionally. Retreating from one another could be considered to be normal behaviour in a relationship; for example, giving each other space, avoiding conflict, and engaging in different interests. However, the majority of the couples communicate that withdrawal in the premenstrual/menstrual time is a negative experience; for example, leading to disconnection. This is largely due to one member of the dyad (the woman) wanting to be left alone.

For example, Elaine says: “*I can see that sometimes I want to just withdraw completely and that leaves Mark with the kids at the weekend*” (165–166). Her desire to retreat has a negative impact on the level of closeness between her and Mark and the rest of the family. For Samantha and Douglas, who do not have children, the experience of withdrawal affects opportunities to enjoy the many activities they share. Samantha describes what happens between her and Douglas:

...we both generally have a lot of energy when we're in, you know, a good mood and, you know, are interested in everything and want to discuss everything and want to go out a lot and see people and do all those things, all of those things are the things about me that change when I go into retreat and that makes it difficult because you still, have all those things going on and I'm just, you know, like, I just want to come home and ... crash and watch rubbish TV and read, and just sleep and hide and not talk and not be very communicative and that's what makes it hard. (Samantha, 502–511).

This excerpt shows how the couple's usual ways of remaining intimate with each other, through socialising and discussion, change when Samantha wants to “retreat” during the premenstrual time. Samantha and Elaine both highlight that their tendency to withdraw during the PMS time opposes how they think of themselves outside of this period. For example, Elaine uses the word “*completely*” while Samantha uses the words “*crash*”, “*sleep*”, “*hide*” and “*go into retreat*”. Their language indicates that they feel overwhelmed by the demands of life and a desire to escape their usual responsibilities, including interacting with their partners and families. The women's withdrawal appears to have a negative impact on the couples' intimacy.

Perhaps both of these couples view withdrawal negatively due to not often engaging in “alone” time outside of the premenstrual time. For Elaine, withdrawal of any kind (for example, time to herself or time alone with Mark) is difficult because of her ongoing family responsibilities as a mother of two young children. For Samantha, withdrawal is perceived to be difficult because she and Douglas find it challenging to separate from each other without one or the other feeling guilty, anxious, or low. Douglas indicates this by describing how he tends to “bury” himself in work when Samantha is experiencing PMS (Douglas, 50–54).

Several of the men describe a desire to withdraw from their partner during the premenstrual time. This is mainly due to fears about their partner's reactions and to avoid potential conflict. This leads to a lack of communication between the couples, increasing a sense of disconnection. In contrast, Bob describes how Margs' tendency to withdraw by leaving the house to socialise with friends actually “*helps*” him. ***Bob's disclosure of this in the interview took Margs by surprise, leading her to probe further. It seemed she may have been hurt by his preference not to be around her at this time, and I detected that Bob did not want to discuss this. I did not question further around this. This may have affected their sense of closeness in the moment,***

which I could have explored further in order to better understand this relationship dynamic and its meaning for the couple.

As discussed in section 3.2.2, withdrawal may be a form of self-protection for the women and their partners. Perhaps normalising the desire to be alone and apart sometimes during the premenstrual time, especially for the women, may help these couples to cope better with its impact on the sense of closeness between them.

3.3.3 Summary

As this superordinate theme has demonstrated, PMS leads the couples to experience various communication difficulties and challenges to their levels of intimacy. Increased conflict caused by the resurfacing of particular issues and a tendency to use partners as scapegoats creates physical and emotional distance. The couples also report feeling disconnected due to a lack of attraction and a sense of not feeling valued or validated by one another. Withdrawal from each other adds to this sense of detachment and isolation. All of these experiences suggest and reiterate the themes explored in section 3.2, which indicates how PMS can have an adverse impact on the couple relationship. The following superordinate theme (3.4) will move on to explore the socio-cultural influences that are found to impact the couples' experience of PMS.

3.4 Beyond the Couple: Socio-cultural Influences on the Relationship

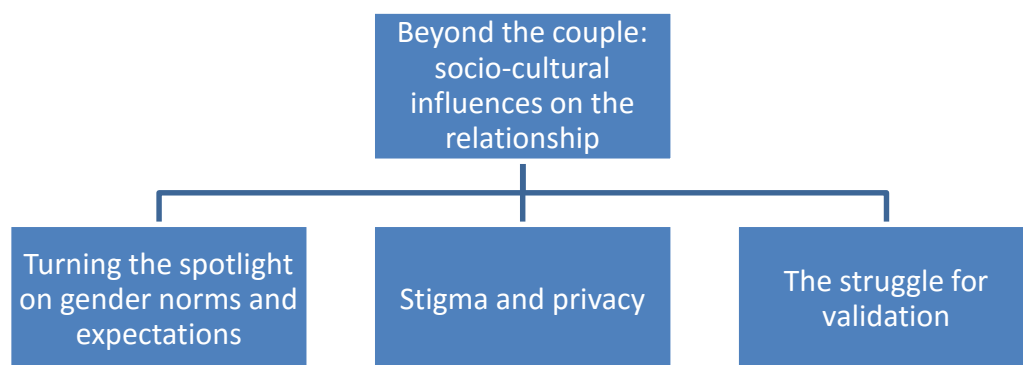


Figure 4. Superordinate theme (3): Beyond the couple: socio-cultural influences on the relationship and related subordinate themes

This superordinate theme explores the socio-cultural contexts in which the couples operate and their potential impact on the PMS experience. The first subordinate theme looks at the couples' accounts of gender roles and expectations related to the premenstrual experience. A discussion of the private nature of PMS and the attached stigma and fear is presented in the second subordinate theme. The third subordinate theme, captures the couples' reported difficulty to be understood and supported by others and the role of self-acceptance in this struggle. This section relates to the second superordinate theme, 3.3 'Connection and disconnection: the importance of intimacy and communication' because it aims to move beyond the couple relationship to explore the many socio-cultural influences that affect the couple's sense of social isolation.

3.4.1 Turning the spotlight on gender norms and expectations

It can be argued that gender itself is relational, as gender roles and characteristics are defined in relationship to one another and through the relationships between men and women. As such, it is not surprising that the couples' accounts highlighted the many gender discourses around PMS. As heterosexual couples, several expressed that expectations, norms, and sanctions affected their functioning. For several couples the experience of PMS seemed to reinforce gender stereotypes (for example, women as irrational and emotional; men as practical and stoic). This limited the couple's ability to communicate and support each other effectively; thus, creating relational inequality. Some of the couples did, however, appear to have skills that enable mutual support.

I was aware that gender issues may influence how the couples interacted with me and with each other. For example, the women might have felt more comfortable or empowered in the presence of another woman, with the men feeling disempowered. In addition, my own experiences as a woman and a mother might have allowed me to empathise with the women's stories, contributing to the men feeling disempowered. To address these issues of gender power in our meetings, I tried to minimise the power distinctions between us and position myself as equally understanding of both partners. Trying to listen to each participant's story through a gender lens helped to facilitate a connection with each participant's emotional experience.

A gender discourse expressed throughout the couples' accounts is the view of the woman as caregiver. For example, Mary, a full-time stay-at-home mother of two young girls, expressed a sense of restricted freedom to manage her PMS symptoms.

Mary discusses the difficulty of taking time for herself due to her care-giving responsibilities:

[...] I find it more difficult being an “at home” mum when I’m like that, because I find being sort of confined to the house quite difficult where I just ... I suppose before I used to, you know, go and meet a friend or go for a walk or [...] do whatever it took to manage it. (Mary, 383-385)

Mary’s description of feeling “*confined*” suggests a feeling of being imprisoned in her role as a full-time mother, as indicated by her inability to leave the house because she has to care for the children. This contrasts with the sense of freedom that she “*used*” to feel before being a mother, when she was able to socialise and exercise to manage PMS. Perhaps Mary is alluding to feelings of anger and resentment toward her husband, James, who does not have such restrictions imposed on him, as he has a career outside of the home. Mary expresses frustration about not being able to easily take time out for self-care. Furthermore, she is unable to express her anger and frustration, having no available space or outlet to do this. For the couple, this creates a sense of inequality in the relationship, with Mary taking care of James and the children and James seeming not to readily notice and attend to Mary’s need for self-care. Contributing to this is Mary’s lack of communication about her needs and James’ inability to notice and take the initiative when housework needs to be done. James comments: “*I’d always be happy if you just said, like, I’d like to be helpful or useful, you know, ‘here’s a load of washing, do it’*” (186–187). James requires Mary to tell him how he can be helpful. Perhaps the inequality in the relationship reflects a dualistic discourse around femininity, in which “good” women are positioned as responsible and able to offer unlimited care and attention to others, while “bad” women are selfish, irritable, and angry.

Similarly, Elaine describes not having the space to effectively express her feelings, which is exacerbated due to her care-giving responsibilities and her experience of living in a house with three other males:

... there are other people in the house now, you know, I can’t just let go and just sob and cry and be hysterical and, or I can’t just lie in bed and go “I don’t want to get out of bed today”, you know, I have to get up and I have to be a reasonable human being so. (Elaine, 471–472)

Elaine suggests that she feels a desire to escape and withdraw from her responsibilities, but also a pressure to be a “*reasonable human being*” (who does not “*cry*”, “*sob*” and “*be hysterical*”); thus, to be emotionally controlled. Similar to Mary’s excerpt, Elaine’s reflects a dualistic discourse around the “good” and “bad” woman. This could be interpreted as the defence of splitting. There is an unconscious separation between the “good mother”, who is gentle and caring (thus, acceptable), and the “bad mother”, who has a frightening and unacceptable side. Perhaps Mary and Elaine are both expressing difficulty with integrating these disparate aspects of themselves, potentially leaving them feeling internally fragmented.

Elaine suggests that she has a tendency to repress her emotions, including anger. Unlike Mary’s partner, however, Elaine’s partner Mark notices her experience of a sense of over-responsibility and attends to it in a positive way. Mark takes on childcare responsibilities when Elaine needs time out particularly at weekends. However, it seems that he is not completely happy with this arrangement, as he explains:

I suppose that has a negative impact on me because, you know, I’ve been at work all week and then I feel if I’m having the kids a lot, that’s doing another sort of form of work and, you know, it’s the unity of the family really as well. I want to spend time with all my family at the weekends... (Mark, 154–157)

Both members of the couple experience a sense of over-responsibility and inequality, with Mark expressing that he takes care of the family’s financial needs in addition to some of the care needs. Later, Mark expresses that Elaine’s role as full-time mother perhaps leads to her desiring some time away from the children, indicating a sense of empathy and understanding of Elaine’s position. Although they try to attune themselves to each other’s needs and accommodate each other’s family and work roles, this is not always easily achieved. This is evident in the tension that is created in the relationship due to the issue of the division of childcare.

For those couples with children, the experience of PMS highlights their parenting roles and the gender differences around these. In particular, it is evident that the responsibility for communicating and educating children about the menstrual cycle and PMS lies with the mothers. Elaine and Mary seem most concerned about this. As Elaine’s children are young boys, she expresses a desire for her sons to understand and empathise with women (for example, future girlfriends). Mary wishes to be honest with her two young girls about the difficulties of PMS so that they may be better able to cope

with it. Interestingly, Elaine and Mary both express that their mothers suffered with PMS. Both of these women are perhaps voicing a desire to open up the dialogue around PMS between the generations and genders so that there is more empathy and understanding in general. This will be further discussed in the next section 3.4.2.

Similar to the women, several of the men communicate a sense of being overburdened by responsibility, creating inequality in the couple relationship. For example, the inequality in the relationship sensed by Mark may reflect a gender discourse of men being stoic providers of support and stability, despite feeling distressed themselves. Dave also suggests that there is a perception of men having to be all-supportive when he describes unmet expectations about his ability to support Denise during the premenstrual time (1695–1698). Similarly, Douglas struggles with being aligned with the traditional male characteristics of stoicism and lack of emotional expression. He explains a felt expectation to be supportive of women but feeling unsupported himself, particularly by other men. This is further highlighted later in Douglas' account:

I suppose I felt a lot there was loads about what you should be doing for your partner, that's really important, I mean that's probably the most important thing, you know, how to act around her, but there seemed to be so little about how to deal with how it affects you as well ... which I suppose I thought was ... it was often presented in a lot of things it was like expecting you to be a totally invulnerable tower of strength all the time and how many people are that?
(Douglas, 1230–1238)

Douglas describes a socio-cultural expectation placed on partners and a dearth of available help and recognition. His metaphor of an “*invulnerable tower of strength*” implies a partner who is consistently emotionally indestructible and supportive. This is perceived as unrealistic and impossible, evidenced by the sceptical tone of his query “*how many people are that?*” Furthermore, his choice of the word “*invulnerable*” indicates a sense of feeling the opposite – helpless and weak. Perhaps Douglas is also expressing a sense of being alone in his experience.

A sense of isolation brought about by socio-cultural gender expectations is striking throughout Douglas and Samantha's account. They both have full-time careers and no dependent children. Unlike any of the other female participants, Samantha works in a male-dominated, high-pressured corporate environment (Margs and Olivia both work in more traditional, feminine caring professions), while Douglas has a highly

accomplished career in a creative field. *In our meeting, at first Samantha appeared less willing than the other women to talk; although she had agreed to participate, it was Douglas who had initiated their involvement. This struck me as unusual, suggesting that the couple was operating outside of traditional gender norms: Samantha orientated toward personal autonomy, while Douglas more toward emotional connection. I sensed Samantha's initial resistance to discussing her experiences, leading me to focus more on Douglas, perhaps reinforcing the distance between them.* This tension and distance seems highlighted during the premenstrual time. For example, Samantha's concerns about her responsibilities as the "breadwinner" in the relationship become exacerbated, as well as the difficulties of working in a male-dominated workplace:

... the last thing you can be is like an emotional woman because that's, you know, they think all women are basket cases anyway, so you really can't do that and that's quite hard ... (Samantha, 80–82).

Samantha explains a stereotype of women of being over-emotional and "mad" (women are "basket cases"). Although her language perhaps reflects the male power dynamic in her workplace, reproducing these terms serves to maintain these negative gendered stereotypes. This may reflect Samantha's own conflict about being a woman who is operating in a male profession. Her use of "they all", reinforces the sense of a gender divide. Repressing or denying these perceived "weaker" feminine characteristics may lead to resentment building up, which is reflected in Samantha's description of not being able "to keep everything under control", including fears about going "mental". This is especially hard during the premenstrual time; Samantha tries to present herself as professional and composed at work, and her emotions then spill out at home, as Douglas explains:

[...] you have to keep something maintained while at work and so perhaps it comes with, with double intensity outside of work. (Douglas, 85-86)

It seems, however, that Douglas and Samantha have different expectations of how they should each react and feel in the relationship, which may be informed by the different gender norms they adhere to. For example, Douglas notices and attends to Samantha's distress by offering to talk about things, but Samantha prefers to be left alone and desires Douglas to provide "practical" rather than "emotional" help (for example, by cooking). This seems to be in contrast with traditional feminine and masculine approaches to intimacy, with women rather than men being orientated toward

achieving closeness through mutual self-disclosure. This is also reported in their self-descriptions of Douglas being an “*emotional extrovert*” and Samantha an “*emotional introvert*”. This leads to a sense of distance, with Samantha feeling blame and guilt and Douglas feeling alone and rejected.

Although many gender stereotypes are evident in the couple relationships, some of the couples demonstrate that they made an effort to defy these and transform the power relation between women and men. This is evident in the way in which the couples show their respect for and responsiveness to each other during the premenstrual time. For example, Bob and Margs generally express a sense of mutuality in their account, as Bob’s describes: “*we’re quite supportive of each other*” (62) enabling the couple to cope with PMS in a positive way, as Margs expresses:

I feel really supported by Bob when I have clearly got PMS ... we’ve been together five years and now he really knows how to be with me ... and is able to be very loving ... whether it’s that I’m feeling that my body’s changed, I am sad or I feel ugly or I feel exhausted and I haven’t slept well ... and he’s very, very loving and, you know, patient every time. (Margs, 45–55)

Margs explains later in her account that Bob’s support and love leads to her being able to “*try*” to employ self-care (for example, doing yoga or having a bath). This contrasts with some of the other women, including Mary, Elaine, and Denise, who express that self-care is more difficult.

3.4.2 Stigma and privacy

As discussed in section 3.3, the majority of couples indicate that a defining feature of the premenstrual experience is its private nature, which leads to embarrassment and difficulties with asserting needs and wishes. This means that PMS is not easily and readily discussed within the relationship or with others, including friends and health professionals (for example, GPs and counsellors). The need to keep PMS private is reported as being couple-driven, but also due to others’ lack of understanding of PMS. Some of the couples report that stigma makes it difficult to talk about PMS, while some male partners perceive privacy as being restrictive, leading to feelings of isolation.

Stigma is defined as a discrediting feature that opens up the possibility of feeling judged by others as inferior or flawed. This is a defining aspect of couples’ PMS experiences. The stigma around PMS is largely captured in the couples’ described fears

about disclosing PMS within the relationship. This hinders communication between the couple (for example, not sharing the timings of the premenstrual cycle), causing misunderstanding and isolation. Couples also discuss fears about exposing details of PMS to others outside of the couple relationship; thus, suggesting a desire to maintain secrecy and protect themselves from shame. This sometimes affects the participants' ability to access support from other people and potentially useful services (for example, counselling) as individuals and as couples.

The women (the stigmatised individuals) express a shared fear of being labelled with PMS due to worries about being judged or discriminated against by others. For example, Samantha's fears of exposure are strongly related to her workplace knowing about her premenstrual difficulties:

I mean it's [PMS is] a taboo thing, I mean this is what I'm sort of stressed about at work is, you know, I mean anti-depressants I really resist because I'm not depressed, you know? (Samantha, 1212–1213)

The term “*taboo*” implies a perception of PMS as forbidden in the workplace. Thus, Samantha expresses a sense of self and social stigma around PMS. Samantha also communicates a strong resistance to being labelled as “*depressed*”, perhaps indicating that she is denying feelings of depression. The “*stress*” Samantha describes could, therefore, be caused by a struggle not to present herself as either premenstrual or depressed to her work colleagues. Samantha may also be protecting herself against feelings of shame.

The other women express a strong resistance to naming PMS, particularly in the context of the couple relationship. For example, Olivia expresses dislike, annoyance and frustration about using PMS as an “*excuse*” for her behaviour (166–171). Perhaps Olivia worries about conforming to the negative stereotype of the premenstrual woman; for example, angry, irrational, and incapable. Olivia may also have worries that naming PMS as an explanation for her behaviour will lead to her partner, Joe, considering PMS as the only reason. As a result, the real reasons for her expressed anger may not be explored as a couple or taken seriously by Joe.

In contrast, Margs and Bob describe how labelling PMS within the relationship is helpful. For example, it allows for a better understanding of the relationship changes, including the friction that occurs between them. Mary perhaps has unexpressed desires to name PMS in the relationship as a way of relieving herself from some of the familial

responsibility she feels during the premenstrual time. Mary communicates this in the following excerpt, in which she discusses how women's menstrual cycles are viewed differently in Eastern and Western societies:

*I think as a culture we don't respect women's cycles enough, do we? If we look in Asian cultures, aren't women in some Asian societies, they are actually excused from duties for, over their menstrual cycle and they're put in a special tent or something aren't they? [...] When I was reading *The Red Tent*, they sort of, you know, rested and are taken away from their duties and, you know, allowed to go through it and then come back. (Mary, 589–593)*

Mary suggests the Western societal view of PMS and menstruation is much less supportive and respectful of women than the Eastern view. Perhaps Mary's reference to the two cultures actually reflects a perception of the PMS experience in her relationship – that of autonomous (male) vs collectivist (female) ways of operating. This is also reflected in Mary's difficulty in openly discussing PMS within her relationship, which she explains is largely due to a gender divide (see section 3.3.2). Mary describes feelings of embarrassment when discussing PMS with James and tends to keep the details of her cycle from him. She may be caught in a cycle of self-silencing due to shame. This supports the perception that others, including James, do not truly understand and empathise (Mary, 502–504).

The experience of stigma is also communicated by many of the men tending not to discuss PMS issues with others, particularly with male friends. *I was aware, however, that my presence might have led them to feel judged by me as well as by their partner if they did expose any contrary experiences; thus, they might have kept some of the discussions that they had had with others private from me and their partners.* For example, in answer to a direct question about talking to others about Olivia's PMS, Joe remarks: “No, it's private, no, I wouldn't” (502–503). This could be interpreted as a discourse of hegemonic masculinity – of “men don't talk” (particularly about emotionally sensitive issues) – that exists in the couples' accounts. It may also be due to many of the men feeling partly excluded from the experience, which is attributable to a perception that PMS belongs to women. Some men did, however, provide an insight into how PMS is discussed privately by other men (for example, as a “moan” or in a “jokey kind of way”). This perhaps indicates men's difficulty talking about PMS; thus, the tendency to repack the experience in a flippant and insensitive

way, possibly as a result of feeling discounted. Mark explains why he does not talk about his experiences of “PMT”:

No, I'm a typical bloke, I've not, I've never spoken to my friends about, you know, and said "Does your wife get PMT?" or gone down that road of conversation. I mean, I suppose, I mean that's partly because, again, a typically male thing, I think I don't feel wildly comfortable ... on the practical level that there's very few friends that I have that don't, because they know Elaine quite well, so I don't really want to be divulging all her stuff or sort of being critical of her, you know, to friends so there's that practical consideration as well.
(Mark, 542–547)

Here Mark aligns himself with a mainstream heterosexual masculinity, identifying himself as a “*typical bloke*” who does not talk about ‘women’s issues’. This may be indicative of a wider socio-cultural stigma among men about discussing relationship issues that arise from women’s distress. Mark also describes the “*practical*” considerations for not “*divulging*” Elaine’s issues, rather than the emotional consequences (for example, Elaine feeling embarrassed).

The partners’ concerns about divulging this sort of information are shared by the women. The women may even have driven these concerns, as the couples communicate a shared perception of PMS as a private matter that should ideally remain with the woman. This suggests a discourse around PMS and menstruation as a largely hidden experience, which may serve to perpetuate the negativity, stigma, and shame around these issues. For example, Margs expresses a perception of PMS as a time when all her “*worst traits*” and “*horrible parts [...] come out*” (572–583). Perhaps concealment helps to manage deep feelings of shame and disappointment related to premenstrual behaviour.

For the majority of couples, keeping PMS private means that such issues are very rarely (if ever) discussed outside of the couple relationship. This also reflects a socio-cultural discourse around PMS as the woman’s issue, rather than a relational problem. It could be interpreted that isolation is inherent in PMS, as it is dealt with by women, men, and couples individually and privately, rather than shared. For example, only one couple (Rita and Maxwell) openly admit to seeking help for relationship difficulties due to PMS, and this was short-lived. For some of the male partners, however, keeping their partner’s PMS as a private matter and dealing with a sense of isolation is not always easy. Some men express desires to talk about PMS outside of the

relationship to feel supported and less isolated in their experience. For instance, Maxwell tentatively contemplates that sharing experiences with others may actually be “*comforting*” (482–485). However, other partners discuss a tendency to refrain from doing so for fears of upsetting their partners. For example, Bob and Margs express their views on Bob sharing PMS experiences with others outside of the relationship:

Bob: *Sometimes I would like to be able to talk to someone but the problem is that I know that if I did and you found out, you’d be so angry.*

Margs: *I suppose it would depend, if you were talking to a therapist I wouldn’t mind.*

Bob: *Yeah, but generally in these situations you probably just want to talk to a mate or your brother, you know.*

Margs: *Yeah, I wouldn’t like that.*

Bob: *So no is the answer, and I would like to be able to do that, I wish there was much more ...*

Margs: *Maybe we need to find someone you can talk to.*

Bob: *... freedom. We’ve been, well, yeah, it would be nice to have that freedom and not feel so, so just having to deal with it. (Bob and Margs, 549–562)*

Bob expresses a sense of restriction in his support options. The word “*freedom*” takes on several meanings, implying that he feels trapped and isolated in his experience of PMS in the relationship and has limited options for voicing his concerns spontaneously with other men he feels close to (a “*mate*”, or his “*brother*”) because PMS is considered as a private matter that “*belongs*” to the woman. Bob appears to ignore Margs’ suggestion to find someone he can talk to, such as a “*therapist*”. This suggests that Bob feels restricted by his own fears of being judged if he were to talk to someone he didn’t know. Alternatively, it may suggest that he fears that he might be critical of Margs if he were given an opportunity to talk. For example, earlier in the account Bob expresses difficulty with aspects of Marg’s premenstrual behaviour, particularly in situations with his parents. Expressing his worries and feelings of frustration and anger may help Bob to feel less distressed and isolated.

In contrast, some couples express far less concern about the male partner discussing PMS and other relationship issues with others close to him. For example, unlike Margs and most of the other women, Samantha encourages Douglas to talk about

his concerns with close friends and his sister-in-law. This may be because Samantha understands how much Douglas likes to talk and feels that friends and family would not judge her as critically as her work colleagues would. Douglas sums up his experience of talking with his sister-in-law and close mutual female friends:

[...] that makes all the difference because other people you talk to, if they've never experienced it [PMS] with someone, you know, they jump to all sorts of conclusions and all sorts of things, whereas someone who's actually been around someone like this, you know, you just know that they'll actually have some sense of how you might be feeling [...] (Douglas, 529–532)

Understanding and empathy from others who have experienced PMS is highly important for Douglas. Perhaps Douglas also fears judgement – of himself, his relationship, and Samantha – as reflected in his concern that someone who has not experienced PMS might jump to “*all sorts of conclusions*”. Douglas, along with Bob in the previous excerpt, may be alluding to a sense of normalising the PMS experience. This may help them to feel less alone, which several other men, including James, also express as important.

3.4.3 The struggle for validation

Throughout the couples' accounts there is an expressed sense of a desire for validation of their PMS experience, as also explored in the previous section 3.3.2. It is also apparent, however, that couples are looking for validation from others, including friends and medical professionals (GPs). The desire for a wider validation of PMS and its emotional, behavioural, and relational consequences could be interpreted as a deeper emotional need for approval that enables the participants to feel secure in themselves. This is evident in the sense of a struggle for self-acceptance that the couples report as emerging during the premenstrual time. This is most obvious in the accounts from Denise and Dave and Mary and James. Denise and Mary both explain how their partners do not necessarily understand or accept their premenstrual changes. For example, Denise expresses an unfulfilled need to be accepted by Dave (1994–1996). Similarly, Mary says to James:

[...] I don't know if you accept the fact that it's just something I go through and then I come up again. (Mary, 141–146).

By pointing out the lack of validation from their partners, Denise and Mary may also be referring to difficulty with self-acceptance. This is suggested later on in their

accounts. For Mary, this relates to accepting that she tends to “go through” a premenstrual change. Similarly, Denise expresses a need to accept PMS-related anger/rage, as reported in her desire to “rant”. Underlying this may be a belief that women should be able to control their bodies. This is communicated in the commonly reported experiences of the challenges of self-acceptance. This appears in the couples’ accounts as a sense of working toward being more self-compassionate and self-accepting, rather than being judgemental and critical of premenstrual changes. For example, Margs expresses a shift in attitude toward her cycle when she identifies more helpful ways of coping by “accepting it happens” rather than “making it [PMS] wrong” (756–757). Olivia and Denise also express the potential to be more self-accepting rather than self-critical (Olivia, 967–970; Denise, 2806–2814). This process could be explained as re-attribution, which involves reflecting on alternative causes of events that occur during the premenstrual time. *For example, during my meetings with the couples, the process of talking through the relational experience of PMS and its meaning seemed to allow them to be able to see the value of accepting PMS. In particular, this was evident for the women. Perhaps the meetings helped to create a space in which they were able to reflect more easily on this potential outside of the more limiting context of their relationships or a professional encounter with a GP. This may also have been more possible due to the women not currently being in the premenstrual period.*

The couples’ struggle for validation of PMS is further demonstrated by the majority of the couples expressing a preference for alternative remedies over conventional treatment for PMS symptoms. For example, many couples discuss the usefulness of diet modification, meditation, relaxation, acupuncture, herbal and mineral supplements, yoga, and exercise (Denise and Dave, 955–971; Margs, 103–108, 405–410, 640–642; Rita, 23–433; Elaine, 288; Douglas and Samantha, 862–864). Some couples openly reject the medical view of PMS and the medical professionals they had encountered (for example, GPs). The general inclination to move away from taking medical advice may be interpreted as the influence of socio-cultural norms and expectations. Alternatively, it may be considered as a reaction to the reported experiences of lack of understanding and unsuccessful attempts to get medical help for PMS. For example, Denise and Dave discuss this:

Denise: I have been back to my doctor... and said, you know, “I am really struggling with PMS, this is what I’ve been doing, I’ve been charting and I know

that this is what's happening" and she was most unhelpful, wasn't she, really? Because Dave came, I even took Dave with me so there was another voice in the room to say "This is my experience of it", you know, "she's not going mad, this is happening" and she basically said "You can go back on anti-depressants".

Dave: *Oh, she was useless.*

Denise: *Because all the symptoms are the same, aren't they?* (Denise and Dave, 1564–1571)

Denise suggests that, despite repeated efforts to express her experiences of PMS, including taking Dave along to prove her sanity, the GP is indifferent and “*unhelpful*”. Dave views the GP as “*useless*”. The couple may have been looking for advice and treatment other than anti-depressants and are disappointed and critical when this is not advised. Underlying this is a resistance to considering PMS as depression, which is contradicted by Denise’s comment: “*all the symptoms are the same*”. This excerpt, therefore, also reflects fear and denial of the diagnosis of depression and the difficult consequences that this may have for the relationship, including dealing with the adverse effects of medication. Additionally, perhaps there is no real “cure” for Denise’s difficulties, reinforcing the sense of PMS as a curse. Another interpretation of Denise’s desire for Dave’s presence in the GP’s office could be to receive support from another woman (the GP). The GP’s validation may provide evidence to Dave that her premenstrual difficulties are “*real*”. Thus, when validation is not provided, the GP is perceived as “*most unhelpful*”.

Like Denise and Dave, Elaine and Mark imply a resistance to using medical treatment for PMS symptoms. The couple explain that their holistic ideas about health have developed within their relationship as a result of individual and joint experiences. These include gaining and losing weight together, experiences of family members struggling with mental health problems, and Elaine’s experience of working in mental health. This contributes to their “*healthy disrespect for doctors*” and only using medical help “*if it's something that we generally can't fathom out ourselves*”. The couple also express a strong resistance to Elaine taking anti-depressants, mainly due to the potential side effects. Like Denise, Elaine experienced depression in the past and took medication for this. Perhaps, therefore, underlying her resistance to doctors is a fear of being diagnosed with depression (or another stigmatised mental health problem) and the potential social and relational consequences for the couple relationship. However, the doctors these couples report on are not necessarily denying their experiences of PMS, as

they are not saying that they are depressed for no particular reason. Rather, as medical professionals they are advising that PMS can be treated with the same medication used for depression (SSRIs). However, some couples feel that this course of medical action invalidates their experiences of PMS. Therefore, they may be seeking a greater validation (for example, societal) of their individual and relational experiences of PMS. They perhaps feel that they are not being listened to and empathised with.

Similarly, Samantha and Douglas grapple with the idea of PMS being diagnosed and treated like depression. However, they do not share the same view on the matter:

Samantha: [...] anti-depressants I really resist because I'm not depressed, you know?

Douglas: But what do you think depression is?

Samantha: Well I know, no, but you know what I mean, I'm not, I know I'm not depressed at certain times of the month ... which is, you know, if you're depressed then you're depressed either all the time or for a prolonged period of time, you're not on a cycle of...

Douglas: Um, I'm not sure that's necessarily true, but... I mean you know more about that than I do. (Samantha and Douglas, 1214–1223)

This couple's differing beliefs about depression and PMS may lead to them both feeling invalidated. Samantha seems highly resistant to taking anti-depressants and to the label of depression. This is probably related to her perceived worries about how a woman, who is depressed, does not fit into a male-dominated workplace. Douglas, however, appears to perceive Samantha as depressed. He may be afraid to voice this, due to a fear of hurting Samantha or affecting the security of their relationship. *It was evident in our meeting that this dynamic was becoming more and more difficult for Douglas. I sensed that Douglas was struggling to cope with the relational impact of PMS and that Samantha was resistant to getting help. He asked for a cigarette break, reinforcing a sense of stress, which I recognised.*

As Samantha and Douglas' excerpt demonstrates, many couples have different opinions about what PMS is and how it should be treated. This creates confusion, which makes gaining validation from others more challenging. For example, in contrast with those couples who seek out a more holistic approach to PMS, Olivia and Joe openly express a pro-medical view of PMS treatment (Olivia, 607–611). This may be in alignment with Olivia's profession as an allied health practitioner in a hospital.

However, it also contradicts her reported perception of PMS as being “*about the psychological symptoms as opposed to physical*” (15–19). A similar sense of confusion about defining PMS was commonly reported by all the couples. Premenstrual patterns are difficult to ascribe to a specific model because they do not fit predominant biological or medical descriptions. This suggests that attempts by medical professionals to define PMS may help to validate it, but may also undermine the individual experience. Therefore, there is a potential gap between the needs of women, partners, and couples who are experiencing PMS and the support that is available to them.

The couples’ tendency to seek validation from doctors despite considering them to be unhelpful could be explained as a need for empathy and additional support for the distress they encounter. More effective support may lead to couples being better able to cope with PMS. Several couple members report that they often turn to others who are close to them for understanding and support, including family (Elaine, Denise, Douglas, and Olivia) and friends (Rita, Mary, and Margs). Douglas is the only male who openly reported seeking support from others outside of the relationship. He also discusses his perception that there is a lack of wider recognition and help for partners, which he finds frustrating (Douglas, 1230–1238). This suggests the existence of a dominant gender discourse of PMS as a private women’s experience, as discussed in sections 3.4.2. It also indicates that there is a dialogue around men’s difficulty with seeking help for emotional troubles, particularly when they are experienced within a heterosexual relationship and relate primarily to women’s reproductive health.

3.4.4 Summary

This superordinate theme reveals that the PMS experience can be isolating for couples. This is due to self-imposed and socially and culturally assumed expectations related to being a man or a woman in a heterosexual couple living through the PMS experience. Added to this is the social stigma attached to PMS, which leads to fears of shaming and being shamed. The male and female members of the couples express a shared desire for more understanding and empathy from others with regard to the PMS experience. This is challenging, because the confusion that surrounds PMS leads to a perception of a lack or mismatch of appropriate treatment.

3.5 Final Summary

This chapter has presented the three superordinate themes identified in the analysis of the interview transcripts of the seven participant couples. The analysis revealed that the majority of the couples’ experiences of PMS are expressed as a curse

and a burden. PMS is commonly perceived as a negative experience which creates additional stress in the relationship, leading to anger, anxiety and depression. Intimacy and communication between the couple are greatly affected due to increased relationship conflict, creating a sense of disconnection between them. Shaping the couples' PMS experiences are various personal and socio-cultural expectations, including those relating to being a man or woman operating within particular social parameters. PMS-related stigma and the perception of PMS as a private matter contributes to the difficulties couples have in being able to disclose and share their PMS experiences and to feel supported. The couples also seem to struggle for a sense of validation, from both within the relationship (from each other) and from others outside the dyad (for example, from health professionals).

Chapter 4: Discussion

4.1 Introduction

The current study aimed to extend existing knowledge and understanding of experiences of PMS in heterosexual couple relationships, which I consider to be an under-researched topic. This chapter reviews my main research findings and takes an interpretive stance to explore the three superordinate themes that emerged from the analysis of the interviews with the couples. In line with Smith's (2004) suggestion, I will discuss my findings in consideration of the existing literature as well as by highlighting and examining the connections and differences between the research findings and the dominant discourse or evidence.

I endeavour to provide recommendations for professional practice throughout. However, as this research was undertaken with a small group of participants, my intention is not to make generalisations from the findings to the wider population; but to add to existing therapeutic knowledge. From listening to and analysing the couples' accounts, it transpired that a number of possible psychological interventions may be helpful when working with this group. I recognise that many approaches could be applied; for example, systemic couples therapy (Jones & Ansen, 2000); systemic-constructivist couples therapy (Reid, Doell, Dalton, & Ahmad, 2008), and psychodynamic couples therapy (Scharff & Scharff, 2014). It is beyond the scope of this research, however, to include all such relevant interventions; thus the suggestions have generally been approached from a psychodynamic perspective and CBT perspective.

Following these recommendations, I aim to critically reflect upon the study's methodology, suggest improvements to be made, and propose directions for future research. The chapter will end with a presentation of my reflections on the research process and methodology, followed by my conclusions.

4.2 Key Findings in Relation to Existing Research

The findings from the current study have helped to understand the particular dynamics of heterosexual couples living with PMS. In addition, they have expanded insight into the male partner's experience of PMS. The findings highlight the need for improved general awareness, as well as enhanced professional attention and support for couples who experience PMS-related relationship difficulties. Before commencing a discussion of the details of my key research findings, I will summarise them in Figure 5 below.

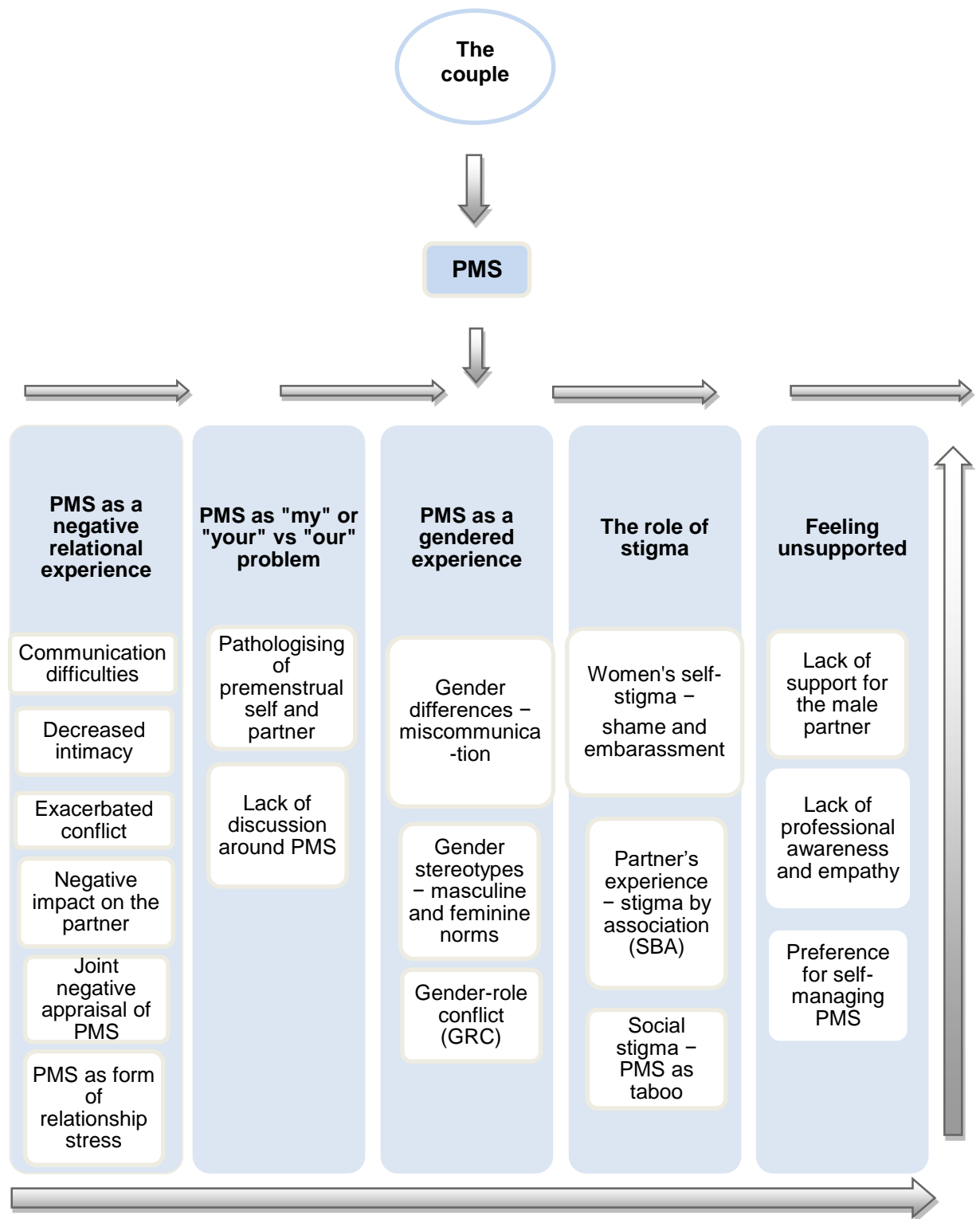


Figure 5. Overview of the key findings

4.2.1 PMS as a negative relational experience

Across the couples' accounts, it was clear that PMS was a highly negative and burdensome experience, reflected in the superordinate theme 'The "curse" of PMS'. All of the participants described having the perception that PMS has an adverse impact on their relationship, particularly on levels of intimacy, communication, and experiences of conflict. The current study, therefore, adds to the growing body of research in the field that suggests the importance of viewing PMS within a relational framework (King, 2013; Ussher & Perz, 2013). Corresponding with the views of Taylor (2006) and Ussher (1996), the findings also challenge the prevailing positivist, bio-medical and psychological discourse around PMS, which considers PMS to be an individual problem. Similar to findings reported in the broader literature on couples within which one member experiences a particular difficulty (for example, breast cancer), the current study found that PMS is a relational experience, which has an impact on both members of the dyad (Loaring et al., 2015). As proposed by these studies, the present study highlighted that the couples' responses to PMS (as an individual difficulty) can be understood as dyadic and dynamic, rather than individual.

In line with research that suggests that women's negative beliefs and attitudes toward menstruation can adversely impact the severity of premenstrual symptoms experienced, (for example, Morse 1999; Ruble, 1977), the majority of couples in the current study described negative expectations of the relational impact of PMS. Although PMS symptom levels were not directly measured, the reported range of adverse emotional and behavioural consequences of PMS suggests that the relational impact of PMS is significant. Additionally, only a few positive features of the PMS experience were described, which included PMS as an opportunity for self-care (Margs) and open expression of emotions (Olivia). These were reported however, as aspects that were not generally focused on in the midst of PMS. Overall, the couples' accounts did not seem to correspond with some other qualitative findings, which have suggested that premenstrual change is not necessarily experienced as debilitating or distressing (Cosgrove & Riddle, 2003; King & Ussher, 2013; Swann, 1997; Ussher & Perz, 2008).

The current findings also support literature, examined from the woman's perspective, on the negative impact of PMS on the quality of the couple (marital) relationship. In these studies PMS has been found to adversely influence relationship satisfaction or happiness, leading to difficulties such as conflict and decreased levels of intimacy and communication between couples (Coughlin, 1990; Frank et al., 1993;

Keye et al., 1986; Kuczmierczyk et al., 1992; Siegel, 1986). Although the present study did not use any particular measures of couple satisfaction, I was overwhelmed by the deep sense of difficulty that most of the participants communicated and the enduring distress that they experienced in their relationships due to PMS. The current findings thus expand upon existing studies, with reports of the adverse impact of PMS deriving from both couple members. This corresponds with the limited existing research that has included the reports of both partners and has described a decline in functioning in the marital relationship due to the manifestation of premenstrual symptoms (Ryser & Feinauer, 1992).

Communication difficulties. The communication difficulties reported by the couples in the current study included withdrawal, demand-withdrawal, increased conflict, criticism, and miscommunication. Overall, there was a sense that the PMS experience made communication with each other more challenging, due to reported gender differences and to the consequences of disconnection and isolation. Although not designed to determine direct relationships between levels of communication and PMS distress, this study's results do support previous research findings that a lack of communication between the couple leads to higher levels of premenstrual distress (Ussher & Perz, 2010) and that more effective communication is associated with lower levels of premenstrual distress (Schwartz, 2001; Smith-Martinez, 1995).

Some couples, it seemed, did use more effective ways of communicating with each other. For example, Margs and Bob stood out from the other couples as employing the most mutually efficacious ways of communicating within their relationship. They also appeared to experience the least relationship conflict. This differs from Denise and Dave, who described ineffective communication – such as being telepathic, leading to feelings of being under “*attack*”, blamed, and unappreciated (Denise and Dave, 1209–1219). Perhaps contributing to Margs and Bob's experience was a tendency to employ more shared ways of managing distress in their relationship, such as joint problem-solving strategies and being mutually supportive of each other's goals (Bob, 310–312, 334–340). This supports previous research that indicates that a conjoint way of dealing with PMS (by husbands and wives monitoring PMS symptoms) leads to lower levels of distress, more problem-solving communication, and less sexual dissatisfaction (Frank et al., 1993). It has been suggested that this is due to increased discussion of individual and couple relationship needs and behavioural strategies (Frank et al., 1993). For the current study, this also seemed to be the case in Margs and Bob's relationship.

Decreased intimacy. Supporting previous research, most couples in the current study described that PMS negatively affected the intimacy between them. In Siegel's (1986) study, low levels of intimacy and high levels of premenstrual distress were reported by participant women. Intimacy was not directly measured in the current study; however, couples reported a mutual sense of decreased sexual desire and attraction during the premenstrual time, similar to reports found in other qualitative studies (Rundle, 2005). Only one couple, Olivia and Joe, expressed increased sexual activity; however, they were also actively trying to conceive. This is consistent with previous research, which has reported some more positive effects on intimacy between couples during the premenstrual time (King & Ussher, 2013; Rundle, 2005). A major barrier to intimacy for many of the couples was an expressed difficulty communicating particular needs, emotions, thoughts, beliefs, and desires to each other. Performing joint interviews seemed to provide the couples with a space to discuss these in more detail than they had done previously. The couples also reported other ways in which they experienced a sense of closeness, including through mutual support and enjoying shared activities. However, for many couples, closeness appeared to be less obvious during the premenstrual time. This suggests that PMS was generally perceived by these couples as having a negative impact on their levels of closeness.

Exacerbated conflict. Corresponding with previous research, participant couples in the current study expressed that PMS seemed to exacerbate conflict in the relationship. Siegel (1986) suggests that conflict during the premenstrual period may be due to unresolved issues between the couple and/or poor conflict-resolution skills. This seemed to be true for many of the participant couples. In particular, Mary and James and Olivia and Joe reported that similar topics of conflict resurfaced during the premenstrual time; these related to the difficulty of self-care and the desire for a child, respectively. Other couples also communicated several complex ways in which conflict seemed to arise during the premenstrual time. These included unmet or mismatched expectations of each other, usually over the kind of support being given and received. For example, Samantha discussed a preference for Douglas to provide practical rather than emotional support (Samantha, 710–719, 740–753). Also commonly reported in the couples' accounts was the partner becoming a "scapegoat"; that is, the focus of the woman's premenstrual irritation. Other qualitative studies have reported that this occurs in heterosexual and lesbian relationships. Ussher and Perz (2013) interpret this as being possibly due to the surfacing of women's deeper feelings of hurt or frustration. For example, in a case study analysis, Ussher and May (2014) describe how one

participant's labelling of her anger and frustration as PMS leads to her being able to express these feelings to her husband and not damage her "good" sense of self. This process, however means that the issues underlying these emotions are not talked about by the couple. This leads to reinforcing the pattern of self-silencing that is reported in many other women's accounts of PMS (Ussher & Perz, 2010).

This pattern appeared to occur frequently for the couples in the current study. The outcome for the relationship was also captured: this was reported as a sense of "mutual attack", which may lead to relationship unhappiness in the long term. This is further suggested in research showing that couples' open expression of anger and disagreement, as opposed to avoiding conflict, contributes to increasing satisfaction in the relationship (Jack, 1991). In the current study, in some cases both members of the dyad were left feeling criticised, distanced, and unsupported, which reduced the intimacy between them. This seemingly led to a sense of fear of a lack of safety and comfort in the relationship, which was expressed by many couples as abandonment and isolation. This was most obvious with Denise and Dave.

It may be useful to understand these couples' ways way of relating during conflict from an attachment perspective (for example, Bowlby, 1973; Hazan & Shaver, 1987). Within this framework, individuals may have differing working models of attachment. This includes their expectations, beliefs, and goals about the self in relation to others, which are likely to shape an individual's thoughts, feelings, and behaviour in conflict situations (Bartholomew & Horowitz, 1991). If there is attachment insecurity, it is more likely, for example, that assessments will be made of the self as undeserving of love and the other as unresponsive, rejecting, and unavailable, leading to hurt and distress. Alternatively, if there is attachment security, more expectations of the other as responsive and available are likely to ensue; this is more likely to be associated with positive aspects of relationship functioning, including high levels of trust and commitment and higher dyadic satisfaction (Kobak & Hazan, 1991). In the current study, the PMS experience highlighted that some couples may have been experiencing attachment insecurity, in particular Denise and Dave. Other couples (for example, Rita and Maxwell; Elaine and Mark) appeared more securely attached in their relationships.

The couples' sense of insecurity was dealt with by both couple members when trying to gain some control of PMS. One way in which this was most apparent was that some men reported wanting to know the timings of the premenstrual period, while the women seemed to withhold this information. This pattern may suggest that the partners

try to attribute undesirable changes, such as tension and hurt, to PMS, rather than recognising their own role in the conflicts that occur. By keeping details (for example, timings) of the premenstrual change hidden from their partners, these women may have been attempting to make their partners more aware of what they do to exacerbate distress. The consequence of this for the couple, however, is a potential inability to discuss any details of PMS and the woman's cycle; and, thus, any underlying emotional issues that tend to resurface and create conflict. This leads to a sense of mutual powerlessness and reinforces the negative perception of the PMS experience. This finding supports previous research that reports on the notion of heterosexual couples' limited discussion of PMS. This is suggested as being due to unhelpful partner responses to women's PMS, as well as women's reported pessimistic attitudes toward their partner's ability to understand their PMS experience (Ussher & Perz, 2013). This dynamic will be further explored in the section 4.2.5.

Negative impact on the partner. Corresponding with previous studies indicating that male partners have been found to be distressed by their partner's PMS (Brown & Zimmer, 1996), the current study also found that the majority of the male partners were adversely affected by PMS. Most partners discussed experiencing confusion, anger, anxiety, hopelessness, and depression alongside the women. These findings are similar to those reported in other in-depth research conducted with male partners (King, 2013; Ussher, 2011). For example, Ussher (2011) found that some men described feeling exhausted due to not knowing how to support their partner. King (2013) also found that most of the 12 male partners interviewed, described the negative effect of their partner's premenstrual changes on themselves and their relationship. The men's descriptions were similar to those reported in the current study, including a perception of the premenstrual time as a "problem" and "irritating" (King, 2013, p.255). Unlike Rundle's (2005) study, which reported that one partner considered the positive impact of PMS on relational dynamics, none of the participant men in the current study discussed PMS as a positive experience. One participant, James, was the closest to contemplating this idea: he saw the potential of discussing PMS in order to better manage it within his relationship with Mary. This corresponds with the majority of existing studies that report on the more negative aspects of the PMS experience and the negative experiences stated by the male partners (Rundle, 2005).

The partner's role in the PMS experience. Previous research has suggested that some men may increase women's premenstrual distress; in particular, through their

negative evaluations of PMS – by labelling women as “mad”, by a lack of empathy, support or acceptance of PMS, or by trivialising women’s emotional responses (Cortese & Brown, 1989; Mooney-Somers et al., 2008; Ussher & Perz, 2008; Ussher & Perz, 2013). It has been suggested, therefore, that these kinds of responses from partners may lead women to feel unable to access support and comfort (Mooney-Somers et al., 2008; Ussher & Perz, 2010). I believe that a more joint negative evaluation of PMS was expressed in the current study than has typically been conveyed in other research (Slade et al., 2009; Ussher & Perz, 2013). This could be attributed to the conjoint interview format, which may have restricted the men’s and women’s ability to express their negative views of each other and PMS (for example, see Valentine, 1999). However, generally this was not the sense that I felt during the interviews; instead, it seemed that couples held a mutually negative view of PMS.

The current research, therefore, perhaps reflects a different perspective – that of the couple – that previous research may have overlooked. For example, none of the women explicitly expressed that their partners contribute to increasing their PMS distress, as previous research has reported (Mooney-Somers et al., 2008; Ussher & Perz, 2013). Although similar wishes and needs to those previously reported were expressed by the women in the current study, the couples seemed to communicate more indirectly than has previously been described. For example, many of the women wanted their partners to express more empathy, understanding, and acceptance of their PMS behaviour and emotions, as well as to be more supportive (for example, offering practical help or emotional support), but they did not generally express this in a direct and transparent way to their partner. In some cases, the women’s wishes seemed to be something that couples had not discussed at length before the research interview. Some of the reported reasons for this were feelings of embarrassment and pessimism (for example, Mary) and earlier experiences of feeling unsupported (for example, Olivia). Many of the men described feeling confused about what their partners wanted from them (for example, Maxwell), while the women were left feeling unsupported, angry, and sad. This seemed to have a damaging effect on the relationship, leading to increased conflict and a sense of disconnection between the couple (for example, Denise and Dave; Olivia and Joe).

In contrast, and corresponding with previous research, this study also included many accounts of partners being understanding and aware of the woman’s PMS; thus, offering support and being considerate of the emotional and physical changes occurring

(Hoga et al., 2010; Ussher & Perz, 2008). In the current study, many of the women described their partners as providing practical and emotional support (for example, Margs and Rita). It could also be argued that the partner's physical presence in the interviews exemplifies this love and support. Again, this may be a reflection of the joint interview process; however, during our meetings I sensed the love, care, and commitment within the majority of the couples, which was shown through their interactions (for example, holding hands and consoling each other when upset). I interpreted this as further evidence of the supportive process that occurs in the relationship during and outside of the premenstrual time. As previous research has shown, these more helpful responses from partners seemed to lessen the women's distress (Ussher & Perz, 2008). This contributes to the argument that male partners have a positive role in a woman's PMS experience (Perz & Ussher, 2006; Ussher et al., 2007). It also adds to the existing evidence that PMS is a relational experience, with both couple members being affected (King, 2013; Ussher & Perz, 2013).

PMS as form of relationship stress. As captured in the couples' accounts, PMS, by its nature, seemed to be a chronic, yet intermittent (monthly) adverse experience. This notion was captured by Elaine, who said, "*women are dealing with this...every single month for a large proportion of their lives so and therefore it's affecting their kids and their husbands*" (Elaine, 983–984). It seems possible that over time, the recurrence of such adversity is likely to impinge on the relationship. For example, many couples reported that PMS creates an emotional and physical distance between them. This experience may possibly lead to the couple contemplating divorce or separation from each other, as indicated in studies of couples' experiences of depression (Gotlib & Hammen, 1992). For the couples in the current study, PMS has the potential to lead to relationship difficulties over the long-term.

One way in which couples expressed this relationship difficulty was in their descriptions of PMS as an additional stressor that added to the existing hassles in their daily lives (as reported in section 3.2.1). PMS may not be viewed as a major external stressor to a couple relationship; for example, in the same way as terminal breast cancer (Badr, Carmack, Kashy, Cristofanilli, & Revenson, 2010). It is argued, however, that PMS was experienced by the couples in this study as a chronic minor stressor, or a daily hassle. This type of hassle has been found to be an underestimated source of significant relationship stress for many couples (Revenson & Lepore, 2012). Some recent research shows that stress from daily irritations can lead couples to experience more intradyadic

(relationship) stress, which, in turn, is associated with lower levels of relationship satisfaction (Falconier, Nussbeck, Bodenmann, Schneider, & Bradbury, 2015). Furthermore, high levels of stress have been shown to negatively affect marriages (Neff & Karney, 2009). None of the couples in the current research talked explicitly about being unhappy in their relationships. However there was an overriding sense that PMS was creating relationship stress, as highlighted by the relationship conflict, feelings of disconnection, and the lack of intimacy reported.

For those couples with young children, including Denise and Dave, Elaine and Mark, Mary and James, and Rita and Maxwell, parental stress is also likely to contribute to these difficulties. Such stress has been described as the adverse psychological response to the demands of being a parent and may affect parenting and the quality of the parent-child relationship (Widarsson et al., 2013). Perhaps the overwhelming negativity around PMS reported by the couples is actually a communication of the wide-reaching effects of the stress that PMS creates for the couple and family relationships. For example, some of the existing research indicates that there is an association between women's stress levels and the severity of their premenstrual symptoms. For example, with higher stress levels it is more likely that a higher number of premenstrual symptoms are reported (Beck et al., 1990; Sadler et al., 2010; Warner & Bancroft, 1990; Woods et al., 1998). The influence of biological and hormonal factors are cited as explanations for this association (Nepomnaschy, Welch, McConnell, Strassmann, & England, 2004; Rabin, Gold, Margioris, & Chrousos, 1988; Roca et al., 2003). The current findings suggest that while stress may affect a woman's premenstrual symptoms on an individual level, this stress is not necessarily limited to the woman; it also affects her relationships and is experienced by her partner and her family.

4.2.2 PMS as a negative relational experience: suggestions for professional practice

Reducing stress. In light of these explanations and the current findings, it would seem important to consider the impact of stress when working with women and couples experiencing PMS distress. These couples may benefit from learning how to reduce their everyday stress levels. Part of the therapy could focus on helping them to develop and improve their individual and joint coping skills in order to be able to manage stress more effectively. For example, cognitive behavioural couples' therapy (CBCT; Epstein & Baucom, 2002) may be used with couples to improve ways of communicating with each other and understanding each other's experiences of stress. Additionally, the

CBCT approach may help couples to enhance their dyadic coping skills. This can be done by focusing on how each partner provides emotional (for example, empathic understanding and responding) and practical support (for example, suggesting solutions). Couples could also benefit from developing joint coping strategies to help them to manage stress together (for example, talking about joint solutions or relaxing together).

Working with negative expectations of PMS. The majority of the couples' accounts included negative expectations of the relational impact of PMS. An advantage of having such expectations is the potential to lessen the couples' PMS distress at the time. However, anticipating the worst outcomes of PMS may lead them to feel worse about PMS during the non-premenstrual time. This phenomenon has been reported in several other studies examining other distressing experiences (for examples, see Golub, Gilbert, & Wilson, 2009). To decrease their sense of dread around PMS, couples may benefit from understanding the power of negative expectations. Within the CBT approach, such negative expectations would be deemed as an unhelpful thinking pattern; namely, catastrophising or predicting. A CBT approach may, therefore, be applicable in order to challenge some of the negative assumptions that the couples may hold around PMS.

Furthermore, couples could benefit from shifting their focus to some of the more positive aspects of their PMS experience. For example, some of the couples expressed that the premenstrual time provides an opportunity for individual for self-care (Margs), for being able to express their emotions (for example, frustration and anger) (Olivia), and for implementing joint coping strategies (for example, problem-solving) (Bob and Margs). However, they also reported that often, they did not focus on these aspects when they were in the midst of PMS. Couples, therefore, could be encouraged to shift their focus away from what they perceive as not working or "wrong" in their relationships during the premenstrual time and toward what does tend to work for them. This may encourage a greater sense of optimism; thus, empowering couples to cope with the adversity of the PMS experience. A therapeutic approach such as positive CBT may be of relevance here (see Bannink, 2014).

Encouraging resilience. Similar to the idea of promoting optimism is the notion of resilience. Resilience can be explained as the ability to endure and recover from adversity. In therapy couples could be helped to focus on their strengths rather than deficits in order to improve their functioning and well-being and enhance their

relationships (Luthar, Cicchetti, & Becker, 2000). For example, the current study found that, despite the challenges posed by PMS, most couples demonstrated a sense of resilience through their expressed love, acceptance, and collaborative problem-solving. A similar phenomenon has been found in research into men's experiences of endometriosis, where the men developed an admiration for their partner's courage in dealing with their difficulties (Fernandez et al., 2006). The authors concluded that this led to strengthening their relationships, improved their emotional awareness, and contributed to the discovery of unrecognised self-strengths.

An apparent way in which the couples in this study could be helped to develop their strengths to promote a sense of resilience is to bring into focus the many different helpful coping strategies reported. These included exercise, diet modification, relaxation, and supportive practical help around the home. For example, a major finding was the women's shared accounts of trying harder to employ self-care (for example, by taking time out or giving some responsibilities to their partners). Therefore, PMS and its relational impact could be framed as an opportunity for these couples to refocus their attention on what is important in their relationships; for example, enjoying shared activities by engaging in individual, couple, or family time.

Developing communication and intimacy within the couple. A further suggested way of helping couples to cope better with the perception of PMS as a burden is to encourage discussions of PMS as a normal relational experience. For example, James and Mary revealed that they had not discussed the PMS experience together at length. They also reported some potential benefits of opening up communication between them about PMS. This is consistent with King's (2013) findings, which showed that couples' discussions of PMS as a normal experience seemed to increase the participant men's positive perceptions of PMS within their relationships. Previous studies have also found that effective communication can improve couples' experiences of PMS (for example, Frank, et al., 1993; King, 2013; Rundle, 2005). It may be useful, therefore, for therapists to help couples to develop more open lines of communication regarding PMS. Hopefully, this will lead to cultivating a more honest understanding of each other; for example, of each other's needs, vulnerabilities, and wishes. This may lead them to have a more empathic perspective of their own and their partner's role in their shared difficulties (Abse, 2014). This understanding, along with the process of acceptance, may help couples become closer.

4.2.3 Positioning of PMS as “my” or “your” versus “our” problem

A central finding of the current study is that PMS is typically perceived by the couple as the woman’s problem (by both members of the couple). This is largely due to the biology of the experience: it is the women who are experiencing the symptoms. When this position was challenged by participants in this study (for example, by Olivia), it was met with the partner’s reluctance and resistance to view it as a joint problem. Contributing to this unwillingness was the men’s tendency to position themselves as ‘other’ to their partners (as premenstrual women), which corresponds with previous research (King, 2103). Similar to the men in King’s (2013) research, many of the men in this study reported not completely understanding their partner’s PMS; thus, they tended to adopt a position of naivety about how to alleviate the effects of PMS within the relationship. Corresponding with the men’s reports in King’s (2013) study, those men who struggled the most to make sense of their partner’s PMS (for example, Joe) tended to respond with anger, aggression, rejection, and avoidance.

Some of the other men were more accepting of their partners than the women were of themselves (for example, Douglas and James seemed to discourage their partners’ tendency to self-blame). These men may have been attempting to support their partners; however, such responses may also be attributed to the men’s perception of PMS as not necessarily being their own biological, hormonal, or emotional “problem” or “fault”. A disadvantage of this perception is that PMS may become recognised by the couple as part of the woman’s character and/or the woman’s weakness, making it difficult for the couples to see it as a shared problem and impeding opportunities to manage PMS effectively within the relationship.

Contributing to the couples’ perception of PMS as an individual rather than a shared problem was the women’s tendency to label themselves as either “mad” or “bad”; for example, “*a demon*” (Margs, 240) and a “*stupid witch*” (Mary, 466–469). The tendency to self-pathologise and position the premenstrual self as evil has been repeatedly reported by heterosexual women in previous research (for example, Cosgrove & Riddle, 2003). For instance, Ussher and Perz (2013) found that women who described their partners as critical, lacking in understanding, or unsupportive were more likely to use self-descriptions such as “mad” or “absolute psycho”. Furthermore, some women labelled the premenstrual self as monstrous, using terms such as “demon” or “bitch”. Such descriptions were also reported in the current study. The tendency for the women and partners to pathologise and stereotype, as well as to frame PMS as the

woman's problem, has the potential to damage the couples' functioning – not only during the premenstrual time. For example, interactions between the couple members may become based around the biased premise that PMS is the woman's problem, rather than a relational problem. This could result in dysfunctional communications, particularly around issues of power and control. This is supported by studies that indicate that effective communication between couples is associated with lower levels of premenstrual distress (Schwartz, 2001; Smith-Martinez, 1995). Ineffective communication, therefore, has the potential to increase the distance between the couple, resulting in feelings of resentment, blame, and anger. This was most evident in Olivia and Joe's account, where there was a clear framing of PMS as Olivia's problem. This contrasted significantly with Margs and Bob, who seemed to perceive PMS as a conjoint issue, leading to many more supportive joint coping efforts. This corresponds with other studies reporting on how conjoint coping strategies benefit the couple's functioning (Frank et al., 1993).

4.2.4 Positioning of PMS as “my” or “your” versus “our” problem: suggestions for professional practice

Framing PMS as a joint problem. It is suggested that in the context of couple therapy, the concept of PMS could be introduced by the therapist as the couple's rather than the woman's problem. This is supported by studies of couple treatment of PMS, which have found that couple therapy improves overall relationship satisfaction and reduces couples' levels of distress (Frank, 1995). This may help the couple by encouraging an examination of any held beliefs and assumptions about living in the position of the PMS sufferer and the non-PMS partner. It would also allow for the impact of these roles on the couple relationship to be explored. It is argued that couples may become more empowered when they are able to view PMS in a balanced way, as a shared relationship issue (Rolland, 1994). The joint reframing may also help the couple to guard against the potential for either member to use PMS against the other; for example, in times of disagreement.

A perceived way in which couples may be able to frame PMS as a joint issue is through the joint monitoring of PMS. For example, a major finding of this study was the reported lack of thinking about the menstrual cycle and the premenstrual phase. This contributed to feelings of anxiety, confusion, and frustration. It is suggested that noting down when PMS symptoms are likely to occur may help couples to be able to bring to it into focus, by being more mindful of particular reactions. I am aware however that

many of the women highlighted a preference for not wanting to share premenstrual details with their partner. If they were to disclose this information, however, it may lead to a sense of control over PMS reactions, through a better understanding of the emotions, thoughts and behaviours that occur in the relationship in the premenstrual time. This could take the form of a standard paper or online diary (for example, as provided by the NAPS website). Both couple members could engage in PMS monitoring, potentially leading to more effective and open communication between them and increasing mutual support. The joint monitoring of PMS symptoms is supported by studies that report on its benefits; these benefits include more discussion between couples around individual and marital relationship needs and their behavioural strategies (Frank et al., 1993).

White and Epston's (1990) concept of externalisation may be useful in this sense. For example, the process of externalising the PMS experience provides a way to position PMS as a problem that is separate and distant from the couple. For example, by referring to PMS as "the" or "this" PMS, rather than personalising it. This process of externalisation may help the couple to recognise that together there is an opportunity to be able to understand PMS, leading them to feel less overwhelmed. Couples may need help to differentiate between externalisation and potentially more unhelpful defences, such as denial or projection. For example, within narrative therapy, constructive externalisation is viewed as the process that individuals follow to create a position of distance between themselves and the problem (White & Epston, 1990).

The process of externalisation may be viewed as being in conflict with the idea of acceptance and the process of normalisation discussed earlier. However, I believe that externalisation could create a position of distance that may enable couples to gain acceptance. This is similar to the processes of cognitive defusion and acceptance outlined in acceptance and commitment therapy (ACT) (Harris, 2006). The ACT approach uses the tradition and practice underpinning mindfulness meditation to enhance acceptance, which has also been suggested to help women to accept PMS symptoms (Ussher, 2011). Therapists could encourage couples to regard PMS symptoms and responses in their relationships as difficult and normal; however, instead of repressing, criticising, or denying these symptoms and responses, couples are encouraged to notice and accept them. Along with ACT, other relevant therapeutic approaches that are also based on mindfulness include: mindfulness-based stress reduction (MBSR) (Kabat-Zinn, 1990), which uses a combination of mindfulness,

meditation, body awareness, and yoga to enhance awareness; mindfulness-based cognitive therapy (MBCT), which combines aspects of cognitive therapy and training in mediation (Teasdale et al., 2000); and mindfulness-based relationship enhancement, which uses mindfulness to foster awareness in order to enhance access to joy, compassion, and connectedness (Carson, Carson, Gil & Baucom, 2004). Drawing on these approaches may help women, partners, and couples to increase acceptance of PMS in their relationship. This may hopefully enhance their overall relational experience of PMS.

It is noted that this may be a challenging process due to the many unhelpful and damaging stereotypes and stigmas that surround women's and heterosexual couples' experiences of PMS. This will be addressed further in the sections 4.2.5 and 4.2.7 below.

4.2.5 PMS as a gendered experience

The issue of gender was expressed throughout the couples' accounts. In particular, it was evidenced in the many expectations that participants placed on themselves and on each other, as well as expectations that were socially and culturally assigned. Gender also seemed to influence the way in which the couples explained the confusion and conflict they experienced during the premenstrual time. This is supported by literature discussing ideas of PMS as a gendered phenomenon (for example, Figert, 1995; Markens, 1996). It also supports the growing body of research which suggests women's experiences of PMS are particularly affected by their partners in heterosexual relationships (Mooney-Somers, Perz, & Ussher, 2008; Rundle, 2005; Ussher & Perz, 2008, 2013). Unlike previous research, however, this study explored both members of a couple alongside each other, focusing on the couple relationship "in action".

Gender differences. The current findings revealed the many gender differences that are highlighted in the heterosexual couples' experiences of PMS. In particular, couples reported disparities in the areas of communication, including conflict, and intimacy. A commonly reported experience was women's perception of their partners as not understanding or listening to them. The majority of the men reported that their partner's responses to their attempts to provide help and solutions were confusing and frustrating. Many of the women also expressed expectations that their partners should be telepathic: their partners should know how they are feeling, what they are thinking, and what they are expecting without having to be told. This suggests that these women may desire to feel close to their partners. Such unrealistic expectations, however, lead to

the opposite effect – leaving partners feeling frustrated, angry, unappreciated, and unloved. It seemed that the women gave the men little information to work with in order to be effective partners; for example, by applying problem-solving skills. This supports previous research that has reported on the notion of discussion around PMS becoming a “double-edged sword”. For example, Ussher and Perz (2013) found that the majority of the women in heterosexual relationships in their study had a pessimistic view of their partners’ abilities to understand their PMS experience. This appeared to limit the couples’ discussion around PMS. A similar dynamic was also clear in the current study. However, rather than being driven by the men or the women only, for some couples it appeared that the lack of discussion around PMS was due to how they related to each other. The women appeared to have a perception of the men as not understanding and the men largely perceived the women’s PMS-related emotions and behaviour as confusing. As such, there seemed to be a reported miscommunication between the couples and many expectations of each other with regard to the PMS experience remained unmet.

Gender stereotypes. In the current study, it was found that the men and women both reported experiencing various gender stereotypes. For the women, PMS seemed to challenge and reinforce their femininity. Various stereotypes of women experiencing PMS were expressed in the couples’ accounts, including women as “*mad*” (Douglas); women as “*hysterical*” (Elaine); the “*mad cow*” and the idea that “*all women are basket cases*” (Samantha). These descriptions suggest that women who experience PMS deviate from the socio-cultural standard of being emotionally stable, unchanging, and nurturing (Ussher, 2004). Additionally, many women reported feeling overwhelmed by the multiple responsibilities of being wives/partners, mothers, and employees. Most of them expressed guilt about not being able to remain in control of all aspects of their lives.

Many of the women, particularly those women with children (Denise and Mary), also seemed to adhere to feminine norms by expressing that they focused on others (children and partners) at the expense of their own needs. This seemed to lead to feelings of anger (usually unexpressed) and to blaming others (usually partners). Other qualitative research conducted with women have reported similar experiences (Ussher, 2004). This perhaps demonstrates that women may inherently observe feminine norms, including those relating to women as carers. It may also demonstrate the power of social and cultural expectations of females as being responsible for the emotional well-being

of others (Ussher, 2006). It is suggested that this is not necessarily always detrimental. For example, it can lead to women choosing to work in perceivably caring professions, including counselling psychology. However, some women may experience difficulties with being able to accept their inability to meet self- and socio-cultural imposed expectations, which is heightened during the premenstrual time when they feel vulnerable to external stress (Ussher & Wilding, 1992).

In the current study, Samantha's struggle with this was the most obvious. She seemed to strongly deny or repress perceived "feminine" or "weaker" characteristics during the premenstrual time, which she explained was due to working in a male-dominated profession and workplace. Samantha's experience highlights a discourse of PMS having no place in the workplace or the public domain. This is supported by the emphasis on secrecy and maintaining sanitation in the socio-cultural portrayal of menstruation (Coutts & Berg, 1993). Samantha's experience also corresponds with studies indicating that PMS has a negative impact upon a women's work life (Dean & Bornstein, 2004; Hylan et al., 1999).

As Elaine and Mary pointed out, parents can actively shape their own children's gender roles throughout childhood. Thus, trying to challenge some of the negative and unhelpful stereotypes borne out in the PMS experience that may limit women and men seems particularly important. For Elaine, it was crucial for her young sons to be "emotionally intelligent"; thus, to transcend the idea of the stoic male who does not express emotion. It was also important that her sons understood and were able to empathise with the emotional and physical difficulties women may face due to PMS. Elaine was perhaps highlighting her own attempts to challenge the stereotype of the premenstrual woman as mad or bad that is often depicted in society; for example, through media representations. Elaine's efforts could be a source of inspiration for how the other couples could challenge the unhelpful dominant gender stereotypes that they encounter. Further ways of achieving this are suggested in section 4.2.6.

The men's accounts also included discourses around stereotypes of masculinity. For example, they generally expressed a stoic attitude to PMS. Many of them described trying to support their partner by attempting not to get angry themselves and remaining in control. Consistent with dominant masculine norms, the findings also indicated that the men seemed to view PMS as a problem to be solved. Dave and Mark, for example, seem to take on an advocate role for their partner in GP consultations, while Bob actively helps Margs to problem-solve. All of the men also described feeling helpless

because they are not able to find a solution to their partner's PMS and the distress it causes her and their relationship. These are similar to findings drawn from qualitative accounts of men's experiences of their partner's endometriosis, which also reported that masculine norms were in some ways reinforced by this experience (Denny et al., 2013).

Similar to the women's accounts, some men also discussed the way in which the PMS experience seemed to highlight some unhelpful male stereotypes. These included men restricting their feelings and their expression of those feelings; as Mark says, being "a typical bloke". This was most evident in that certain men seemed to feel constrained by not being able to discuss their own and their relational experiences of PMS outside of the couple relationship. This difficulty seemed to be most obvious for Bob and for Douglas. For example, throughout Douglas' account there was a struggle to meet perceived expected masculine norms. In particular, these related to being in control and being all-supportive – in his words, an "invulnerable tower of strength" (Douglas, 1230–1238) – rather than emotionally expressive. This led to feelings of isolation from society (by not living up to expectations of men) as well as within his own relationship (by not being able to be more practical than emotional). This was made more difficult because his wife, Samantha, seemed to be experiencing her own gender conflict – not wanting to appear weak or feminine within her male-dominated profession.

These findings could be viewed in light of the experience of men's gender role conflict (GRC). O'Neil (2008) defines GRC as a psychological state in which socialised gender roles have negative consequences for the individual and others. This occurs when rigid, sexist, or restrictive gender roles lead to personal restrictions, devaluation, or the violation of others or oneself. For example, the emotional restriction of men may have positive outcomes, such as helping them to remain calm during a crisis. However, such a restriction may also lead to difficulties with establishing an emotional connection within their relationships. If men do express their feelings within their relationships, they may experience gender role strain and the impact of GRC, including feelings of loneliness and detachment. GRC has been proposed as potentially leading to psychological and interpersonal problems for boys and men. For example, O'Neil's (2015) review of over 90 studies indicates that there are significant relationships between masculine norms and various adverse outcomes, including negative psychological attitudes toward women, low self-esteem, negative attitudes toward help-seeking, hostility and aggression, depression, anxiety, and marital and family problems.

In terms of the current study's findings, the majority of the men discussed feeling marginalised and confused, not knowing how to best respond to and support their partners, or how to share their own needs with others. This is similar to Ussher's (2011) study, which found that some of the participants felt exhausted by not knowing how to provide support. Such findings are also similar to qualitative studies of male partners' experiences of other women's health issues, including endometriosis and gynaecological cancer (for example, Denny et al., 2013; Fernandez et al., 2006; Maughan et al., 2002). In the current study, the men's accounts also indicated a gender experience of woman as "other" to man. This was evidenced by the men's reports that PMS and menstruation are private matters and a woman's problem, along with feeling ostracised and helpless to support their partners. This may be partly due to a lack of empathetic language around such issues. The perceived inability to discuss experiences of PMS distress with others was particularly concerning for some men. This corresponds with the men's accounts in King's (2013) study, which reported that discussions within the couple that constructed premenstrual change as a normal experience contributed to a more positive perception of PMS within their relationships.

4.2.6 PMS as a gendered experience: suggestions for professional practice

Gender therapy. To understand and manage the consequences of gender differences in their relationships, it is suggested that a first step may be for these couples to recognise and understand those consequences. As such, gender therapy may be appropriate. Psycho-educational interventions integrated into therapy may be of use, by re-contextualising couples' problems to include a gender dialogue. Parker (1999) suggests that such practices could include naming gender differences in order to normalise those that are reported by the couple. In this case, the therapist would need to be careful not to promote gender stereotypes. Additionally, couples could explore and discuss the gender role stereotypes that might have shaped each partner's current beliefs and practices, as well as the social and political contexts that support these stereotypes. Lastly, the couples could engage in exercises that allow them to understand each other's needs and wants (for specific examples, see Parker, 1999).

It seems that some men in this study may benefit from trying to reduce the negative effects of GRC. Although challenging, particular therapeutic approaches developed specifically to resolve GRC in men may be relevant. For example, gender role journey therapy (GRJT), which draws on aspects of the transtheoretical therapy approach (Brooks, 2010; Prochaska & Norcross, 2001) and the deepening framework

(Rabinowitz & Cochran, 2002) may be of use. GRJT involves evaluating thoughts, feelings, and behaviours about gender roles, sexism, and GRC (O’Neil, 2015). It also includes looking at the development and influence of the client’s beliefs about gender roles. By being helped to re-assess their ideas of masculinity and femininity, the client is able to then critically evaluate any unhelpful stereotypes that they may adhere to; for example, those leading to the experience of discrimination or oppression in their personal and professional lives.

4.2.7 The role of stigma

The majority of the couples described their experience of PMS as encompassing a stigma that was self- and socially derived. Menstruation-related stigma has received some research attention (Johnston-Robledo & Chrisler, 2013; Oxley, 1998); however, while reviewing the literature, it was evident that less consideration has been given to PMS-related stigma. This may reflect how PMS is understood. It seems that there is an added “silence” around PMS, which is not only related to socio-cultural perceptions of women as not coping with a “normal” “female” experience, but also, in some cases, related to their partners and the couple together. This was seen in the way in which many couples seemed to be mentally disengaged from the menstrual cycle and PMS. For example, the couples tended not to record or discuss the menstrual cycle with each other. Many of the couples discussed being surprised by and unaware of the arrival of the premenstrual period. By not talking about PMS together, the couples may have been aiming to guard against potential feelings of shame associated with PMS and its impact on the relationship (for example, increased conflict and resulting disconnection). With limited studies examining couples’ experiences of PMS-related stigma, there is little evidence to base the current study’s findings on. It could be suggested, however, that a lack of discussion around the issue of PMS within the relationship serves to maintain the experience as unrecognised and shameful.

Self-stigma. Several women in the study reported feeling embarrassed about disclosing PMS to their partners (Mary), family members (Margs), and work colleagues (for example, Elaine and Samantha). Similar negative attitudes toward PMS, including embarrassment and considering the symptoms as a sign of weakness, have been reported by Robinson and Swindle (2000) as being associated with women’s reluctance to receive any help. The women’s experiences in this study could be described as the experience of self-stigma, as mentioned in other studies (Ussher, 2006). The concept of self-stigma has been defined as a perception of the self as being socially unacceptable,

which leads to an internalising of stereotypes, triggering lowered self-esteem and self-efficacy (Corrigan & Shapiro, 2010; Vogel, Wade, & Haake, 2006). The majority of the women in the current study spoke about negative self-perceptions related to PMS, including being “mental” and “out of control”, resulting in anxiety, isolation, and shame. This suggests that stigma can have a detrimental impact on psychological well-being (Stutterheim et al., 2009).

The partner’s experience of stigma. The current study found that PMS-related stigma was not an experience confined to women. Broadening the existing research, the current study also found that the silence around PMS also affected partners. Having to keep PMS a private issue for fear of going against social norms and putting the couple relationship at risk of criticism from others, or fear of exposing their partner’s personal issues, seemed to lead some male partners to feel restricted, anxious, and unsupported (for example, Bob and Douglas). A similar experience was reported by some of the men in King’s (2013) study, adding to the suggestion that these men may benefit from discussing their concerns with others but have not found the right context in which to do so. Most of the men in the present study described tendencies not to speak to others about PMS experiences and a desire for increased opportunities to feel understood. These findings contrast with existing literature that suggests that, compared with women, men are able to speak more openly about menstruation (Laws, 1991).

The male partner’s experience in the current study may be understood in relation to stigma by association (SBA). SBA has been found to lead to decreased self-esteem and increased psychological distress in those connected with stigmatised individuals (Mak & Kwok, 2010; Struening, Link, Hellman, Herman, & Sirey, 2001). As the current study showed, many of the men reported fears connected with discussing their partner’s PMS with others. Someone affiliated with a PMS sufferer may be perceived as potentially “exposing” their partner as having some sort of defect and revealing a deficiency in themselves and their relationship. Research on experiences of SBA related to mental illness has suggested that in order to reduce SBA, and encourage social support, individuals may be open with selective others about the difficulties they face (Bos et al., 2009). In the current study, this was something that Douglas in particular engaged in and Bob wished to do more of.

Social stigma. All participants’ accounts revealed that a social stigma is attached to PMS. Social stigma has been described as originating from people’s held cognitive representations regarding those with a stigmatised condition, potentially

leading to adverse emotional and behavioural reactions (Dijker & Koomen, 2003; Weiner, Perry & Magnusson, 1988). This is supported by some of the couples' reports, which indicated concern about others discovering their PMS and other people's potential negative responses (for example, Samantha and Douglas; Margs and Bob), including being labelled as depressed or mad. As discussed in section 4.2.5, various gender stereotypes expressed in the couples' accounts also indicate that there is a social stigma around PMS; in particular, perceived norm violations of emotional stability. The couples' accounts also revealed a perception of PMS as a taboo topic. They expressed several cultural beliefs that seemed to reinforce this notion, including views that there is no place for PMS in the workplace. Also conveyed were descriptions of particular social, economic, and political powers operating within their worlds; specifically, the idea of Western societies promoting a sense of individualism in dealing with PMS compared with collectivist and "respectful" Eastern cultures (Mary and James). Such political and social ideas were expressed as perhaps contributing to maintaining PMS as an individual problem that should be treated as such. It seemed that the couples would have preferred PMS to be considered as a relational issue, deserving of support and empathy from others. This was largely conveyed in section 3.4.3.

These findings could be understood in terms of the operating of structural stigma (Bos et al., 2013). This refers to societal ideologies and institutions perpetuating and exacerbating the stigma around PMS (Corrigan & Lam, 2007). For example, contributing to negative attitudes and cultural beliefs about menstruation and PMS through their portrayal in the media and through menstrual products that promote secrecy (Erchull, 2013). A further way in which social and structural stigma around PMS may be maintained is through the positioning of severe PMS as a mental illness. For example, feminist critics, such as Chrisler and Levy (1990), have debated the inclusion of late luteal phase dysphoric disorder (LLPDD) as a category in the DSM-IV (see Chrisler & Levy, 1990). They argue that this inclusion increases stigma around PMS. Such recognition, however, may also encourage women to seek treatment; thus, in fact, decreasing stigma. As the current study found, most of the couples did try to seek help for PMS distress; thus, in a way they were attempting to challenge the stigma. However, the couples who sought support were either not in agreement with, or did not like, the treatment advice being offered by GPs (anti-depressants). Others did not wish to be perceived as depressed and generally did not feel "heard" by health-care professionals. In the couples' accounts, it appeared that stigma was operating on a socio-cultural and structural level, as well as on an individual and couple level.

4.2.8 The role of stigma: suggestions for professional practice

Reducing self-stigma. In the current study, Mary provided a clue about what may help to reduce these women's sense of self-stigma related to PMS and facilitate a sense of feeling less isolated. She says, "*when I can move away from being embarrassed about it and talk to you (James) about it*" (Mary, 449–450). Perhaps a therapeutic approach that helps to explore some of the fears around disclosing PMS to others, including partners, would reduce self-stigma. A relevant approach may incorporate CBT to explore unhelpful thoughts and beliefs about the self that can be challenged through collecting feedback from others. Such exercises may help clients to develop more helpful self-statements and behaviours and, thus, decrease self-stigma. Alternatively, ACT could be used to address self-critical thoughts and become more accepting of the self through the processes of mindfulness and cognitive defusion (Harris, 2006).

Elaine offers a further suggestion for what may help women to deal with PMS-related self-stigma: "*women don't spend time with other women any more, we don't spend time with generations of women so you're dealing with it really on your own*" (996–998). The stigma around PMS could be reduced by helping women and girls to openly discuss PMS and menstruation, potentially leading to more positive attitudes. This may take the form of group therapy or, as Culpepper (1992) suggests, workshops in order to raise women's and girls' "menstrual consciousness".

Reducing stigma. Given the evidence, it would seem that trying to reduce the stigma around PMS is not straightforward or without obstacles. Several researchers, however, have identified the need to attempt the issue, and attention has begun to focus on ways of working to decrease stigma by debating and normalising women's experiences of PMS and menstruation (Johnston-Robledo & Chrisler, 2013). Raising public and health professionals' awareness of the issues faced by women, their partners, and the couple is one way of doing this. This is currently a major aim of NAPS. In turn, improved awareness and understanding of PMS may lead to more available and reliable support. Developing the profile of PMS through schools and the media, using up-to-date and relevant information, may also help to reduce stigma. Efforts should also be directed at increasing the awareness of the relational impact of PMS on partners and couples, so as to help men feel less marginalised.

For counselling psychologists working with women and their partners, it is proposed that a therapist who has some knowledge of PMS, such as common

premenstrual symptoms and their possible impact (for example, increased anger and conflict) could significantly enhance the level of support experienced by couples. This may improve the client's ability to manage their own distress. For example, if relevant to the therapy, to the client's concerns, and to the therapeutic model being followed, counselling psychologists and other health professionals could acknowledge PMS within sessions. If appropriate to the client and their presenting issues, professionals using a CBT approach could ask about premenstrual symptoms/PMS as part of the initial client assessment. This would be done collaboratively, using relevant information for the client formulation.

4.2.9 Feeling unsupported

As discussed in previous sections, including 4.2.7, the majority of couples expressed a difficulty in seeking out and receiving support, both from each other and from people and organisations outside the relationship. This corresponds with qualitative research on couples' experiences of depression, which found that couples described a sense of bewilderment and struggle with regard to the support process in the relationship (Harris, Pistrang, & Barker, 2006). This was complicated by the couples' ways of communicating and relating, leading to isolation and frustration.

Despite this, many of the men were supportive of their partners in various ways, which has also been reported in previous research (Hoga et al., 2010; King, 2013; Ussher & Perz, 2008). For example, like the men in Rundle's (2005) and Ussher and Perz's (2013) studies, many of the men in the current study reported giving their partner physical and emotional space. Many couples also described how practical and emotional support from the male partner eased premenstrual distress in the relationship, corresponding with existing studies (Mooney-Somers et al., 2008). Similar to the men as reported by the women in Mooney-Somers et al.'s (2008) study, the partners demonstrated their reassurance and understanding through expressions of love and support (for example, hugs).

Lack of support for the partner. As joint interviews were used in the current study, I believe this allowed for a more in-depth perspective of the male partner's PMS experience than has previously been explored in studies of PMS. Thus, a key finding in the current study was that many of the male partners seemed to experience a lack of support. For example, it was found that it was very difficult for the woman to be able to communicate her PMS experience to her partner in ways that enabled them to act in order to be supportive. Many of the women, for example, reported that their partners did

not really understand them. As Olivia states: “*all I want is for my PMS to be validated*” (417). In this study, it was found that this particular need for validation was echoed across the couples and applied to both couple members. A similar communication problem in heterosexual couples was reported by Harris et al. (2006), which caused the non-depressed partner to feel confused about what their partner was experiencing; thus, they turned to others (friends and family) in order to cope. While some of the male partners in the current study successfully turned to others for support (for example, Douglas), many reported feeling unable to do this. This was mainly due to fears of breaking confidentiality in the relationship by exposing their partner’s difficulties and relationship difficulties to others.

It was also found that masculine norms seemed to hinder men’s help-seeking efforts; this finding corresponds with some of the men’s reports in King’s (2013) study. In the current study, in particular, men did not feel able to talk about PMS-related issues with their male friends. However, it was not necessarily a stance that was liked or agreed with. For example, Douglas and Bob openly expressed opinions that it is restrictive. James also seemed to hint at this. It is suggested that some of the men may be influenced by masculine characteristics and cultural stereotypes, such as dominance and self-reliance and values of emotion suppression and stoicism (Seymour-Smith, Wetherell, & Phoenix, 2002). Such stereotypes and values have been found to potentially impede men’s access to health services and, thus, to information and support (Courtenay, 2003; Mahalik, Good, & Englar-Carlson, 2003; Smith, Braunack-Mayer, & Wittert, 2006). Studies also show that men may be more likely to internalise public stigma and society’s negative views toward psychological distress and help-seeking (for example, beliefs of being “inferior” or “weak” because of needing help) (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Although this was not the focus of the current study, and questions around this were not explored in depth, none of the men explicitly expressed similar negative views toward help-seeking. In fact, some men (Dave and Douglas) discussed receiving various therapeutic help in the past for particular emotional difficulties. This may be largely due to this particular participant group being more open and willing to discuss their difficulties; for example, in comparison with several male partners who decided not to take up the opportunity to participate in the study for unexplained reasons. Examining this further may give some clues to why some of the men found it less or more difficult to speak about PMS and seek help for emotional difficulties.

Lack of professional awareness and empathy. As section 4.2.7 also demonstrated, further contributing to the difficulty of the couple to feel supported was the stigma attached to the PMS experience. Some couples reported feelings of shame and embarrassment about discussing PMS-related issues. This potentially led to hindering both couple members accessing informal (for example, friends and family) and formal (for example, health professionals, such as GPs or counsellors) forms of support. Despite this, in the current study, some couples did seek help from others (for example, Rita and Maxwell). Participation in the interviews could also be seen as an attempt to open up about their relationship difficulties around PMS. The support that the couples had experienced was generally medical (for example, from a GP), rather than psychological (apart from Rita and Maxwell, who sought counselling) and was reported by the majority of the couples as being inadequate or unhelpful, suggesting their needs were unmet. It was also largely reported that PMS was not widely acknowledged or accepted by health professionals; thus, the couples perceived those professionals to lack empathy and be unaware of the potential impact of PMS. Denise and Elaine both described unsuccessful attempts to get help from their GPs, while Samantha reported problems with the medical treatment suggested (anti-depressants). This is supported by UK research that indicates that women seeking assistance for PMS distress found GPs, gynaecologists and other health professionals less helpful than alternative medicine services (Corney & Stanton, 1991). Further, the RCOG (2008) suggests that there is a shortcoming in the NHS of the provision of care for PMS.

Preference for self-management of PMS. The couples' reported negative and unsuccessful help-seeking attempts from medical professionals seemed to contribute to their desire to self-manage PMS. Even if no such experiences were explicitly stated, there appeared to be a general view of not wanting to rely on medical advice and treatment. As such, many of the couples indicated that they had a preference for complementary and alternative treatments (CAMs). For example, the use of diet modification, meditation, relaxation, self-acceptance, acupuncture, and herbal and mineral supplements were favoured over conventional medication (for example, anti-depressants). This view was driven by the women and actively supported by their partners. A resistance to medical authority and a questioning of pharmaceutical modifications (for example, the contraceptive pill) compared with "natural" processes has also been found in qualitative studies investigating women's decision-making around suppressing menstrual cycles (Repta & Clarke, 2011). This seems to indicate the importance that women place on being able to trust their body (Dan, 2013).

The current study also found that some women reported that their symptoms did not seem to fit with the diagnostic criteria of depression or PMS (for example, Elaine and Samantha). Furthermore, when treatment was offered, usually anti-depressants, couples seemed to become annoyed or upset about being labelled as “*depressed*” (Denise and Dave; Elaine and Mark). This seemed to make couples feel that their PMS experience was not considered as “real” or important, and that the treatment did not fit the experience or symptoms. There seemed to be a gap between what the medical professionals were offering and what the couples were experiencing. The reported preference for CAMs may be a reflection of the increasing UK and worldwide trend of seeking non-mainstream therapies and moving away from traditional Western medical practice (Ernst & White, 2000). Complementary therapies are also included in RCOG’s Green-top Guidelines for PMS (2007), despite the lack of evidence for their effectiveness. The recommendation of CAMs for PMS is compared with evidence-based pharmacological treatment options (for example, contraceptive pills and SSRIs), which are suggested for women with severe PMS or for whom simple treatment measures have been unsuccessful (for efficacy studies, see Brown, O’ Brien, Marjoribanks, & Wyatt, 2009; Dimmock, Wyatt, Jones, & O’Brien, 2000; Yonkers et al., 2005). The RCOG (2007) suggests that an integrated approach to treating PMS is beneficial. This also seemed to be expressed by the couples in the current study. However, there is limited provision of such services in the UK, as identified by many of the couples and reiterated by the RCOG (2007).

The participants’ desire to use CAMs could be considered as a reflection of wider socio-cultural views of PMS, in particular the confusion surrounding current PMS definitions and available treatments. The couples expressed that moving away from conventional medical models of PMS may reflect experiences of PMS as not just biological, but as an idiosyncratic experience that affects the whole person: emotionally, physically, behaviourally, psychologically, and relationally. The idea of PMS as a “multifactorial” experience has been discussed by other researchers and has led to the development of the MDI model, which has been used as a framework for a woman-centred therapy package (Ussher et al., 2002). This study adds to the idea of PMS as “multifactorial” by providing evidence that PMS is a relational experience that deserves greater professional focus.

4.2.10 Feeling unsupported: suggestions for professional practice

Improving support for women and couples. Overall, the couples' accounts suggest that there is a need for more support resources that aim to improve understanding of PMS among partners and other family members of the relational impact of PMS. GPs and other health practitioners could provide this alongside organisations such as NAPS. Information may include general facts about PMS, including the common symptoms and how women and relationships may be affected. It could also contain shared experiences, an explanation of what to expect as a couple, advice on how to support female partners and minimise the effect of PMS on various life aspects, and, for partners, advice on thinking about and attending to PMS effects. It may also be useful to provide opportunities for partners and couples to share with others in the same situation some advice based on their own experiences. Support resources, including audio-visual recordings and couple-focused support-group sessions, could also help couples to feel less alone. An online group similar to that provided for male partners of women who struggle with endometriosis, 'Men who Love Women with Endometriosis (MENDO)', could be established for partners of women suffering from PMS. This may help to reduce the social stigma around PMS, while encouraging men to feel less alone, supported, and more able to engage in help-seeking – a key finding in the current study. The benefits of online support would, however, need to be considered along with any potential risks; for example, the possibility of online relationships detracting from offline social involvement with friends (Cummings, Butler, & Kraut, 2002).

An additional way to improve support for women and couples living with PMS is to increase health professionals' awareness and understanding of PMS and its relational impact. This is in light of the present study's finding that couples often reported that GPs frequently misunderstood or misdiagnosed PMS. This likely to be due to a lack of medical consensus about PMS; thus, resulting in confusion about effective treatment and a dearth of awareness of the potential impact of PMS on women's as well as couples' lives. This research adds to the view that PMS is more than a biological issue; it is a complex, emotional, idiosyncratic, and relational experience, as reflected in the couples' reports of wanting to treat PMS in a more holistic way.

It is suggested that health professionals working with women and couples tailor treatment to meet the needs of the individual, the couple, and the family; for example, by considering PMS as more than a medical issue, offering empathy and alternative

treatments including CAMs and psychological input. This is supported by existing research that has identified the value of women feeling supported and listened to (Blake et al., 1998). Further reinforcing this is research that has begun to focus on alternative and progressive ways of providing PMS support to women (for example, iCBT) and recognises the importance of the awareness of women's thoughts and feelings related to their PMS experiences (Kues et al., 2014).

4.3 Summary

The focus of this study was to explore the relational experiences of seven couples identified as experiencing PMS. The couples discussed PMS as a highly negative relational experience that created difficulties communicating with each other, exacerbated conflict, and decreased their sense of intimacy. Amongst these couples there was a 'joint' negative appraisal and, thus, experience, of PMS.

Contributing to the adverse relational experience was the tendency for the couples to consider PMS as the woman's problem, rather than as a shared difficulty. This was made more difficult by the women's inclination to pathologise the premenstrual self and by the partners' tendency not to challenge this perception. In some cases, the partner rejected the idea of PMS as a joint problem to be faced together. Other partners seemed to make genuine attempts to support the women; however, there were difficulties communicating this within the relationship. This led to conflict, disconnection, and isolation. This was also largely due to gender differences, which seemed to be highlighted during the premenstrual time.

Shaping the couples' experiences was the stigma around PMS, which created communication difficulties within the relationship and with others outside of the dyad. This led to an overall sense of struggling for validation: from each other, from others (including health-care professionals) and of the self (in particular, the women). Overall, these findings highlight the need for increased awareness of PMS among individuals and couples, and more widely at a social and professional level.

4.4 Evaluation of the Validity and Quality of the Research

There are a number of suggested guidelines for good practice in qualitative research (for example, Elliot, Fischer, & Rennie, 1999; Yardley, 2000). The current study aimed to follow Smith's (2011) quality criteria for IPA as well as Yardley's (2008) principles for assessing qualitative research. Smith's (2011) criteria were developed to distinguish between good, acceptable, and unacceptable IPA studies. The current study aspired to achieve the "good" quality standard. It aimed to produce high-

quality work by: clearly subscribing to the theoretical principles of IPA; making the research process transparent to the reader; and providing a coherent and interesting analysis. Additionally, it has endeavoured to provide a well-focused, in-depth analysis of couples' experiences of PMS by offering engaging and enlightening interpretations. Evidence that a study meets Smith's (2011) criteria for an appropriate analysis and write-up includes an engaging analysis with a well-produced, sustained, rigorous narrative. This was done by following the suggested guidelines for evidence; thus, for the sample size, which was larger than 4–8, examples were given from at least three or four participants per theme and an indication was given of how the prevalence of a theme had been determined. Following Smith's (2011) criteria for a carefully composed write-up, the report provides an opportunity for the reader to learn in depth about participants' experiences of the investigated phenomenon.

Yardley (2000) suggests that for qualitative methods to be practical it is necessary for the research to be validated by criteria that are significant to those who are intended to benefit from the research. I attempted to address Yardley's (2000) four quality criteria, which include: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Yardley's (2000) first principle, sensitivity to context, encompasses a range of issues. First, the study is sensitive to the context of existing theory and research in the development of the research topic and question (Yardley, 2008). My attempts to address this criterion are shown in efforts to provide a thorough review of the relevant literature and determine gaps in the existing research on PMS and relationships. Additionally, Chapter 1 offers evidence for the argument that this research adds to existing quantitative research and provides the rationale and development of the research questions. Further, throughout the research process, awareness was developed of the context in which the material obtained from the participants was understood and analysed. I achieved this by examining how my own assumptions and point of view influenced the research, as discussed in section 4.6. I also considered the socio-cultural context of the participants. To ensure that the participant couples felt comfortable and were able to engage in the interview, I informed them about the research by phone or email beforehand. Additionally, I asked the interview questions in an open-ended, flexible manner to encourage participants to give their accounts. I briefed the participant couples at the beginning of the interview and de-briefed them at the end in order to allow them to express any concerns and ask me any questions.

Yardley's (2000) second principle, commitment and rigour, involves a personal commitment and investment by the researcher and thoroughness of the study, which is demonstrated through an in-depth analysis. Adherence to this criterion is demonstrated by my efforts to engage with the couples' narratives and by the analysis. I did this by giving examples from the participants' transcripts and continuously reviewing these to determine whether the analysis stayed close to the couples' accounts. I made attempts to give an adequate rationale for the choice of sample, to show that the participants were selected to match the research question, and to demonstrate that the sample was representative of the group chosen (Smith et al., 2009).

Yardley's (2000) third issue of importance relates to transparency and coherence. Transparency refers to how clearly the stages of the research process are described in the write-up (Smith et al., 2009). Coherence refers to how much the study makes sense as a consistent whole (Yardley, 2008). Measures to achieve transparency and coherence were taken by providing a detailed description of the design and procedures employed in order to make the research aims clear to the reader. The research process was supported by a paper trail concerned with the construction of exploratory comments, themes, superordinate themes, and analysis, all of which is intended to provide evidence of how I connected the initial data to the final report. From this information, the reader can decide the appropriateness of the methodology and how systematically the process of analysis was conducted (Meyrick, 2006). Attention to transparency is shown through my endeavours to demonstrate reflexivity throughout the research process; in particular by stating the study's epistemological stance and awareness of how my experience and related beliefs and assumptions have shaped the findings throughout the study (Meyrick, 2006).

The final criterion is that of impact and importance (Yardley, 2008). This was addressed by focusing on the meaning of the lived experience of PMS in the relationships of this group of couples in order to increase counselling psychologists' and other related professionals' awareness of their specific issues. The aim is to illuminate these issues to encourage deeper understanding and a sense of empathy to enhance clinical practice. This is viewed as important, as research has indicated that 95% of women experience at least mild premenstrual symptoms (Steiner & Born, 2000) and that PMS can adversely affect numerous areas of a woman's life, including her interpersonal relationships, social and leisure activities, sexual functioning, and quality

of life (Dean & Borenstein, 2004). Further, only very limited research has sought a deeper understanding and insight into PMS experiences, particularly for couples.

4.5 Limitations of the Study and Possible Directions for Future Research

Although I aimed to meet Smith's (2011) and Yardley's (2000) quality and validity criteria, some limitations were observed. The first is that the research findings cannot be generalised to all couples who experience PMS; instead, they give insight into and an interpretation of a small group of participants' experiences. This research had several exclusion criteria, which meant that some couples were overlooked by the study. The selected couples were heterosexual. This decision was based upon existing qualitative research, which has mainly focused on women's accounts or has been conducted with lesbian couples. Couples were also required to be cohabiting for more than one year, which excluded other potential couples; for example, those in a relationship but not living together due to religious beliefs or being in a long-distance relationship (as were two potential participant couples).

In addition, a few prospective participant women communicated via email that they were not currently living with their partners, partly due to the tension that PMS was creating in the relationship. It may be argued that they were suffering significantly and were highly vulnerable to the relational impact of PMS. Furthermore, many couples living with PMS may not experience the same level of relational understanding and support as those who participated; for example, due to couple members' differing perceptions about providing and accepting support from one another. This may have led to couples who were greatly affected by PMS not being able to participate, as evidenced by many women choosing not to participate in the study because their partner did not want to be interviewed. Future studies could investigate this further by using methods that do not require joint interviews, such as individual interviews with each couple member, or couple interviews done using alternative methods, such as Skype.

A further exclusion criterion was a co-occurring clinical mental health issue (for example, depression). Given that many women suffering from PMS may also be highly distressed, anxious, or depressed, this may have led to excluding some women and couples from participating. The nature of the study may have meant that those who were most severely affected by PMS did not partake. These people may have different experiences of PMS; therefore, future studies could explore this by using methods that do not require face-to-face participation, such as telephone interviews.

A further methodological limitation, outlined previously in Chapter 2 is the epistemological misalignment of the use of a medical-model questionnaire with IPA and the research aims. In hindsight, I would not have included the PAF as part of this study's recruitment process. Perhaps this categorising of PMS actually reflects a more general lack of awareness and understanding of PMS, which is a major finding of this study. Future research could build upon this by either taking a more positivist approach to couples research: using quantitative methods, such as questionnaires, to look at aspects such as relationship outcomes. Alternatively, it could build upon the current findings by conducting more in-depth qualitative studies with couples and relying on participants' self-identification of PMS.

The approach to data collection and analysis in this study, despite the strengths outlined in Chapter 2, could also be considered to have some weaknesses. Conducting couple interviews and analysing their joint accounts meant that the narratives were not clearly separate or individual, as each participant reacted to the other during the interviews; this could be perceived as challenging the idiographic nature of IPA. IPA research involving focus groups and variations of focus-group interviews, such as "facilitated group discussion" (for example, de Visser & Smith, 2007; Dunne & Quale, 2001; Flowers, Knussen, & Duncan, 2001) and other naturally occurring groups, such as "family units" (Macleod, Booth, & Crauford, 2002), have also challenged the idiographic nature of IPA. As Palmer, Larkin, de Visser, & Fadden (2010) argue, group discussion may actually elicit more experiential reflection than an individual interview. Furthermore, Flowers et al. (2001) suggest that, rather than diluting accounts of personal experience, the group dynamics in their study added something extra to the analysis that otherwise would have been missed (see also Wilkinson, 2003).

The approach in this study provides a representation of couples' experiences of PMS from a joint perspective across several couples. In line with Harris et al. (2006), an in-depth dyadic analysis of accounts within each couple was not possible due to the amount of data collected and the timescales of the study. Despite this, the current study's findings contribute to understanding the couples' experiences of PMS and highlight the significance of including both couple members in interventions aimed at helping them to cope with the adverse impact of PMS. This is further supported by the findings of research looking at other related mental health problems, such as depression, which suggest the usefulness of couple therapy for depression (for example, Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Cordova & Gee, 2001; Jones & Asen, 1999).

The helpfulness of couple therapy is also evidenced in this study via participants' reports of perceptions that the interviews were useful for them (for example, Denise and Douglas).

Despite the usefulness of couple interviews, it is noted that there is limited existing research from the male partners' perspective, with interviews understandably being conducted mainly with women. Future research may benefit from using more in-depth qualitative interviews with men whose partners experience PMS. Along with providing greater insight, this may help men to feel less marginalised; in turn contributing to challenging the stigma and assisting in informing the development of men's support resources to encourage their help-seeking efforts.

Due to the lack of research on couples' experiences of PMS, there are numerous areas for potential further research, some of which have been outlined. This is encouraged by the general interest in the topic area, as indicated by the large number of potential participants who expressed curiosity and interest in the study. It may be useful to use other methods of gathering the details of couples' experiences, either alongside or instead of interviews. This could take the form of written or video diaries of premenstrual experiences. These could be used to assess couples' experiences over a longer period of time, providing a more longitudinal perspective of PMS experiences within the couple relationship.

Given that the couples' experiences of PMS seemed to be largely affected by social and cultural influences, further studies may explore this in greater detail, perhaps including more specific questions around such issues. Being a UK-based study, conducted mainly with white English participants, cultural influences could be further explored by interviewing participants from a variety of cultural backgrounds. Another interesting area for future research to explore is the concept of resilience. More specific questions about support processes and other aspects promoting resilience in couples' relationships during the premenstrual time may help to better understand support processes in the couple relationship regarding PMS; thus, helping to inform therapeutic approaches and support resources. As this study highlighted many interesting findings related to couples' experiences, couples could be examined in the context of various other encountered physical and mental health difficulties. For example, a qualitative research project examining endometriosis and its impact on heterosexual couples has helped to raise awareness and provide an evidence base for improving couple support (Denny et al., 2013). Lastly, given that many participant couples had children and

reported the impact of the PMS experience on immediate and extended family relationships, future studies could employ a family study approach to examine the processes and dynamics within the family; for example, family resilience.

4.6 Personal Reflexivity

Consistent with Yardley's (2000) transparency criteria, in this section I will explore my personal experiences of the research process; thus, my influence on the research will be considered as well its impact on me.

For some participants, the interview process seemed to be therapeutic, Denise reported: *"It's been a very useful morning"*. This was perhaps due to being able to view PMS differently, as she said: *"I think being a bit more accepting of where I am and not putting so much pressure on myself..."* (Denise, 1687–1691). Positive feedback was also received after the interviews; for example, from Douglas, who emailed: *"it was in some ways helpful to us to talk about things in that type of context"*.

On reflection, these responses indicated a possible occurrence of an overlapping of my dual roles as a counselling psychologist and a researcher. I was aware that the interviews might be a way for some couples to broach a difficult topic to discuss and open up about it. I was mindful of my role as a researcher rather than as a therapist and how these could potentially become unclear. For example, after the interview with Douglas and Samantha, I suggested potential suitable therapy contacts, as requested by Douglas (see Appendix C). This experience helped me to consider how at times there is a potential difficulty in separating my counselling and research identities: an issue that was further explored in research supervision and personal therapy.

My influence as a researcher is clear from the topic chosen and the definition used (PMS) to describe a women's health issue. Having feminist views, I found I increasingly became uneasy with the way in which PMS is socially constructed as an unspoken issue, a "joke" and a "condition" positioning women as "mad", "irrational", and "angry". This is the kind of dilemma that has been discussed by Lavie and Willig (2005), who talk about how during the research process they became increasingly uncomfortable about using the term "inorgasmia". They believed that the term tended to define the experience as a problem, by labelling the women and inadvertently distinguishing them from others. Although this issue was considered at the beginning of the research process and I wanted to avoid it, during the process I too became very uncomfortable with the label of PMS. I recognised that I was perhaps contributing to a pathologisation of premenstrual distress and adding to the gender divide.

Similar to Lavie and Willig (2005), besides being careful with my choice of words during interviews, for example, by avoiding terms like “problem” and “solution”, there was no easy way to do this. I hope that this research contributes to a better understanding of PMS and to normalising women’s health and couple relationship issues related to PMS and other distress. However, I realise that it may contribute to the problematising and pathologising dialogue that exists around PMS. In retrospect, I may have approached the topic in a different manner by not including questionnaires (for example, PAF) and instead asking women to self-identify as experiencing PMS.

IPA was a very useful way of understanding couples’ experiences and I feel that this approach integrated well with my work as a counselling psychologist, as I aim to acknowledge and understand each client’s specific experience. The use of in-depth, semi-structured interviews allowed me to establish rapport between myself and the couples and this method of data collection helped to relieve the anxiety I initially felt about joint interviews. Having no familiarity of couple interviews, I was unsure about how this would transpire and sometimes worried about the possibility of creating tension between the couple. I was aware that we may discuss some sensitive issues and that couples may talk (or not talk) about previously unexplored material between them, possibly creating conflict during and after the interviews. Such concerns may have led to some important issues being unexplored in detail (for example, the causes of conflict). Despite this, the couples were honest and open and I felt privileged listening to their rich accounts. The amount of useful data, however, made it difficult during the analysis stages to determine how to best represent couples’ voices, particularly as I chose to mainly present the participants as couples as opposed to individuals in a couple relationship. This decision was based on what I felt best reflected their experience together as a couple. Reading the participants’ accounts, it was evident that most of the exploration during the interviews was done as a couple: details were discussed and agreed upon (or not) together. Overall, the accounts described a joint narrative and gave insight into the dynamics of the relationship. It was evident in some cases that individual narratives were occurring, but they seemed to be situated in the context of the relationship; for example, describing individual ways of coping/not coping in the relationship during premenstrual conflict.

Throughout the research process, I played a central role in attempting to make sense of the participants’ endeavours to make sense of their experiences. The interview process, analysis, and presentation of the themes would undoubtedly have been different

if it had been conducted by another researcher. By acknowledging my role in the research, I hope that I have demonstrated my awareness of my part in it while aiming to honestly present the lived worlds of the participants. As such, I reflected on my PMS experiences, including my symptoms and how these impact on my own relationship with my husband and children. I feel aware of the difference between my own PMS experience, considered as mild, and participants' experiences, which seemed to be more severe, having a strong impact on their relationship.

I was at times very moved by the participants' accounts; in particular, when hearing some of the women's feelings of guilt related to the impact that they perceived that their PMS responses had on their children and partners. As a woman with children and a trainee counselling psychologist specialising in CBT, I sometimes wanted to challenge their assumptions and beliefs and perhaps normalise them. Despite this, I was aware that my role as a researcher is to listen and understand the participants and not to provide therapy. I was mindful that being a woman may have given me a natural instinct to empathise with the women and how this could have motivated my interview behaviour and my interpretation of the accounts as opposed to those of the male participants. I wondered if in some ways I may have been contributing to the gender divide occurring around PMS.

I was mindful of my position of power as a researcher with knowledge of PMS and as a trainee counselling psychologist with an understanding of psychological issues. Additionally, I was aware of my position as a woman who was not disclosing her PMS to participants; therefore, couples may have perceived me as judging them and their relationships. I was mindful of the complexity of power; thus, the couples also held some influence. For example, during one particular interview I felt under pressure and uncomfortable, as the couple seemed to express annoyance with each other.

Many couples expressed that PMS is a stigmatised and private issue. I was aware of the possible impact of this on the research-participant relationship in the interview, which may have led to their discomfort when discussing particular issues or may have led to them feeling "safe" enough to express themselves. Aware of the differences between my identity as a researcher and as a counselling psychologist, I feel I appropriately took my counselling skills into the interviews, leading participants to be willing to share honest experiences. Skills I endeavoured to use included: empathy and unconditional positive regard, establishing rapport, and actively listening and giving couples space to explore relevant issues; thus, being flexible with the interview

schedule. I tried to be aware of any participant distress or tension, allowing time and space in the interviews for this.

As Finlay (2011) suggests, there is value in researchers attending reflexively to the body of the participant and to themselves. The research process was sometimes an embodied experience during which I felt great tension due to the physical nature of sitting and writing and due to the participants' emotional accounts, which were powerful, intense, and, at times, distressing. I found, like many participants, that exercise helped to balance the mind and body. Swimming, walking, running, and a new interest in ballet have been invaluable in providing me with the energy and stamina to continue to write and to feel more relaxed and body-aware. Like many of the women reported, what I found helpful were attempts at greater acceptance of myself and of my situation as a mother, wife, and researcher. Taking time out for myself and employing self-care when feeling overwhelmed by responsibilities was helpful. I also learnt about Buddhist mindfulness meditation, attending a course during the research process to employ these skills to encourage self-awareness and acceptance. Encouraging clients to be more self-accepting is something that I will also endeavour to do, by assisting them to become aware of their vulnerabilities and foster acceptance rather than shame. At times, the research process has felt overwhelming and never-ending. It has also been an enjoyable, insightful, and fulfilling experience that has allowed me to engage in-depth with a unique group of people who live with PMS.

4.7 Conclusions

This research has endeavoured to investigate couples' experiences of PMS. In light of the paucity of research on this subject, the literature on women's experiences of PMS was explored, including the impact of PMS on women, as well as various theories of PMS and current treatments available for women. The existing quantitative research on couples' experiences of PMS was also reviewed, as well as some limited qualitative research. The review enabled the identification of aspects of heterosexual couples' experiences of PMS to be further understood, in particular from a qualitative perspective, as explored in the current research. These aspects were: What is the PMS experience like for a heterosexual couple? What does PMS mean for the couple? How do couples make sense of their PMS experience? and How does PMS impact on the couple relationship? The research aimed to understand how health professionals, in particular counselling psychologists, can better support couples.

As I aimed to primarily gain an in-depth understanding of couples' perceptions, beliefs, and feelings within and toward their experiences of PMS, Smith et al.'s (2009) IPA was identified as a suitable methodology. Transcripts taken from semi-structured interviews with couples were used in the IPA analytical process, clearly outlined by Larkin et al. (2006) and Smith et al. (2009), which facilitated a rigorous and consistent approach to the data. Three superordinate themes emerged from the couples' accounts, revealing a shared lived experience of PMS. These themes were: (1) 'The "curse" of PMS'; (2) 'Connection and disconnection: the importance of communication and intimacy'; (3) 'Beyond the couple: social influences on the relationship'. The study found that couples' experiences of PMS are highly negative and distressing. PMS was generally considered to be a negative and problematic experience, leading to increased conflict and communication difficulties and, for the majority of the couples, creating distance between them.

Shaping the couples' experiences of PMS were the many gendered expectations of the women and the men. Several gender norms and stereotypes were expressed in the couples' accounts as being emphasised during the premenstrual time, including: men as stoic and unemotional; woman as carer and premenstrual woman as mad. The stigma surrounding the couples' experiences of PMS was also evident. This left the majority of couples feeling socially isolated, as well as separated from each other, due to fears of being shamed or shaming the other. Despite these challenges, the couples demonstrated a sense of resilience through love and acceptance of each other, and a desire to learn more about PMS and help themselves and each other by seeking various forms of treatment and help, even if this was not always straightforward.

This study has contributed to the current body of knowledge on the subject; supporting and extending some of the existing findings. Some implications for the practice of counselling psychology were identified. In particular, it seems that a greater awareness and understanding of PMS for professionals working with this client group is needed, as well as more available support for couples. It appears that professionals could take a more holistic and idiosyncratic approach to PMS, as the bio-medical model does not seem to meet most couples' needs. Attention also needs to be directed toward helping to challenge and reduce the stigma surrounding PMS, which impacts on a couple's efforts to seek and receive support and makes it difficult for them to communicate their distress to each other, friends, family, and health professionals. The findings also revealed that male partners felt ostracised from the PMS experience and

did not know how best to support the women and seek help for themselves. Future research could benefit from focusing on male partners and their needs. It is hoped that the current findings and new insights into couples' experiences of PMS, along with the proposed therapeutic suggestions, will help to support couples during difficult experiences with PMS and contribute to the existing and future body of research.

References

- Abse, S. (2014). Intimacy and the couple – the long and winding road. In D.E. Scharff & J.E. Scharff (Eds.), *Psychoanalytic couple therapy: Foundations of theory and practice*. (pp. 35–43). London: Karnac.
- Acitelli, L.K., & Antonucci, T.C. (1994). Gender differences in the link between marital support and satisfaction in older couples. *Journal of Personality and Social Psychology*, 67(4), 688–698. doi:10.1037/0022-3514.67.4.688
- Alcoff, L., & Potter, E. (Eds.). (1993). *Feminist epistemologies*. New York: Routledge.
- Allen, S., McBride, C., & Pirie, P. (1991). The shortened Premenstrual Assessment Form. *Journal of Reproductive Medicine*, 36(11), 769–772.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders. A 5-year prospective longitudinal study*. (4th ed.). Washington, DC: American Psychiatric Press.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. (5th ed.). Washington, DC: American Psychiatric Press.
- Angermeyer, M.C., Liebelt, P., & Matschinger, H. (2001). Distress in parents of patients suffering from schizophrenia or affective disorders. *Psychotherapie, Psychosomatik, Medizinische Psychologie*, 51(6), 255.
- Angermeyer, M.C., Schulze, B., & Dietrich, S. (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology*, 38(10), 593–602. doi:10.1007/s00127-003-0680-x
- Angst, J., Sellaro, R., Stolar, M., Merikangas, K.R., & Endicott, J. (2001). The epidemiology of perimenstrual psychological symptoms. *Acta Psychiatrica Scandinavica*, 104(2), 110–116. doi:10.1034/j.1600-0447.2001.00412
- Antoine, P., Vanlemmens, L., Fournier, E., Trocmé, M., & Christophe, V. (2013). Young couples' experiences of breast cancer during hormone therapy: An interpretative phenomenological dyadic analysis. *Cancer Nursing*, 36(3), 213–220. doi:10.1097/NCC.0b013e31826429a5

- Armitage, C. (2012, December 22). Could PMS be more about relationship stress? *The Sydney Morning Herald*. Retrieved May 15, 2014, from: <http://www.smh.com.au/national/health/could-pms-be-more-about-relationship-stress-20121221-2brmx.html#ixzz36uRK7kYT>
- Ashworth, P. (2015). Conceptual foundations of qualitative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. (2nd ed.). (pp. 4–25). London: Sage.
- Bailey, C. (2001). Geographers doing household research: Intrusive research and moral accountability. *Area*, 33(1), 107–110. doi:10.1111/1475-4762.00011
- Bancroft, J. (1993). The premenstrual syndrome – a reappraisal of the concept and the evidence. *Psychological Medicine*. Monograph Supplement, 24, 1-47. doi:10.1017/S0264180100001272.
- Bannink, F.P. (2014). Positive CBT: From reducing distress to building success. *Journal of Contemporary Psychotherapy*, 44(1), 1–8. doi:10.1007/s10879-013-9239-7
- Barbour, R. (2007). *Doing focus groups*. London: Sage.
- Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology: An introduction for students and practitioners*. (2nd ed.). Chichester: John Wiley and Sons.
- Bartholomew, K., & Horowitz, L.M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61(2), 226. doi:10.1037/0022-3514.61.2.226
- Baucom, D.H., Shoham, V., Mueser, K.T., Daiuto, A.D., & Stickle, T.R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, 66(1), 53-88. doi:10.1037/0022-006X.66.1.53
- Beach, S.R.H. (Ed.). (2001). *Marital and family processes in depression: A scientific foundation for clinical practice*. Washington, DC: APA Books.

- Beck, L., Gevirtz, R., & Mortola, J.F. (1990). The predictive role of psychosocial stress on symptom severity in premenstrual syndrome. *Psychosomatic Medicine*, 52(5), 536–43.
- Benazon, N.R., & Coyne, J.C. (2000). Living with a depressed spouse. *Journal of Family Psychology*, 14(1), 71–79. doi:10.1037/0893-3200.14.1.71
- Benjamin, J. (1999). Recognition and destruction: An outline of intersubjectivity. In S.A. Mitchell & L. Aron (Eds.), *Relational psychoanalysis: The emergence of a tradition*. (pp. 181–209). Hillside, NJ: The Analytic Press.
- Bertone-Johnson, E.R., Hankinson, S.E., Johnson, S.R., & Manson, J.E. (2008). Cigarette smoking and the development of premenstrual syndrome. *American Journal of Epidemiology*, 168(8), 938–945. doi:10.1093/aje/kwn194
- Bertram, G., & Stickley, T. (2005). Mental health nurses, promoters of inclusion or perpetrators of exclusion? *Journal of Psychiatric and Mental Health Nursing*, 12(4), 387–395. doi:10.1111/j.1365-2850.2005.00849.x
- Bhatia, S.C., & Bhatia, S.K. (2002). Diagnosis and treatment of premenstrual dysphoric disorder. *American Family Physician*, 66(7), 1239–1248.
- Blake, F., Salkovskis, P., Gath, D., Day, A., & Garrod, A. (1998). Cognitive therapy for premenstrual syndrome: A controlled trial. *Journal of Psychosomatic Research*, 45(4), 307–318.
- Bloch, M., Schmidt, P.J., Su, T., Tobin, M.B., & Rubinow, D.R. (1998). Pituitary–adrenal hormones and testosterone across the menstrual cycle in women with premenstrual syndrome and controls. *Biological Psychiatry*, 43(12), 897–903. doi:10.1016/S0006-3223(98)00403-X
- Blumer, H. (1969). *Symbolic interactionism*. Englewood Cliffs, NJ: Prentice Hall.
- Bobel, C. (2006). “Our revolution has style”: Contemporary menstrual product activists “Doing feminism” in the third wave. *Sex Roles*, 54(5), 331–345. doi:10.1007/s11199-006-9001-7
- Bobel, C. (2010). *New blood: Third-wave feminism and the politics of menstruation*. New Brunswick: Rutgers University Press.

- Bos, A.E.R., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing*, 30(8), 509–513. doi:10.1080/01612840802601382.
- Bos, A., Kok, G., & Dijk, A. (2001). Public reactions to people with HIV/AIDS in the Netherlands. *AIDS Education and Prevention*, 13(3), 219–228.
- Bos, A., Pryor, J., Reeder, G., & Stutterheim, S. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology*, 35(1), 1–9. doi:10.1080/01973533.2012.746147
- Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research. *Journal of Constructivist Psychology*, 18(2), 157–181. doi:10.1080/10720530590914789
- Brinkmann, S., & Kvale, S. (2008). Ethics in qualitative psychological research. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology*. (pp. 263–280). London: Sage.
- British Psychological Society. (2006). *British Psychological Society's Code of Ethics and Conduct*. Retrieved April 29, 2008, from British Psychological Society: [http://www.bps.org.uk/document-download-area/documentdownload\\$.cfm?file_uuid=5084A8](http://www.bps.org.uk/document-download-area/documentdownload$.cfm?file_uuid=5084A8)
- British Psychological Society. (2010). *What is Counselling Psychology?* Retrieved March 2, 2011, from British Psychological Society: http://www.bps.org.uk/dcop/home/about/about_home.cfm
- Brooks, G.R. (2010). A transtheoretical model. In G.R. Brooks (Ed.), *Beyond the Crisis of Masculinity: A Transtheoretical Model for Male-Friendly Therapy*. (pp. 139-169). DC;US;Washington: American Psychological Association doi:10.1037/12073-007
- Brown, J., O' Brien, P.M.S., Marjoribanks, J., & Wyatt, K. (2009). Selective serotonin reuptake inhibitors for premenstrual syndrome. *The Cochrane Database of Systematic Reviews*, 15(2), CD001396.

- Brown, M., & Zimmer, P. (1986). Personal and family impact of premenstrual symptoms. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 15(1), 31–38. doi:10.1111/j.1552-6909.1986.tb01364.x
- Burr, V. (2003). *Social constructionism* (2nd ed.). London: Routledge.
- Busse, J.W., Montori, V.M., Krasnik, C., Patelis-Siotis, I., & Guyatt, G.H. (2009). Psychological intervention for premenstrual syndrome: A meta-analysis of randomized controlled trials. *Psychotherapy and Psychosomatics*, 78(1), 6–15. doi:10.1159/000162296
- Camp, D.L., Finlay, W.M.L., & Lyons, E. (2002). Is low self-esteem an inevitable consequence of stigma? an example from women with chronic mental health problems. *Social Science & Medicine*, 55(5), 823–834. doi:10.1016/S0277-9536(01)00205-2
- Campbell, C., & Deacon, H. (2006). Unravelling the contexts of stigma: From internalization to resistance to change. *Journal of Community and Applied Social Psychology*, 16(6), 411–417.
- Caplan, J., & Cosgrove, L. (2004). Is this really necessary? In J. Caplan, & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. xix–3). Lanham, MD: Jason Aronson.
- Carson, J.W., Carson, K.M., Gil, K.M., & Baucom, D.H. (2004). Mindfulness-based relationship enhancement. *Behavior Therapy*, 35(3), 471–494. doi:10.1016/S0005-7894(04)80028-5
- Carver, C.S., Pozo-Kaderman, C., Price, A.A., Noriega, V., Harris, S.D., Derhagopian, R.P., . . . Moffat, J.F.L. (1998). Concern about aspects of body image and adjustment to early stage breast cancer. *Psychosomatic Medicine*, 60(2), 168–174. doi:10.1097/00006842-199803000-00010
- Chandra, P.S., & Chaturvedi, S.K. (1989). Cultural variations of premenstrual experience. *The International Journal of Social Psychiatry*, 35(4), 343.
- Chapman, E., & Smith, J.A. (2002). Interpretative phenomenological analysis and the new genetics. *Journal of Health Psychology*, 7(2), 125–130. doi:10.1177/1359105302007002397

- Charmaz, K., & Henwood, K. (2008). Grounded theory. In C. Willig, & W. Stainton-Rogers (Eds.), *Handbook of Qualitative Research in Psychology* (pp. 240–260). London: Sage.
- Chrisler, J.C. (2008). 2007 presidential address: Fear of losing control: Power, perfectionism, and the psychology of women. *Psychology of Women Quarterly*, 32(1), 1–12. doi:10.1111/j.1471-6402.2007.00402.x
- Chrisler, J.C., & Caplan, P. (2002). The strange case of dr. jekyll and ms. hyde: How PMS became a cultural phenomenon and a psychiatric disorder. *Annual Review of Sex Research*, 13, 274–306. doi:10.1080/10532528.2002.10559807
- Chrisler, J., & Levy, K. (1990). The media construct a menstrual monster: a content analysis of PMS articles in the popular press. *Women and Health*, 16(2), 89–104.
- Clayton, B., & Harris, J. (2004). Footballers' wives: the role of the soccer player's partner in the construction of idealized masculinity. *Soccer & Society*, 5(3), 317–335. doi:1466097042000279580
- Clifton, E., Watts, S., & Larkin, M. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102–120. doi:10.1191/1478088706qp062oa
- Clipp, E., & George, L.K. (1992). Patients with cancer and their spouse caregivers. Perceptions of the illness experience. *Cancer*, 69(4), 1074–1079. doi:10.1002/10970142(19920215)69:4
- Condon, J. (1993). The premenstrual syndrome: A twin study. *The British Journal of Psychiatry*, 162(4), 481–486. doi:10.1192/bjp.162.4.481
- Coppen, A. & Kessel, N. (1963). Menstruation and personality. *The British Journal of Psychiatry*, 109(463), 711–721. doi: 10.1192/bjp.109.463.711
- Cordova, J.V., & Gee, C.B. (2001). Couples therapy for depression: Using healthy relationships to treat depression. In S.R.H Beach, *Marital and family processes in depression: A scientific foundation for clinical practice*. (pp.185–203) Washington, DC: American Psychological Association [PsycBOOKS]. doi:10.1037/10350-010

- Corney, R.H., & Stanton, R. (1991). A survey of 658 women who report symptoms of premenstrual syndrome. *Journal of Psychosomatic Research*, 35(4-5), 471–482.
- Corrigan, P.W., & Lam, C. (2007). *Challenging the structural discrimination of psychiatric disabilities: Lessons learned from the American disability community*. Carbondale: Springer Publishing Company.
- Corrigan, P.W., & Shapiro, J.R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review*, 30(8), 907–922. doi:10.1016/j.cpr.2010.06.004
- Cortese, J., & Brown, M.A. (1989). Coping responses of men whose partners experience premenstrual symptomatology. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 18(5), 405–412. doi: 10.1111/j.1552-6909.1989.tb00494.x
- Cosgrove, L. & Riddle, B. (2003). Constructions of femininity and experiences of menstrual distress. *Women & Health*, 38(3), 37–58.
- Coughlin, P. (1990). Premenstrual Syndrome: How marital satisfaction and the role of choice affect symptom severity. *Social Work*, 35(4), 351–355.
- Courtenay, W. (2003). Key determinants of the health and well-being of men and boys. *International Journal of Mens Health*, 2(1), 1–30.
- Coutts, L., & Berg, D. (1993). The portrayal of the menstruating woman in menstrual product advertisements. *Health Care for Women International*, 14(2), 179–191. doi:10.1080/07399339309516039
- Coyne, J. C, Kessler, R.C., Tal, M., Turnbull, J., Wormian, C.B., & Greden, J.F. (1987). Living with a depressed person. *Journal of Consulting and Clinical Psychology*, 55, 347-352.
- Crocker, J., Major, B., Steele, C.M. (1998). Social stigma. In D. Gilbert, S.T. Fiske, G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 504-553). New York: McGraw-Hill.

- Culley, L., Law, C., Hudson, N., Denny, E., Mitchell, H., Baumgarten, M., & Raine-Fenning, N. (2013). The social and psychological impact of endometriosis on women's lives: A critical narrative review. *Human Reproduction Update*, 19(6), 625–639. doi: 10.1093/humupd/dmt027
- Culpepper, E.E. (1992). Menstrual consciousness raising: A personal and pedagogical process. In A. Dan & L. Lewis (Eds.), *Menstrual health in women's lives*. (pp. 274–284). Chicago: University of Illinois Press.
- Cummings, J., Butler, B., & Kraut, R. (2002). The quality of online social relationships. *Communications of the ACM*, 47(7), 103–108.
- Cunningham, J., Yonkers, K.A., O'Brien, S., & Eriksson, E. (2009). Update on research and treatment of premenstrual dysphoric disorder. *Harvard Review of Psychiatry*, 17(2), 120–137. doi: 10.1080/10673220902891836.
- Dan, A. (2013). Emancipatory research: Then and now. *Sex Roles*, 68(1), 163–167.
- Dan, A., & Mongale, L. (1994). Socio-cultural influences on women's experiences of perimenstrual symptoms. In J. Gold & S.K. Severino (Eds.), *Premenstrual dysphorias: Myths and realities*. (pp. 201–212). London: American Psychiatric Press.
- Dancyger, C., Smith, J.A., Jacobs, C., Wallace, M., & Michie, S. (2010). Comparing family members' motivations and attitudes towards genetic testing for hereditary breast and ovarian cancer: A qualitative analysis. *European Journal of Human Genetics*, 18(12), 1289–1295.
- de Visser, R., & Smith, J. (2007). Alcohol consumption and masculine identity among young men. *Psychology and Health*, 22(5), 595–614.
- Dean, B., & Borenstein, J. (2004). A prospective assessment investigating the relationship between work productivity and impairment with premenstrual syndrome. *Journal of Occupational Environmental Medicine*, 46(7), 649–656.
- Denny, E., Culley, L., Hudson, N., Mitchell, H., Law, C., Raine-Fenning, N., & Baumgarten, M. (2013). Gender differences in the emotional impact of living with endometriosis. Paper presented to the 18th World Congress on

Controversies in Obstetrics, Gynaecology and Infertility (COGI), Vienna, Austria, 24–27 October 2013.

- Dijker, A., & Koomen, W. (2003). Extending Weiner's attribution-emotion model of stigmatization of ill persons. *Basic and Applied Social Psychology*, 25(1), 51–68.
- Dimmock, P., Wyatt, K., Jones, P., & O'Brien, P. (2000). Efficacy of selective serotonin-reuptake inhibitors in premenstrual syndrome: a systematic review. *Lancet*, 356(9236), 1131–1136.
- Dowling, M. (2007). From Husserl to Van Manen: A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44(1), 131–142. doi:10.1016/j.ijnurstu.2005.11.026
- Dunne, E., & Quale, E. (2001). The impact of iatrogenically acquired Hepatitis C infection on the well-being and relationships of a group of Irish women. *Journal of Health Psychology*, 6(6), 679–92.
- Eatough, V., & Smith, J.A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology*. (pp. 179–194). London: Sage.
- Einstein, G., & Shildrick M. (2009). The postconventional body: retheorising women's health. *Social Science and Medicine*, 69(2) 293–300. doi:10.1016/j.socscimed.2009.04.027
- Elliott, R., Fischer, C., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215–229. doi:10.1348/014466599162782
- Emanuels-Zuurveen, L., & Emmelkamp, P.M.G. (1997). Spouse-aided therapy with depressed patients. *Behavior Modification*, 21(1), 62–77. doi:10.1177/01454455970211003
- Epstein, N.B., & Baucom, D.H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association [PsycBOOKS]. doi:10.1037/10481-000

- Erchull, M.J. (2013). Distancing through objectification? Depictions of women's bodies in menstrual product advertisements. *Sex Roles: A Journal of Research*, 68(1–2), 32. doi:10.1007/s11199-011-0004-7
- Ernst, E., & White, A. (2000). The BBC survey of complementary medicine use in the UK. *Complementary Therapies in Medicine*, 8(1), 32–36.
- Eysenbach, G., Powell, J., Englesakis, M., Rizo, C., & Stern, A. (2004). Health related virtual communities and electronic support groups: Systematic review of the effects of online peer to peer interactions. *BMJ: British Medical Journal*, 328(7449), 1166–1170. doi:10.1136/bmj.328.7449.1166
- Falconier, M.K., Nussbeck, F., Bodenmann, G., Schneider, H., & Bradbury, T. (2015). Stress from daily hassles in couples: Its effects on intradyadic stress, relationship satisfaction, and physical and psychological well-being. *Journal of Marital and Family Therapy*, 41(2), 221–235. doi:10.1111/jmft.12073
- Fernandez, I., Reid, C., & Dziurawiec, S. (2006). Living with endometriosis: The perspective of male partners. *Journal of Psychosomatic Research*, 61(4), 433–438. doi:10.1016/j.jpsychores.2006.06.003
- Figert, A.E. (1995). The three faces of PMS: The professional, gendered, and scientific structuring of a psychiatric disorder. *Social Problems*, 42(1), 56–73. doi:10.2307/3097005
- Finlay, L. (2002). "Outing" the researcher: The provenance, process and practice of reflexivity. *Qualitative Health Research*, 12(4), 531–545.
- Finlay, L. (2011). *Phenomenology for therapists: researching the lived world*. Chichester: Wiley-Blackwell.
- Flowers, P., Knussen, C., & Duncan, B. (2001). Re-appraising HIV testing among scottish gay men: The impact of new HIV treatments. *Journal of Health Psychology*, 6(6), 665–678.
- Forrester-Knauss, C., Zemp Stutz, E., Weiss, C., & Tschudin, S. (2011). The interrelation between premenstrual syndrome and major depression: Results from a population-based sample. *BMC Public Health*, 11(1), 795–795. doi:10.1186/1471-2458-11-795

- Foucault, M. (1979). *The history of sexuality, part 1*. London: Penguin.
- Frank, B., Dixon, D., & Grosz, H. (1993). Conjoint monitoring of symptoms of premenstrual syndrome: Impact on marital satisfaction. *Journal of Counselling Psychology*, 40(1), 109–114.
- Frank, C.E. (1995). *Conjoint treatment: Impact on married couples with and without PMS*. Indiana, US: ProQuest Information Dissertations Publishing.
- Frank, R. (1931). The hormonal causes of premenstrual tension. *Archives of Neurology and Psychiatry*, 26(5), 1053–1057.
doi:10.1001/archneurpsyc.1931.02230110151009
- Fredrickson, B.L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, 21(2), 173–206. doi:0.1111/j.1471-6402.1997.tb00108.x
- Freeman, E.W., Halberstadt, S.M., Rickels, K., Legler, J.M., Lin, H., & Sammel, M.D. (2011). Core symptoms that discriminate premenstrual syndrome. *Journal of Women's Health (2002)*, 20(1), 29–35. doi:10.1089/jwh.2010.2161
- Gee, P. (2011). Approach and sensibility: A personal reflection on analysis and writing using Interpretative Phenomenological Analysis. *Qualitative Methods in Psychology Bulletin*, 11, 8–22.
- Girdler, S.S., Pedersen, C.A., Straneva, P.A., Leserman, J., Stanwyck, C.L., Benjamin, S., & Light, K.C. (1998). Dysregulation of cardiovascular and neuroendocrine responses to stress in premenstrual dysphoric disorder. *Psychiatry Research*, 81(2), 163–178. doi:10.1016/S0165-1781(98)00074-2
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Engelwood Cliffs, NJ: Prentice-Hall.
- Golding, J., Taylor, D., Menard, L., & King, M. (2000). Prevalence of sexual abuse history in a sample of women seeking treatment for premenstrual syndrome. *Journal of Psychosomatic Obstetrics and Gynecology*, 21(2), 69–80.
- Golub, S.A., Gilbert, D.T., & Wilson, T.D. (2009). Anticipating one's troubles: The costs and benefits of negative expectations. *Emotion*, 9(2), 277–281.

- Goodale, I.L., Domar, A.D., & Benson, H. (1990). Alleviation of premenstrual syndrome symptoms with the relaxation response. *Obstetrics and Gynecology*, 75(4), 649–655.
- Gotlib, I.H., & Hammen, C.L. (1992). *Psychological aspects of depression: Toward a cognitive-interpersonal integration*. New York: Wiley.
- Gottman, J., Levenson, R., Gross, J., Frederickson, B., McCoy, K., Rosenthal, L., & Yoshimoto, D. (2003). Correlates of gay and lesbian couples' relationship satisfaction and relationship dissolution. *Journal of Homosexuality*, 45(1), 23–43. doi: 10.1037/0022-006X.57.1.47
- Greene, R., & Dalton, K. (1953). The premenstrual syndrome. *The British Medical Journal*, 1(4818), 1007–1014.
- Gunnell, D., Saperia, J., & Ashby, D. (2005). Selective serotonin reuptake inhibitors (SSRIs) and suicide in adults: Meta-analysis of drug company data from placebo controlled, randomised controlled trials submitted to the MHRA's safety review. *BMJ: British Medical Journal*, 330(7488), 385–388. doi:10.1136/bmj.330.7488.385
- Halbreich, U. (2003). The etiology, biology, and evolving pathology of premenstrual syndromes. *Psychoneuroendocrinology*, 28(3), 55–99. doi:10.1016/S0306-4530(03)00097-0
- Harris, R. (2006). Embracing your demons: an overview of acceptance and commitment therapy. *Psychotherapy in Australia*, 12(4), 2–8.
- Harris, T.J.R., Pistrang, N., & Barker, C. (2006). Couples' experiences of the support process in depression: A phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 79(1), 1–21. doi: 10.1348/147608305X41218
- Hasin, M., Dennerstein, L., & Gotts, G. (1988). Menstrual cycle related complaints: A cross cultural study. *The Journal of Psychosomatic Obstetrics and Gynaecology*, 9(1) 5–42. doi: 10.3109/01674828809030947

- Haywood, A., Slade, P., & King, H. (2002). Assessing the assessment instruments for menstrual cycle symptoms: A guide for clinicians and researchers. *Journal of Psychosomatic Research*, 52(4), 223–237.
- Haywood, A., Slade, P., & King, H. (2007). Psychosocial associates of premenstrual symptoms and the moderating role of social support in a community sample. *Journal of Psychosomatic Research*, 62(1), 9–13.
- Health Professions Council. (2008). *Standards of conduct, performance and ethics policy*. Retrieved 11 January, 2011, from <http://www.hpc-uk.org>.
- Hebl, M., & Mannix, L. (2003). The weight of obesity in evaluating others: A mere proximity effect. *Personality and Social Psychology Bulletin*, 29(1), 28–38. doi: 10.1177/0146167202238369
- Heidegger, M. (2004). *Being and time*. (J. Macquarrie and E. Robinson, Trans.). Oxford: Blackwell.
- Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the subject: Psychology, social regulation and subjectivity*. London: Methuen.
- Hilton, B.A., Crawford, J.A., & Tarko, M.A. (2000). Men's perspectives on individual and family coping with their wives' breast cancer and chemotherapy. *Western Journal of Nursing Research*, 22(4), 438-459. doi:10.1177/019394590002200405
- Hoerster, K., Chrisler, J., & Gorman, J. (2003). Attitudes toward and experiences with menstruation in the US and India. *Women & Health*, 38(3), 77–95.
- Hoga, L.A.K., Vulcano, M.A., Miranda, C.M., & Manganiello, A. (2010). Male behavior in front of women with premenstrual syndrome: Narratives of women. *Acta Paulista de Enfermagem*, 23(3), 372–378. doi:10.1590/S0103-21002010000300010
- Holmes, P., Paul, S., & Pelham, G. (1996). A relational model of counselling. *Counselling: Journal of the British Association of Counselling*, 7(3), 229–231.

- Hunter, M. (2003). Cognitive behavioural interventions for premenstrual and menopausal symptoms. *Journal of Reproductive and Infant Psychology*, 21(3), 183–193. doi:10.1080/0264683031000155006
- Hunter, M.S., Ussher, J.M., Browne, S.J., Cariss, M., Jelley, R., & Katz, M. (2002). A randomized comparison of psychological (cognitive behavior therapy), medical (fluoxetine) and combined treatment for women with premenstrual dysphoric disorder. *Journal of Psychosomatic Obstetrics and Gynecology*, 23(3), 193–199. doi:10.3109/01674820209074672
- Husserl, E. (1927). Phenomenology. For Encyclopedia Britannica (T. Sheehan, Trans. and revised). Retrieved November 20, 2012 from <http://www.stanford.edu/dept/relstud/faculty/sheehan.bak/EHtrans/5-eb.pdf>
- Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology* (D. Carr, Trans.). Evanston: Northwestern University Press.
- Hylan, T.R., Sundell, K., & Judge, R. (1999). The impact of premenstrual symptomatology on functioning and treatment-seeking behavior: Experience from the United States, United Kingdom and France. *Journal of Women's Health and Gender-Based Medicine*, 8(8), 1043–1052.
- Jack, D.C. (1991). *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press.
- Jack, D.C., & Ali, A. (2010). *Silencing the self across cultures: Depression and gender in the social world*. Oxford;New York: Oxford University Press. doi:10.1093/acprof:oso/9780195398090
- Jahanfar, S., Lye, M., & Krishnarajah, I.S. (2011). The heritability of premenstrual syndrome. *Twin Research and Human Genetics*, 14(5), 433–436.
- Jang, S.H., Kim, D.I., & Choi, M. (2014). Effects and treatment methods of acupuncture and herbal medicine for premenstrual syndrome/premenstrual dysphoric disorder: Systematic review. *BMC Complementary and Alternative Medicine*, 14(1), 11. doi:10.1186/1472-6882-14-11
- Jensen, J., Rauer, A., & Volling, B. (2013). A dyadic view of support in marriage: The critical role of men's support provision. *Sex Roles*, 68(7–8), 427–438.

- Johnson, S.L., & Jacob, T. (1997). Marital interactions of depressed men and women. *Journal of Consulting and Clinical Psychology*, 65(1), 15–23. doi:10.1037/0022-006X.65.1.15
- Johnson, T. (1987). Premenstrual syndrome as a Western culture-specific disorder. *Culture, Medicine and Psychiatry*, 11(3), 337–356. doi:10.1007/BF00048518
- Johnston-Robledo, I., & Chrisler, J.C. (2013). The menstrual mark: Menstruation as social stigma. *Sex Roles*, 68(1), 9–18. doi:10.1007/s11199-011-0052-z
- Joiner, T., Coyne, J.C., & Blalock, J. (1999). On the interpersonal nature of depression: Overview and synthesis. In T. Joiner and J.C. Coyne (Eds.), *The interactional nature of depression: Advances in interpersonal approaches*. (pp. 3–19). Washington, DC: American Psychological Association. doi:10.1037/10311-013
- Jones, A., Theodos, V., Canar, W.J., Sher, T.G., & Young, M. (2000). Couples and premenstrual syndrome: Partners as moderators of symptoms? In K.B. Schmaling and T.G. Sher (Eds.), *The psychology of couples and illness: Theory, research, and practice*. (pp. 217–239). Washington, DC: American Psychological Association. doi:10.1037/10360-008
- Jones, E., & Asen, E. (2000). *Systemic couple therapy and depression*. London: Karnac.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness*. New York: Delacorte.
- Kessler, R. (2003). Epidemiology of women and depression. *Journal of Affective Disorders*, 74(1), 5–13. doi:10.1016/S0165-0327(02)00426-3
- Keye, W., Hammond, D., & Strong, T. (1986). Medical and psychologic characteristics of women presenting with premenstrual symptoms. *Obstetrics and Gynaecology*, 68(5), 634–637.
- King, M.B. (2013). *Men's constructions and experiences of PMS and their partner's premenstrual changes*. Unpublished doctoral thesis, University of Western Sydney, Sydney, Australia.

- King, M., & Ussher, J.M. (2013). It's not all bad: Women's construction and lived experience of positive premenstrual change. *Feminism and Psychology*, 23(3), 399–417. doi:10.1177/0959353512440351
- Kissling, E.A. (1996). Bleeding out loud: Communication about menstruation. *Feminism and Psychology*, 6(4), 481–504. doi:10.1177/0959353596064002
- Kleinstäuber, M., Witthöft, M., & Hiller, W. (2012). Cognitive-behavioral and pharmacological interventions for premenstrual syndrome or premenstrual dysphoric disorder: A meta-analysis. *Journal of Clinical Psychology in Medical Settings*, 19(3), 308–319. doi:10.1007/s10880-012-9299-y
- Kobak, R. & Hazan, C. (1991). Attachment in marriage: Effects of security and accuracy of working models. *Journal of Personality and Social Psychology*, 60(6), 861–869.
- Koch, P. (2006). Women's bodies as a "puzzle" for college men. *American Journal of Sexuality Education*, 1(3), 51–72. doi:10.1300/J455v01n03_04
- Kuczmierczyk, A.R., Johnson, C.C., & Labrum, A.H. (1994). Coping styles in women with premenstrual syndrome. *Acta Psychiatrica Scandinavica*, 89(5), 301–305. doi:10.1111/j.1600-0447.1994.tb01519.x
- Kuczmierczyk, A.R., Labrum, A.H., & Johnson, C.C. (1992). Perception of family and work environments in women with premenstrual syndrome. *Journal of Psychosomatic Research*, 36(8), 787–795. doi:10.1016/0022-3999(92)90137-Q
- Kues, J.N., Janda, C., Kleinstäuber, M., & Weise, C. (2014). Internet-based cognitive behavioural self-help for premenstrual syndrome: Study protocol for a randomised controlled trial. *Trials*, 15(1), 472. doi:10.1186/1745-6215-15-472
- Kurdek, L.A. (2003). Differences between gay and lesbian cohabiting couples. *Journal of Social and Personal Relationships*, 20(4), 411–436. doi:10.1177/02654075030204001
- Lamke, L.K., Sollie, D.L., Durbin, R.G., & Fitzpatrick, J.A. (1994). Masculinity, femininity and relationship satisfaction: The mediating role of interpersonal competence. *Journal of Social and Personal Relationships*, 11(4), 535–554. doi:10.1177/0265407594114003

- Landén, M., & Eriksson, E. (2003). How does premenstrual dysphoric disorder relate to depression and anxiety disorders? *Depression and Anxiety*, 17(3), 122–129. doi:10.1002/da.10089
- Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow: Pearson Education.
- Larson, J.E., & Corrigan, P.W. (2008). The stigma of families with mental illness. *Academic Psychiatry*, 32(2), 87–91. doi:10.1176/appi.ap.32.2.87
- Lavie, M., & Willig, C. (2005). “I don't feel like melting butter”: An interpretative phenomenological analysis of the experience of ‘inorgasmia’. *Psychology and Health*, 20(1), 115. doi:10.1080/08870440412331296044
- Laws, S. (1991). *Issues of blood: The politics of menstruation*. London: Macmillan.
- Lee, J., & Sasser-Coen, J. (1996). *Blood stories: Menarche and the politics of the female body in contemporary U.S. society*. New York: Routledge.
- Lee, A.M., So-Kum Tang, C., & Chong, C. (2009). A culturally sensitive study of premenstrual and menstrual symptoms among chinese women. *Journal of Psychosomatic Obstetrics and Gynecology*, 30(2), 105-114. doi:10.1080/01674820902789241
- Liebert, R., & Gavey, N. (2009). “There are always two sides to these things”: Managing the dilemma of serious adverse effects from SSRIs. *Social Science and Medicine*, 68(10), 1882–1891. doi:10.1016/j.socscimed.2009.02.047
- Limosin, F., & Ades, J. (2001). Psychiatric and psychological aspects of premenstrual syndrome. *Encephale*, 27, 501–8.
- Loaring, J.M., Larkin, M., Shaw, R., & Flowers, P. (2015). Renegotiating sexual intimacy in the context of altered embodiment: The experiences of women with breast cancer and their male partners following mastectomy and reconstruction. *Health Psychology*, 34(4), 426–436. doi:10.1037/hea0000195
- Lopez, L.M., Kaptein, A.A., & Helmerhorst, F.M. (2012). Oral contraceptives containing drospirenone for premenstrual syndrome. *The Cochrane Database of Systematic Reviews*, 2, 1-60, CD006586.

- Lu, Y., & Haase, J. (2009). Experience and perspectives of caregivers of spouse with mild cognitive impairment. *Current Alzheimer Research*, 6(4), 384–391. doi:10.2174/156720509788929309
- Lustyk, M., Widman, L., & Becker, L.L. (2007). Abuse history and premenstrual symptomatology: Assessing the mediating role of perceived stress. *Women and Health*, 46(4), 61–80.
- Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543–562. doi:10.1111/1467-8624.00164
- Macleod, R., Craufurd, D., & Booth, K. (2002). Patients' perceptions of what makes genetic counselling effective: An interpretative phenomenological analysis. *Journal of Health Psychology*, 7(2), 145–156. doi:10.1177/1359105302007002454
- Mahalik, J.R., Good, G.E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional Psychology: Research and Practice*, 34(2), 123–131. doi:10.1037/0735-7028.34.2.123
- Mak, W.W.S., & Kwok, Y.T.Y. (2010). Internalization of stigma for parents of children with autism spectrum disorder in Hong Kong. *Social Science and Medicine*, 70(12), 2045–2051. doi:10.1016/j.socscimed.2010.02.023
- Marjoribanks, J., Brown, J., O'Brien, P.M.S., & Wyatt, K. (2013). Selective serotonin reuptake inhibitors for premenstrual syndrome. *The Cochrane Database of Systematic Reviews*, 6, CD001396.
- Markens, S. (1996). The problematic of “experience”: A political and cultural critique of PMS. *Gender and Society*, 10(1), 42–58. doi:10.1177/089124396010001004
- Masho, S.W., Adera, T., & South-Paul, J. (2005). Obesity as a risk factor for premenstrual syndrome. *Journal of Psychosomatic Obstetrics and Gynecology*, 26(1), 33–39. doi:10.1080/01443610400023049

- Maughan, K., Heyman, B., & Matthews, M. (2002). In the shadow of risk. How men cope with a partner's gynaecological cancer. *International Journal of Nursing Studies*, 39(1), 27.
- McCabe, S.B., & Gotlib, I.H. (1993). Interactions of couples with and without a depressed spouse: Self-report and observations of problem-solving situations. *Journal of Social and Personal Relationships*, 10(4), 589–599. doi:10.1177/0265407593104007
- McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage.
- Mead, G.H. (1934). *Mind, self, and society: From the standpoint of a social behaviorist*. Chicago: University of Chicago Press.
- Merleau-Ponty, M. (1964). *The primacy of perception: And other essays on phenomenological psychology, the philosophy of art, history and politics* (J.M. Edie, Trans). Evanston: Northwestern University Press.
- Metz, M.E., Rosser, B.R.S., & Strapko, N. (1994). Differences in conflict resolution styles among heterosexual, gay, and lesbian couples. *Journal of Sex Research*, 31(4), 293–308. doi:10.1080/00224499409551764
- Meyrick, J. (2006). What is good qualitative research?: A first step towards a comprehensive approach to judging Rigour/Quality. *Journal of Health Psychology*, 11(5), 799-808. doi:10.1177/1359105306066643
- Miota, P., Yahle, M., & Bartz, C. (1991). Premenstrual syndrome: A bio-psycho-social approach to treatment. In D. Taylor (Ed.), *Menstruation and health*. (pp. 143–152). Washington, DC: Hemisphere Publishing.
- Mitchell, S. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.
- Mooney-Somers, J., Perz, J., & Ussher, J. (2008). A risky negotiation: Women's experiences of naming and not naming PMS in couple relationships. *Women and Health*, 47(3), 57–77.

- Moradi, M., Parker, M., Sneddon, A., Lopez, V., & Ellwood, D. (2014). Impact of endometriosis on women's lives: A qualitative study. *BMC Women's Health*, 14(1), 123. doi:10.1186/1472-6874-14-123
- Moran, D. (2000). *Introduction to phenomenology*. London: Routledge.
- Morgan, D.H.J. (1996). *Family connections: An introduction to family studies*. Cambridge: Polity Press.
- Morrow, S.L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35(2), 209–235. doi:10.1177/0011000006286990
- Morse, G. (1999). Positively reframing perceptions of the menstrual cycle among women with premenstrual syndrome. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 28(2), 165–174. doi:10.1111/j.1552-6909.1999.tb01981.x
- Mortola, J.F., Girton, L., Beck, L., & Yen, S. (1990). Diagnosis of premenstrual syndrome by a simple, prospective, and reliable instrument: The calendar of premenstrual experiences. *Obstetrics and Gynecology*, 76(2), 302–307.
- Neal, L. (2013). *Touching on touchy subjects: Approaches to combatting stigmas*. Unpublished master's thesis. Paper 45. Carnegie Mellon University, Pittsburgh.
- Neff, L.A., & Karney, B.R., (2009). Stress and reactivity to daily relationship experiences: How stress hinders adaptive processes in marriage. *Journal of Personality and Social Psychology*, 97(3), 435–450.
- Nepomnaschy, P., Welch, K., McConnell, D., Strassmann, B., & England, B. (2004). Stress and female reproductive function: A study of daily variations in cortisol, gonadotrophins, and gonadal steroids in a rural Mayan population. *American Journal of Human Biology*, 16(5), 523–532.
- Nichols, S. (1995). Positive premenstrual experiences: Do they exist? *Feminism and Psychology*, 5(2), 162–169.
- O'Grady, H. (2005). *Woman's relationship with herself: Gender, Foucault, therapy*. Hove: Routledge.

- O'Neil, J.M. (2008). Summarizing 25 years of research on men's gender role conflict using the gender role conflict scale: New research paradigms and clinical implications. *The Counseling Psychologist*, 36(3), 358–445. doi:10.1177/0011000008317057
- O'Neil, J.M. (2015). *Men's gender role conflict: Psychological costs, consequences, and an agenda for change*. Washington: American Psychological Association. doi:10.1037/14501-000
- O'Shaughnessy, M., Lee, K., & Lintern, T. (2010). Changes in the couple relationship in dementia care: Spouse carers' experiences. *Dementia*, 9(2), 237–258. doi:10.1177/1471301209354021
- Östman, M., & Kjellin, L. (2002). Stigma by association, psychological factors in family members of people with mental illness. *The British Journal of Psychiatry*, 181(6), 494–498. doi:10.1192/bjp.181.6.494
- Oxley, T. (1998). Menstrual management: An exploratory study. *Feminism and Psychology*, 8(2), 185–191.
- Pachankis, J.E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioural model. *Psychological Bulletin*, 133(2), 328–345.
- Paige, K.E. (1973). Women learn to sing the menstrual blues. *Psychology Today*, 7(4), 41–46.
- Palmer, M., Larkin, M., Fadden, G., & de Visser, R. (2010). Developing an interpretative phenomenological approach to focus group data. *Qualitative Research in Psychology*, 7(2), 99–121. doi:10.1080/14780880802513194
- Parker, L. (1999). Bridging gender issues in couples work: Bringing “Mars and Venus” back to earth. *Journal of Family Psychotherapy*, 10(2), 1–15. doi:10.1300/J085v10n02_01
- Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine*, 57(1), 13–24. doi:10.1016/S0277-9536(02)00304-0

- Parlee, M.B. (1992). On PMS and psychiatric abnormality. *Feminism and Psychology*, 2(1), 105–108. doi:10.1177/0959353592021016
- Parry, B. (1994). Biological correlates of premenstrual complaints. In J. Gold (Ed.), *Premenstrual dysphoria: Myths and realities*. (pp. 47–66). London: American Psychiatric Press.
- Payne, M. (2010). *Couple counselling: A practical guide*. London: Sage.
- Pearlstein, T., & Steiner, M. (2008). Premenstrual dysphoric disorder: Burden of illness and treatment update. *Journal of Psychiatry and Neuroscience*, 33(4), 291–301.
- Perz, J., & Ussher, J.M. (2006). Women's experience of premenstrual syndrome: A case of silencing the self. *Journal of Infant and Reproductive Psychology*, 24(4), 289–303. doi: 10.1080/02646830600973883
- Perz, J., Ussher, J.M., Butow, P., & Wain, G. (2011). Gender differences in cancer carer psychological distress: An analysis of moderators and mediators. *European Journal of Cancer Care*, 20(5), 610–619. doi:10.1111/j.1365-2354.2011.01257.x
- Phelan, J.C., Bromet, E.J., & Link, B.G. (1998). Psychiatric illness and family stigma. *Schizophrenia Bulletin*, 24(1), 115–126.
- Pilver, C., Levy, B., Libby, D., & Desai, R. (2011). Posttraumatic stress disorder and trauma characteristics are correlates of premenstrual dysphoric disorder. *Archives of Women's Mental Health*, 14(5), 383–393. doi:0.1007/s00737-011-0232-4
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Prochaska, J.O., & Norcross, J.C. (2001). Stages of change. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 443–448. doi:10.1037/0033-3204.38.4.443
- Pryor, J.B., Reeder, G.D., & Monroe, A.E. (2012). The infection of bad company: Stigma by association. *Journal of Personality and Social Psychology*, 102(2), 224–241. doi:10.1037/a0026270

- Rabin, D., Gold, P., Margioris, A., & Chrousos, G. (1988). Stress and reproduction: Physiologic and pathophysiologic interactions between the stress and reproductive axes. In G. Chrousos, D. Loriaux, & P. Gold (Eds.) *Mechanisms of Physical and Emotional Stress*, (pp. 377–387). NYC, NY: Plenum Press.
- Rabinowitz, F.E., & Cochran, S.V. (2002). *Deepening psychotherapy with men*. Washington, DC: American Psychological Association. doi:10.1037/10418-000
- Racher, F.E. (2003). Using conjoint interviews to research the lived experience of elderly rural couples. *Nurse Researcher*, 10(3), 60–72.
- Racher, F., Kaufert, J., & Havens, B. (2000). Conjoint research interviews with frail, elderly couples: Methodological implications. *Journal of Family Nursing*, 6(4), 367–379. doi:10.1177/107484070000600404
- Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in the light of our ‘mission’. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*. (pp. 41–55). Oxford: Wiley-Blackwell. doi: 10.1002/9780470667279.ch3
- Rapkin A. (2003). A review of treatment of premenstrual syndrome and premenstrual dysphoric disorder. *Psychoneuroendocrinology*, 28(3), 39–53.
- Rautiainen, E., & Aaltonen, J. (2010). Depression: The differing Narratives of Couples in Couple Therapy. *The Qualitative Report*, 15(1), 156-175.
- Reid, D.W., Doell, F.K., Dalton, E.J., & Ahmad, S. (2008). Systemic-constructivist couple therapy (SCCT): Description of approach, theoretical advances, and published longitudinal evidence. *Psychotherapy: Theory, Research, Practice, Training*, 45(4), 477–490. doi:10.1037/a0014334
- Reid, K., Flowers, P., and Larkin, M. (2005), Exploring lived experience. *Psychologist*, 18(1), 20-23.
- Reilly, M.E., & Lynch, J.M. (1990). Power-sharing in lesbian partnerships. *Journal of Homosexuality*, 19(3), 1-30. doi:10.1300/J082v19n03_01

- Repta, R., & Clarke, L.H. (2013). "Am I going to be natural or not?": Canadian women's perceptions and experiences of menstrual suppression. *Sex Roles A Journal of Research*, 68(1-2), 91-106. doi:10.1007/s11199-011-0038-x
- Revenson, T.A., & Lepore, S.J. (2012). Coping in social context. In A. Baum, T.A. Revenson, & J.E. Singer (Eds.), *Handbook of health psychology*. (2nd ed.). (pp.191–216). London: Psychology Press.
- Reynolds, F., & Lim, K. (2007). Contribution of visual art-making to the subjective wellbeing of women living with cancer: A qualitative study. *Arts in Psychotherapy*, 34(1), 1–10.
- Robinson, R.L., & Swindle, R.W. (2000). Premenstrual symptom severity: Impact on social functioning and treatment-seeking behaviors. *Journal of Women's Health and Gender-Based Medicine*, 9(7), 757–768. doi:10.1089/15246090050147736
- Roca, C.A., Schmidt, P.J., Altemus, M., Deuster, P., Danaceau, M.A., Putnam, K., & Rubinow, D.R. (2003). Differential menstrual cycle regulation of hypothalamic-pituitary-adrenal axis in women with premenstrual syndrome and controls. *The Journal of Clinical Endocrinology and Metabolism*, 88(7), 3057–3063. doi:10.1210/jc.2002-021570
- Rodin, M. (1992). The social construction of premenstrual syndrome. *Social Science and Medicine*, 35(1), 49–56. doi:10.1016/0277-9536(92)90118-A. PMID 1496412.
- Rolland, J.S. (1994). In sickness and in health: The impact of illness on couples' relationship. *Journal of Marital and Family Therapy*, 20(4), 327–347. doi: 10.1111/j.1752-0606.1994.tb00125.x
- Romans, S., Clarkson, R., Einstein, G., Petrovic, M., & Stewart, D. (2011). Mood and the menstrual cycle: A review of prospective data studies. *Gender Medicine*, 9(5), 361–84. doi:10.1016/j.genm.2012.07.003.
- Ross, C., & Goldner, E. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 16(6), 558–567.

- Rostill-Brookes, H., Larkin, M., Toms, A., & Churchman, C. (2011). A shared experience of fragmentation: Making sense of foster placement breakdown. *Clinical Child Psychology and Psychiatry*, 16(1), 103-127. doi:10.1177/1359104509352894
- Royal College of Obstetricians and Gynaecologists (RCOG). (2007). *Green-top guideline 48: Management of premenstrual syndrome*. London: RCOG.
- Royal College of Obstetricians and Gynaecologists (RCOG). (2009). *Managing premenstrual syndrome (PMS) Information for you*. London: RCOG.
- Ruble, D. (1977). Premenstrual symptoms: A reinterpretation. *Science*, 197(4300), 291–292. doi:10.1126/science.560058
- Rule, W., & Gandy, G. (1994). A thirteen-year comparison in patterns of attitudes toward counseling. *Adolescence*, 29(115), 575–589.
- Rundle, R. (2005). *A qualitative exploration of couples' relational experiences when one partner suffers from symptoms of PMS: A systems approach*. Unpublished doctoral dissertation, Alliant International University, San Diego.
- Russo, K., & Thompson, A. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology*, 9(1), 32–46.
- Ryser, R., & Feinauer, L.L. (1992). Premenstrual syndrome and the marital relationship. *The American Journal of Family Therapy*, 20(2). doi: 10.1080/01926189208250887
- Sadler, C., Smith, H., Hammond, J., Bayly, R., Borland, S., Panay, N. ... Inskip, H. (2010). Lifestyle factors, hormonal contraception, and premenstrual symptoms: The United Kingdom Southampton women's survey. *Journal of Women's Health*, 19(3), 391–396. doi:10.1089/jwh.2008.1210
- Sanden, R.L.M., Bos, A.E.R., Stutterheim, S.E., Pryor, J.B., & Kok, G. (2015). Stigma by association among family members of people with a mental illness: A qualitative analysis. *Journal of Community and Applied Social Psychology*, 25(5), 400-417. doi:10.1002/casp.2221

- Scharff, D.E., & Scharff, J.E. (2014). *Psychoanalytic couple therapy: Foundations of theory and practice*. London: Karnac.
- Schwartz, C.B. (2001). The relationship between partner social support and premenstrual symptoms. *Abstracts International: Section B: The Sciences and Engineering*, 61(10-B): 5580.
- Seymour-Smith, S., Wetherell, M., & Phoenix, A. (2002). "My wife ordered me to come!": A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology*, 7(3), 253–267.
- Shah, N.R., Jones, J.B., Aperi, J., Shemtov, R., Karne, A., & Borenstein, J. (2008). Selective serotonin reuptake inhibitors for premenstrual syndrome and premenstrual dysphoric disorder: A meta-analysis. *Obstetrics and Gynecology*, 111(5), 1175–1182. doi: 10.1097/AOG.0b013e31816fd73b
- Shechory, M., & Ziv, R. (2007). Relationships between gender role attitudes, role division, and perception of equity among heterosexual, gay and lesbian couples. *Sex Roles*, 56(9), 629-638. doi:10.1007/s11199-007-9207-3
- Siegel, J.P. (1986). Marital dynamics of women with premenstrual tension syndrome. *Family Systems Medicine*, 4(4), 358–366. doi: 10.1037/h0089694
- Slade, P., Haywood, A., & King, H. (2009). A qualitative investigation of women's experiences of the self and others in relation to their menstrual cycle. *British Journal of Health Psychology*, 14(1), 127–141.
- Smart, C. (2007). Same sex couples and marriage: negotiating relational landscapes with families and friends. *The Sociological Review*, 55(4), 671–686. doi: 10.1111/j.1467-954X.2007.00747.x
- Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11(2), 261–271.
- Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative psychology. *Qualitative Research in Psychology*, 1(1), 39–54.

- Smith, J., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, 182(2), 81–83.
- Smith, J., & Eatough, V. (2006). Interpretative phenomenological analysis: Research methods in psychology. In G. Breakwell, S. Hammond, C. Fife-Schaw, & J. Smith (Eds.), *Research methods in psychology*. (3rd ed.). (pp. 322–41). London: Sage.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research*. London: Sage.
- Smith-Martinez, K.L. (1995). Premenstrual symptomatology and its impact on marital communication. *Abstracts International: Section B: The Sciences and Engineering*, 56(6–B): 2887.
- Steiner, M., & Born, L. (2000). Advances in the diagnosis and treatment of premenstrual dysphoria. *CNS Drugs*, 13(4), 287–304.
- Stewart, D.E. (1989). Positive changes in the premenstrual period. *Acta Psychiatrica Scandinavica*, 79(4), 400–405. doi:10.1111/j.1600-0447.1989.tb10276.x
- Struening, E.L., Link, B., Hellman, F., Herman, D., & Sirey, J. (2001). Stigma as a barrier to recovery: The extent to which caregivers believe most people devalue consumers and their families. *Psychiatric Services*, 52(12), 1633–1638.
- Stutterheim, S.E., Pryor, J.B., Bos, A., Hoogendijk, R., Muris, P., & Schaalma, H. (2009). HIV-related stigma and psychological distress: The harmful effects of specific stigma manifestations in various social settings. *AIDS*, 23(17), 2353–7 doi: 10.1097/QAD.0b013e3283320dce.
- Sveinsdottir, H., Lundman, B., & Norberg, A. (2002). Whose voice? Whose experiences? Women's qualitative accounts of general and private discussion of premenstrual syndrome. *Scandinavian Journal of Caring Sciences*, 16(4), 414–423.
- Swann, C. (1997). Reading the bleeding body: Discourses of premenstrual syndrome. In J.M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. (pp. 176–198). London: Routledge.

- Swann, C.J., & Ussher, J.M. (1995). A discourse analytic approach to women's experience of premenstrual syndrome. *Journal of Mental Health*, 4(4), 359–368. doi:10.1080/09638239550037415
- Takeda, T., Tasaka, K., Sakata, M., & Murata, Y. (2006). Prevalence of premenstrual syndrome and premenstrual dysphoric disorder in Japanese women. *Archives of Women's Mental Health*, 9(4), 209–212. doi:10.1007/s00737-006-0137-9
- Taylor, D. (2006). From “It's all in your head” to “Taking back the month”: Premenstrual syndrome (PMS) research and the contributions of the society for menstrual cycle research. *Sex Roles*, 54(5), 377–391. doi:10.1007/s11199-006-9009-z
- Talley, A.E., & Bettencourt, B.A. (2008). Evaluations and aggression directed at a gay male target: The role of threat and antigay prejudice. *Journal of Applied Social Psychology*, 38(3), 647–683. doi:10.1111/j.1559-1816.2007.00321.x
- Teasdale, J.D., Segal, Z.V., Williams, J.M. G., Ridgeway, V.A., Soulsby, J., & Lau, M. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 615–623
- Tecimer, S.N., Jaworsky, D., Newmeyer, T., Chihrin, S., Gough, K., Rachlis, A., . . . Loutfy, M.R. (2011). Learning from interviews with HIV-discordant couples (male positive, female negative): The challenges and successes. *The Open AIDS Journal*, 5(1), 37–43. doi:10.2174/1874613601105010037
- Thompson, A.R., & Marriott, C. (2008). Managing threats to femininity: Personal and interpersonal experience of living with vulval pain. *Psychology and Health*, 23(2), 243–258. doi:10.1080/14768320601168185
- Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? *British Journal of Psychiatry*, 190(3), 192–193. doi:10.1192/bjp.bp.106.025791
- Tomkins, L., & Eatough, V. (2010). Reflecting on the use of IPA with focus groups: pitfalls and potentials. *Qualitative Research in Psychology*, 7(3), 244–262.

- Treloar, S., Heath, A., & Martin, N. (2002). Genetic and environmental influences on premenstrual symptoms in an Australian twin sample. *Psychological Medicine*, 32(1), 25–38.
- Usman, S., Indusekhar, R., & O'Brien, S. (2008). Hormonal management of premenstrual syndrome. *Best Practice and Research Clinical Obstetrics and Gynaecology*, 22(2), 251–260.
- Ussher, J.M. (1989). *The psychology of the female body*. Critical psychology series. Florence, KY: Taylor and Francis/Routledge.
- Ussher, J. (2002). Premenstrual syndrome: Fact, fantasy, or fiction? In C. von Hofsten & L. Backman (Eds.), *Psychology at the turn of the millennium*, Vol. 2. (pp. 497–527). East Sussex: Psychology Press.
- Ussher, J. (2003). The ongoing silencing of women in families: An analysis and rethinking of premenstrual syndrome and therapy. *Journal of Family Therapy*, 25(4), 388–405.
- Ussher, J. (2004). Premenstrual syndrome and self-policing: Ruptures in self-silencing leading to increased self-surveillance and blaming of the body. *Social Theory and Health*, 2(3), 254–272.
- Ussher, J. (2006). *Managing the monstrous feminine: Regulating the reproductive body*. London: Routledge.
- Ussher, J. (2008). Challenging the positioning of premenstrual change as PMS: The impact of a psychological intervention on women's self-policing. *Qualitative Research in Psychology*, 5(1), 33–44. doi:10.1080/14780880701863567
- Ussher, J. (2011). *The madness of women: Myth and experience*. New York: Routledge.
- Ussher, J., Hunter, M., & Cariss, M. (2002). A woman centred psychological intervention for premenstrual symptoms, drawing on cognitive behavioural and narrative therapy. *Clinical Psychology and Psychotherapy*, 9(5), 319–331.

- Ussher, J.M., & Perz, J. (2008). Empathy, egalitarianism and emotion work in the relational negotiation of PMS: The experience of women in lesbian relationships. *Feminism and Psychology*, 18(1), 87–111. doi: 10.1177/0959353507084954
- Ussher, J., & Perz, J. (2010). Disruption of the silenced self: The case of premenstrual syndrome. In D. Jack & A. Ali (Eds.), *Silencing the self across cultures – depression and gender in the social world*. (pp. 435–459). New York: Oxford University Press.
- Ussher, J.M., & Perz, J. (2013). PMS as a gendered illness linked to the construction and relational experience of hetero-femininity. *Sex Roles*, 68(1), 132–150. doi:10.1007/s11199-011-9977-5
- Ussher, J.M., Perz, J., & May, E. (2014). Pathology or source of power? The construction and experience of Premenstrual Syndrome (PMS) within two contrasting cases. *Feminism and Psychology*, 24(3), 332–351. doi: 10.1177/0959353514539650
- Ussher, J.M., Perz, J., & Mooney-Somers, J. (2007). The experience and positioning of affect in the context of intersubjectivity: The case of premenstrual syndrome. *International Journal of Critical Psychology*, 21, 144–165.
- Ussher, J.M., & Wilding, J.M. (1991). Performance and state changes during the menstrual cycle, conceptualised within a broad band testing framework. *Social Science and Medicine*, 32(5), 525–534. doi: 10.1016/0277-9536(91)90286-L
- Ussher, J.M., & Wilding, J.M. (1992). Interactions between stress and performance during the menstrual cycle in relation to the premenstrual syndrome. *Journal of Reproductive and Infant Psychology*, 10(2), 83–101.
- Valentine, G. (1999). Doing household research: Interviewing couples together and apart. *Area*, 31(1), 67–74.
- van Leusden, H. (1995). Premenstrual syndrome no progesterone; premenstrual dysphoric disorder no serotonin deficiency. *Lancet*, 346(8988), 1443–1444.

- Vickers, R., & McNally, R. (2004). Is premenstrual dysphoria a variant of panic disorder?: A review. *Clinical Psychology Review*, 24(8), 933–956. doi:10.1016/j.cpr.2004.08.001
- Vigod, S., Ross, L., & Steiner, M. (2009). Understanding and treating premenstrual dysphoric disorder: an update for the women's health practitioner. *Obstetrics and Gynecology Clinics of North America*, 36(4), 907–924. doi:10.1016/j.ogc.2009.10.010
- Vogel, D., Heimerdinger-Edwards, S., Hammer, J., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, 58(3), 368–382. doi:10.1037/a0023688
- Vogel, D.L., Wade, N.G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 53(3), 325–337. doi:10.1037/0022-0167.53.3.325
- Wade, N., Post, B., Cornish, M., Vogel, D.L., & Tucker, J. (2011). Predictors of the change in self-stigma following a single session of group counseling. *Journal of Counseling Psychology*, 58(2), 170–182. doi:10.1037/a0022630
- Walker, A. (1995). Theory and methodology in premenstrual syndrome research. *Social Science and Medicine*, 41(6), 793–800.
- Warner, P., & Bancroft, J. (1990). Factors related to self-report of the premenstrual syndrome. *British Journal of Psychiatry*, 157(2), 249–260.
- Warr, D.J. (2005). "it was fun... but we don't usually talk about these things": Analyzing sociable interaction in focus groups. *Qualitative Inquiry*, 11(2), 200–225. doi:10.1177/1077800404273412
- Watson, W.L., & Nanchoff-Glatt, M. (1990). A family systems approach to premenstrual syndrome. *Clinical Nurse Specialist*, 4(1), 3–9. doi:10.1097/00002800-199000410-00002
- Weiner, B., Perry, R., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, 55(5), 738–748.

- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. London: Norton.
- Widarsson, M., Engström, G., Rosenblad, A., Kerstis, B., Edlund, B., & Lundberg, P. (2013). Parental stress in early parenthood among mothers and fathers in sweden. *Scandinavian Journal of Caring Sciences*, 27(4), 839-847. doi:10.1111/j.1471-6712.2012.01088.x
- Wilkinson, S. (2003). Focus groups. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. (pp. 184–204). London: Sage.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Willig, C. (2008). *Introducing qualitative research in psychology. Adventures in theory and method*. (2nd ed.). Berkshire: Open University Press.
- Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P.M. Camic, D.L. Long, A.T. Panter, D. Rindskopf, & K.J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 1: Foundations, planning, measures, and psychometrics*. (pp. 5–21). Washington DC, US: American Psychological Association. doi:10.1037/13619-002
- Wimberly, S.R., Carver, C.S., Laurenceau, J., Harris, S.D., & Antoni, M.H. (2005). Perceived partner reactions to diagnosis and treatment of breast cancer: Impact on psychosocial and psychosexual adjustment. *Journal of Consulting and Clinical Psychology*, 73(2), 300. doi:10.1037/0022-006X.73.2.300
- Winter, E., Ashton, D., & Moore, D. (1991). Dispelling myths: a study of PMS and relationship satisfaction. *Nurse Practitioner*, 16(5), 37–40.
- Woods, N.F., Lentz, M.J., Mitchell, E.S., Shaver, J., & Heitkemper, M. (1998). Luteal phase ovarian steroids, stress arousal, premenstrual perceived stress, and premenstrual symptoms. *Research in Nursing and Health*, 21(2), 129–142. doi:10.1002/(SICI)1098-240
- World Health Organization (WHO). (1996). *International Classification of Diseases*. (10th rev.). Geneva: World Health Organization.

- Yanos, P.T., & Ziedonis, D.M. (2006). The patient-oriented clinician researcher: Advantages of being a double agent. *Psychiatric Services*, 57(2), 249–253.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215–228.
- Yardley, L. (2008). Demonstrating validity in qualitative research. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. (2nd ed.) (pp. 235–251). London: Sage.
- Yonkers, K., Brown, C., Pearlstein, T., Foegh, M., Sampson-Landers, C., & Rapkin, A. (2005). Efficacy of a new low-dose oral contraceptive with drospirenone in premenstrual dysphoric disorder. *Obstetrics and Gynecology*, 106(3), 492–501.

Appendix A
Ethics Release Form

Ethics Release Form for Psychology Research Projects

All trainees planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) [Guidelines for minimum standards of ethical approval in psychological research](#) (BPS: Leicester) should be referred to when planning your research.
- **Trainees are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ DPsych x N/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Couples' experiences of PMS: An Interpretative Phenomenological (IPA) Analysis

2. Name of student researcher (please include contact address and telephone number)

Name: Zoe Starnawski

Contact address: [REDACTED]

ph: [REDACTED]

3. Name of research supervisor

Name: Maggie Mills

Contact address: [REDACTED]

Ph [REDACTED]

4. Is a research proposal appended to this ethics release form? **Yes.** Please see attached report (**Appendix 1**).

5. Does the research involve the use of human subjects/participants? **Yes**
If yes,

a. Approximately how many are planned to be involved? 8-12 participants (4-6 couples). This number is based on Smith, Flowers and Larkin's (2009) suggestion that Professional doctorate research using IPA method of analysis is typically between four and ten interviews and that higher numbers of participants is not indicative of 'better' work.

b. How will you recruit them?

Participants will be recruited from organizations that deal with women who suffer from PMS symptoms such as support groups (e.g. The National Association for Premenstrual Syndrome (NAPS)). Participants will also be recruited from services that are aimed at couples, such as Relate. Flyers will be used to also recruit participants from health centres and gyms and at London universities. Participants will also be recruited through word of mouth. Advertisements will be placed online as well in newsletters and bulletins.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

Inclusion Criteria:

The participant experiencing PMS symptoms:

- Will be between the ages of 18 and 35 years (women in the typical age range of child-bearing but have not entered into perimenopause)
- Will be married or cohabitating with her partner for at least 1 year
- Will have regular menstruation cycles (between 25 to 35 days + or - 3 days) for the last 12 months
- They will affirm that they suffer from PMS symptoms (moderate to severe). This will be affirmed by their own verbal accounts and cross-checked against a measure for severity of PMS symptoms (Shortened Premenstrual Assessment Form) (see **Appendix 3**)

Exclusion Criteria:

- Participants suffering from a clinical disorder (i.e. Depression, Schizophrenia) and taking psychiatric medication (e.g. antipsychotics, antidepressants). This is because the research involves partaking in interviews about a potentially distressing experience which may cause undue stress to individuals who are likely to be already experiencing stress. Also, the study aims to look at the impact of PMS rather than other experiences such as depression on the couple relationship.
- The woman is breastfeeding or pregnant within the last 6 months (research indicates pregnant or lactating women usually do not have PMS symptoms Coughlin, 1990).

Please see attached recruitment flyer (**Appendix 2**).

If a participant does not meet the research criteria, they will be thanked for their interest and time and they will be informed that they do not meet the criteria of the study at this time. If for example a participant is experiencing clinical mental illness (e.g. depression, schizophrenia) then they will be told that ethically it would not be beneficial for them to

partake in the research as it may cause undue distress/stress. The participant would be offered contact details of relevant support services should they require (Appendix 8) by hard copy or email at their request. They would also be directed to seek help from their GP if they feel this is needed. They would also be offered a copy of the results of the study once it is completed if they wish to know more about the research.

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? **No**

e. If yes, will signed parental/carer consent be obtained? **N/A**

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Each participant identified as experiencing PMS will be required to complete:

1. Shortened Premenstrual Assessment Form (PAF) – 10 questions 5 minutes (see **Appendix 3**)

2. Calendar of Premenstrual Experiences (COPE) – 2 menstrual cycles (see **Appendix 4**)

Both participants will be required to complete:

2. Screening interview (by telephone) – 5-10 minutes for partner and 10-15 for woman (see **Appendix 5**)

3. Functional Impairment questions (global & social) based on questions developed by Dean and Borenstein (2004) – 2 questions, 2 minutes (see **Appendix 6**)

4. Demographic questionnaire – 2 minutes (**Appendix 7**)

5. Couple interview – 11/2 – 2 hours (**Appendix 8**)

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes (possibly) If yes,

a. Please detail the possible harm?

There may be a possibility of temporary distress as participants give accounts of their relationships and PMS experiences. There will be no risk of physical harm.

b. How can this be justified?

It is unlikely if any distress does occur that it will be long-lasting, however it is necessary to get accounts of the participant's relationships and the levels of distress they experience related to PMS to investigate the research topic. In the unlikely event that a participant shows temporary distress, all participants will be supported and will be provided with a list of counselling services, including PMS specialist services, couple relationship counselling services and will be suggested to seek a GP referral if they feel they need additional help for PMS or psychological distress. Please see appended list (**Appendix 8**).

As participants will be sufferers of PMS, it is likely that they already experience some level of distress/difficulty in their everyday lives and relationships and perhaps experience the negative effects of the stigma attached to having PMS symptoms. This research therefore aims to help explore some of these experiences and allow participants to discuss them in a non-judgemental and confidential environment. By exploring such issues, it is possible that participants will hopefully feel more understood and able to share their difficulties within the

research setting and possibly outside, which may lead them to feel more confident and less embarrassed/self-conscious about having PMS.

Participants will have the opportunity to fully discuss any concerns they may have during the de-brief session. The researcher will ensure that a significant amount of time is available for the provision of psychological support and debriefing at the end of the interview. This will include asking participants about their experience of the interview, a full exploration of how participants are feeling and discussion of any areas which the participant found helpful or not. The focus of this de-brief may differ for each participant; however, every effort will be made to ensure that participants leave feeling fully supported and positive about their experience in taking part in the research. All participants will be given contact details of the researcher and supervisor, in case they have any further questions. As mentioned, they will also be provided with suitable numbers for counselling services should they require (**Appendix 8**). All participants will be contacted by the researcher 48 hours after the interview to ensure that they have all the support they need.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes. Please see attached Information Sheet (**Appendix 9**).

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes. Please see attached Consent Form (**Appendix 10**).

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Digital recordings of semi-structured interviews will be kept with participant's permission. Transcribed interview notes which will be anonymized and coded using a pseudonym, will be kept as computer records. Hard-copy research notes (COPE diary information) will be kept with participant's permission. Consent forms and contact details will also be kept.

12. What provision will there be for the safe-keeping of these records?

Each participant will be given a pseudonym, which will be used for all records (research notes, audio tapes, transcripts). The master list identifying each participant, together with consent forms and contact details will be held in a locked filing cabinet to which only the researcher has access. All computer records (including audio recordings & transcripts) will

be held on a personal computer at the researcher's home which is password protected and used only by the researcher.

13. What will happen to the records at the end of the project?

All digital recordings will be destroyed after transcribing. Transcriptions will be uploaded to a password protected computer. All hard copy notes will be destroyed when no longer needed i.e. after being transferred to password protected computer.

14. How will you protect the anonymity of the subjects/participants?

Anonymity of participants will be protected by not linking individual interview responses with participant's identities as a pseudonym will be used. The pseudonym given at the beginning of the research will be used in all subsequent research materials and in the research write-up all identifying details will be removed.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be fully de-briefed and will also be given a De-brief Form (**Appendix 11**). The researcher will ensure that a considerable amount of time is available for the provision of psychological support and debriefing at the end of the interview and questionnaires. This will include asking participants about their experience of the interview, a full exploration of how participants are feeling and discussion of any areas of which the participant found useful/helpful or difficult/uncomfortable. The focus of this de-brief session may differ for each participant; however, every effort will be made to ensure participants leave feeling fully supported and positive about their experience in taking part in the research. All participants will be given contact details of the researcher and supervisor to use if they have any further questions or comments to give after the de-brief session. All participants will also be provided with a list of counselling services (including PMS specialist services) and will be suggested to seek a GP referral if they feel they need additional help for PMS or psychological distress. Please see attached Resource List (**Appendix 8**). Finally, all participants will be contacted by the researcher 48 hours after the interview and questionnaire session, to ensure that their support needs are met.

Each participant will have the opportunity to receive a copy of the findings of the study and to make any comments on the findings should they wish.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in bold print, please provide further explanation here:

Signature of student researcher

Date

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

- ☒ Ethical approval granted
☐ Refer to the Department of Psychology Research Committee
☐ Refer to the University Senate Research Committee

Signature

Date

Section C: To be completed by the 2nd Department of Psychology staff member
(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)

- ☒ I agree with the decision of the research supervisor as indicated above

Signature

Date

Appendix B

Consent Form for Interviews and Questionnaires

Relationships and PMS

- I am willing to take part in the interview and questionnaires for this research and for the interview to be recorded.
- I understand all of the information provided about the research and if I need clarification about something, I understand I have the opportunity to ask questions.
- I understand that no one will have access to the recording beyond the researcher and her supervisor.
- I understand that I may be contacted by the researcher after the interview if clarification of issues discussed in the interview is required by the researcher.
- I understand that any personal statements made in the interview will be confidential. As far as possible all comments will be appropriately made anonymous as well as any reports or papers that are produced as a result of the research. Names and job titles will not be included in reports and all transcribed information will be appropriately made anonymous.
- I understand that taking part in the research is voluntary and that I may withdraw at any time and that if I do all material provided will be destroyed.
- I understand that the data from this research will be used for the following:
 1. DPsych dissertation (including viva)
 2. Academic research papers and presentations
 3. A summary report to be circulated to all interested participants or other interested parties.

Name of Participant:

Signature of Participant:

Date:

Name of Researcher:

Signature of Researcher:

Date:

This study is part of a thesis for City University, London, School of Social Sciences, Department of Psychology, Professional Doctorate of Counselling Psychology. This research is under the supervision of Maggie Mills (email: [REDACTED])

Appendix C

Debrief for Participants

Title of Study: Couples' experiences of PMS: An Interpretative Phenomenological Analysis (IPA)

Thank you for participating in the current study.

There is very little understanding in the area of PMS and couple and family relationships. Therefore, a main aim of the current research is to better understand the relational factors related to PMS.

Confidentiality, Anonymity and Withdrawal

Any personal statements made in the interview will be confidential. As far as possible all comments made will be anonymised as well as any reports or papers that are produced as a result of the research. Taking part in the research is voluntary; therefore, you may withdraw at any time.

If you would like to find out more about the subject of PMS the following reading may be of interest to you:

- Ussher, J.M. (2006). *Managing the monstrous feminine: Regulating the reproductive body*. London: Routledge

If you have been affected by this research, you may wish to contact the following organisations:

National Association for Premenstrual Syndrome (NAPS)

Website: <http://www.pms.org.uk>

Email: contact@pms.org.uk

Phone: 0870 777 2178

Address: 41 Old Road, East Peckham, Kent TN12 5AP

Additionally, please see the attached list of PMS Specialists and Clinics and Counselling Services. If you feel you need further support, please do not hesitate to contact me.

Once again, I thank you for taking part in the present study.

Please feel free to contact me, **Zoe Starnawski**, via **email:** [REDACTED]
or **phone:** [REDACTED] if you have any questions or comments regarding this study.
Or Maggie Mills, Research Supervisor, **email:** [REDACTED]

Counselling Services

The British Psychological Society

St Andrews House
48 Princess Road East
Leicester LE1 7DR
Tel: +44 (0)116 254 9568
Fax: +44 (0)116 227 1314
Email: enquiries@bps.org.uk
Website: www.bps.org.uk

British Association for Counselling and Psychotherapy (BACP)

Tel: General Enquiries: 01455 883300
Mailing address: British Association for
Counselling and Psychotherapy
BACP House, 15 St John's Business Park,
Lutterworth, Leicestershire LE17 4HB, United
Kingdom
Email: bacp@bacp.co.uk
Website: www.bacp.co.uk

Relate – Relationship Counselling

Tel: 0300 100 1234
Relate offers advice, relationship counselling,
sex therapy, workshops, mediation,
consultations and support face-to-face, by
phone and through their website
Website: <http://www.relate.org.uk>

Mind – Mental Health Charity

Address: 15-19 Broadway, London E15 4BQ
T: 020 8519 2122, **F:** 020 8522 1725
Email: contact@mind.org.uk
Information helpline: MindinfoLine - **0845
766 0163**
Website: <http://www.mind.org.uk>

City University Counselling Service

Tel: 0207 040 8094 (internal extension 8094)
Email: coun@city.ac.uk
Address: Student Counselling Service, Health
Centre Building, 20 Sebastian Street, London
EC1V 0JA (off Northampton Square).
Website:
www.city.ac.uk/studentcentre/counselling/

PMS Specialists and Clinics

SOUTH CENTRAL

NHS Dr Margaret Rees
The John Radcliffe Hospital
Headley Way
Headington
Oxford OX3 9DU
Phone: 01865 741166

Accepts GP referrals from outside area

EAST OF ENGLAND

NHS Mr Andrew Prentice and Miss Jane MacDougall
Consultant Obs and Gynae
University Department of Obs and Gynae
Rosie Hospital
Robinson Way
Cambridge CB2 2SW
Phone: 01223 216469

Menstrual Dysfunction Clinic
Every other week

PRI Mr Andrew Prentice
Spire Cambridge Lea Hospital
30 New Road
Impington
Cambridge
CB24 9EL
Phone: 01223 336881

NHS Richard Warren
Consultant Obs and Gynae
Department of Obs and Gynae
Norfolk and Norwich University Hospital NHS Trust
Colney Lane
Norwich NR1 3SR
Phone: 01603 286286

Referrals only from East Anglia
PMS and Menopause clinics

PRI Richard Warren
Spire Norwich Hospital
Watton Road
Norwich
NR4 7TD
Phone: 01603 456181

No GP referral necessary

LONDON

NHS Mr Nicholas Panay
Consultant Obs and Gynae
PMS and Menopause Clinic
Chelsea and Westminster Hospital
369 Fulham Road
London SW10 9NH
Phone: 0208 383 3513

NHS clinic – GP referrals country wide

NHS Mr Nicholas Panay
Consultant Obs and Gynae
Queen Charlotte and Chelsea Hospital
150 Ducane Road
Shepherds Bush
London W12 0HJ
Phone: 0208 746 8790

GP written referral only

PRI Mr Nicholas Panay
92 Harley Street
London
W1G 7HU
Phone: 0207 034 1300

No GP referral necessary

PRI Mr Nicholas Panay
Women's Wellness Clinic
204 Fulham Road
London
SW10 9PJ
Phone: 0207 751 4489

NHS Dr Claudine Domoney
Consultant Obs and Gynae
Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH
Phone: 0208 383 3513 Ext 4083

NHS Miss Sheila Radhakrishnan
Consultant Obs and Gynae
Royal Free Hospital
Pond Street
Hampstead
London NW3 2QG
Phone: 0207 830 2495

Weekly PMS clinic
GP referral only

PRI Professor John Studd
46 Wimpole Street
London
W1G 8SD
Phone: 0207 486 0497

GP referrals only

PRI Dr Maurice Katz
London Medical Centre
142-6 Harley Street
London
W1G 7LD

Wed pm Phone: 0207 935 0023
(for appointments)
Phone: 0207 383 7911
(Dr Katz Secretary)

NORTHERN IRELAND

NHS Dr Joanne McManus
Royal Victoria Hospital
Grosvenor Road
Belfast
Phone: 02890 633493

HRT clinic – will also see PMS patients

YORKSHIRE AND THE HUMBER

NHS Dr Julie Ayres
Rosalind Bolton PMS Clinic
Colposcopy Suite
Gledhow Wing
St James' University Hospital
Beckett Street
Leeds LS9 7TF
Phone: 0113 392 6598

GP NHS referrals from anywhere. No waiting list.
Clinics - Thursday mornings.

NHS Dr Lynda Turner and Dr Patricia Stephenson
The Central Health Clinic
Mulberry Street
Sheffield
S1 1PJ
Phone: 0114 271 6818 (Sec: Ros Belcher)

Joint PMS/Menopause clinic
3-4 clinics each week

NHS Kate Guthrie
Consultant Gynaecologist
The Princess Royal Hospital
Salthouse Road
Hull
E Yorkshire HU8 9HE
Phone: 01482 701151

Clinic – Tuesday evening
GP referral

NHS Community Gynae Clinic
Conifer House
Prospect Street
Hull
Phone: 01482 336 332

Ring for appointment
Can self-refer

SCOTLAND

NHS Dr Heather Currie
Associate Specialist Obs and Gynae
Dumfries and Galloway Royal Infirmary
Bankend Road
Dumfries
Phone: 01387 246246

Menopause and PMS clinic twice weekly

NHS Dr Ailsa Gebbie and Dr Hazel Quarrell
Consultant Community Gynaecologists
Mrs Alison Craig (nurse consultant)
PMS Clinic
Family Planning Service
18 Dean Terrace
Edinburgh EH4 1NL
Phone: 0131 332 7941
fax 0131 332 2931

PMS Clinic every Monday
0131 3430907
Menopause 0131 343 0902
Urgent appointments
0131 332 7941
GP referral and self-referral
(in writing)

NHS Dr Lucy Caird
Raigmore Hospital
Old Perth Road
Inverness IV3 5SF
Phone: 01463 704000

Monthly menopause clinic but does see PMS patients

GP referrals only

NHS Gilbert Bain Hospital
Lerwick
Shetland
Phone: 01595 743000 Ext. 3148

Menopause clinic – will see PMS patients

SOUTH WEST

NHS Dr Sarah Gray
St Austell Community Hospital
Porthpean Road
St Austell
Cornwall
PL26 6AD
Phone: 01726 291100

PRI Dr Sarah Gray
Duchy Hospital
Penventinnie Lane
Tresliske
Truro
Cornwall TR1 3UP
Phone: 01872 242192

GP referral not necessary

PRI Dr Sarah Gray
The Plymouth Nuffield Hospital
Derriford Road
Plymouth
Devon PL6 8BG
(Use Truro number: 01872 242192)

GP referral not necessary

EAST MIDLANDS

NHS Professor PMS O'Brien
Consultant Gynaecologist
Treatment Care
Keele University School of Medicine
Hilton Road
Stoke on Trent
Staffordshire ST4 6SD
Phone: 01782 552472
Phone: 01782 552446

GP referrals

PRI Professor PMS O'Brien
Nuffield Hospital
Clayton Road
Newcastle under Lyme
Stoke on Trent
ST5 4DB

Phone: 07880 996329

WALES

NHS Mr Richard Penketh
Consultant Gynaecologist
Clinical Director Obs and Gynae
Gynae Outpatients Department
Llandough Hospital
Llandough
Penarth CF64 2XX
Phone: 029 2074 4390 (direct line)

PMS clinic
GP referral

PRI Mr Richard Penketh
Spire Hospital
Cardiff
CF23 8XL
Phone: 02920 736011

Tuesday am
GP referral preferred

NHS Dr Charlotte Fleming
Consultant in Gynaecology and Sexual Health
Llanyraton House
Llanfrecha Grange
Cwmbran
Gwent NP44 8VN

No specific PMS Clinic – will see women in Gynae clinic
Helpline: 01633 623714

NHS Dr Jeannie Heard
Breconshire War Memorial Hospital
Cerigochion Road
Brecon
Powys LD3 7NS
Phone: 01874 622443

GP referral to women's health clinic
(includes PMS advice)

WEST MIDLANDS

NHS Mrs Susan Blunt
Consultant Obs and Gynae
Dr Jennie Williamson (Associate Specialist)
Birmingham Women's Hospital
Edgbaston
Birmingham
W Midlands
Phone: 0121 472 1377

Ask for PMS and Menopause clinic
Weekly Clinic

NHS Miss E Payne
Consultant Gynaecologist
Prince of Wales Women's Unit
Birmingham Heartlands Hospital
Edgbaston
Birmingham
W Midlands B95 5SS
Phone: 0121 424200

Appendix D

Participant Recruitment Material

Participant flyer (female)

Do you experience PMS?

- Do you feel agitated and restless?
- Do you get angry and feel 'out of control'?

Do you meet the following criteria?

- You are a woman between the ages of 18 and 35
- You or your partner feels you experience moderate to severe PMS
- You have been living with your partner for no less than 1 year

If so you may be interested in participating in a study looking at the ***experiences of couples*** when one partner is experiencing PMS

I am a trainee Counselling Psychologist completing a Professional Doctorate in Counselling Psychology at City University who is interested in how PMS symptoms may affect heterosexual couple relationships. The study will involve couple interviews which will be conducted confidentially.

If you and your partner are interested in participating, or would simply like to find out more, please contact

Zoe Starnawski on email: [REDACTED]

Or mobile: [REDACTED]

I look forward to hearing from you.

This study is part of a thesis for City University, London, School of Social Sciences, Department of Psychology, Professional Doctorate of Counselling Psychology. This research is under the supervision of Maggie Mills (email: [REDACTED])

Participant flyer (male)

Does your wife/girlfriend/partner experience PMS?

- Do they feel agitated and restless?
- Do they get angry and feel 'out of control'?

Do they meet the following criteria?

- They are a woman between the ages of 18 and 35
- You or your partner feels they experience moderate to severe PMS
- You have been living with your wife/girlfriend/partner for no less than 1 year

If so you may be interested in participating in a study looking at the ***experiences of couples*** when one partner is suffering PMS

I am a trainee Counselling Psychologist completing a Professional Doctorate in Counselling Psychology at City University who is interested in how PMS symptoms may affect heterosexual couple relationships. The study will involve couple interviews which will be conducted confidentially.

If you and your partner are interested in participating, or would simply like to find out more, please contact

Zoe Starnawski on email: [REDACTED]

Or mobile: [REDACTED]

I look forward to hearing from you.

This study is part of a thesis for City University, London, School of Social Sciences, Department of Psychology, Professional Doctorate of Counselling Psychology. This research is under the supervision of Maggie Mills (**email:** [REDACTED])

Appendix E
Shortened Version of Premenstrual Assessment Form (PAF)
(Allen, McBride, & Pirie, 1991)

Here is a list of 10 typical PMS symptoms and I am wondering if you could tell me on a scale of 1-6 (with 1 being not present or no change from usual) to 6 (extreme change, perhaps noticeable even to casual acquaintances) what you experienced during your last cycle?

1. Pain, tenderness, enlargement or swelling of breasts	1	2	3	4	5	6
2. Feeling unable to cope or overwhelmed by ordinary demands	1	2	3	4	5	6
3. Feeling under stress	1	2	3	4	5	6
4. Outbursts of irritability or bad temper	1	2	3	4	5	6
5. Feeling sad or blue	1	2	3	4	5	6
6. Backaches, joint and muscle pain, or joint stiffness	1	2	3	4	5	6
7. Weight gain	1	2	3	4	5	6
8. Relatively steady abdominal heaviness, discomfort or pain	1	2	3	4	5	6
9. Edema, swelling, puffiness, or water retention	1	2	3	4	5	6
10. Feeling bloated	1	2	3	4	5	6

Appendix F

Calendar of Premenstrual Experiences (COPE)

(Mortola, Girton, Beck, & Yen, 1990)

Name: _____

Date: _____

Age: _____





Instructions:

Begin your calendar on the first day of your menstrual cycle. Enter the calendar date below the cycle day. Day 1 is your first day of bleeding.

Shade in the box above the cycle day if you have bleeding



Put an X for spotting ☒

Bleeding					X	X	X
Cycle day	1	2	3	4	5	6	11

Example:

If more than one symptom is listed in a category i.e., nausea, diarrhoea, constipation, you **do not** need to experience all of these. Rate the most disturbing of the symptoms on the scale of 1-3. (0=None present (symptom not present), 1=Mild (noticeable but not troublesome), 2=Moderate (interferes with normal activities), 3=Severe (intolerable, unable to perform normal activities)).

Symptoms: Indicate the severity of your symptoms by using the scale below:

0=None present (symptom not present), 1=Mild (noticeable but not troublesome), 2=Moderate (interferes with normal activities), 3=Severe (intolerable, unable to perform normal activities).

Try to rate each symptom at about the same time each evening

Other symptoms: If there are other symptoms you experience, list and indicate severity.

Medications: List any medications taken. Put an X on the corresponding day(s).

Bleeding	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Cycle day																														
Date																														
Symptoms																														
Acne																														
Bloatedness																														
Breast tenderness																														
Dizziness																														
Fatigue																														
Headache																														
Hot flashes																														
Nausea, diarrhoea, constipation																														
Angry outbursts, arguments,																														
Palpitations																														
Swelling (hands, ankles, breasts)																														
Anxiety, tension, nervousness																														
Confusion, difficulty concentrating																														
Crying easily																														
Depression																														
Food cravings (sweets, salt)																														
Forgetfulness																														
Irritability																														
Increased appetite																														
Mood swings																														
Overly sensitive																														
Wish to be alone																														
Other symptoms																														
1.																														
2.																														
Medications																														
1.																														

Appendix G

Website Participant Recruitment Advertisement

Research into the experience of PMS and heterosexual couple relationships

- Do you feel agitated and restless?
- Do you get angry and feel 'out of control'?

Do you meet the following criteria?

- You are a woman between the ages of 18 and 35
- You or your partner feels you experience moderate to severe PMS
- You have been living with your partner for no less than 1 year

If so, you may be interested in participating in a study looking at the experiences of couples when one partner is experiencing PMS.

If you are interested in participating, please contact Zoe Starnawski for further information.

Email: [REDACTED] or call **Mobile:** [REDACTED]

This project is part of a Doctorate thesis carried out on the Professional Doctorate of Counselling Psychology at City University, London. It is supervised by Dr Maggie Mills.

Appendix I

Example of Participant Screening Interview (Telephone or Email)

Introduction

Phone and email: Thank you for contacting me about possibly taking part in a research project on PMS and relationships that I am conducting as part of my Doctorate in Counselling Psychology at City University, London.

Phone: If it's OK, I would like to talk to you both briefly over the phone to see if you meet the criteria for the study and, if you do, to see if you are still interested in participating. It will take around 5 to 10 minutes of your time. Is it possible to do this now? If not, when may be a good time to schedule a time to talk?

Email: Before you and your partner are able to take part in the study, there are some criteria that need to be met. I have attached a few questions that are related to these criteria. If you are able to answer these and email your responses back to me, this would be much appreciated. Some of these questions may seem quite personal; please feel free not to answer any that you don't feel you can.

Interview

Phone: OK, as you may or may not be aware, to take part in the study there are a few criteria that need to be met. So, if it's OK with you, I will now ask you both a few questions about yourselves and your relationship related to these criteria. Some of these questions may seem quite personal, so please feel free not to answer them if you don't feel that you can.

Questions for the partner who is experiencing PMS:

1. How old are you?
2. Have you been in a relationship with [partner] for more than 1 year?
3. Do you have regular periods (between 25 to 35 days + or – 3 days)?
4. Have you had your periods for the last 12 months? If not, why?
5. Do you experience premenstrual symptoms?
6. Would you say they are mild, moderate or severe?

I have a list of 10 typical PMS symptoms and I am wondering if you could tell me on a scale of 1 to 6 (with 1 being not present or no change from usual) to 6 (extreme change, perhaps noticeable even to casual acquaintances) what you experienced during your last cycle.

1. Pain, tenderness, enlargement or swelling of breasts	1	2	3	4	5	6
2. Feeling unable to cope or overwhelmed by ordinary demands	1	2	3	4	5	6
3. Feeling under stress	1	2	3	4	5	6
4. Outbursts of irritability or bad temper	1	2	3	4	5	6
5. Feeling sad or blue	1	2	3	4	5	6
6. Backaches, joint and muscle pain, or joint stiffness	1	2	3	4	5	6
7. Weight gain	1	2	3	4	5	6
8. Relatively steady abdominal heaviness, discomfort or pain	1	2	3	4	5	6
9. Edema, swelling, puffiness, or water retention	1	2	3	4	5	6
10. Feeling bloated	1	2	3	4	5	6

7. Are you taking medication for your PMS symptoms?

8. Have you been diagnosed with a clinical illness (for example, depression)? (If yes, go to question 9; if no, go to question 10.)

9. Are you taking any medication for this? If so, what?

10. Are you breastfeeding or have you been in the last 6 months?

11. Have you been pregnant in the last 6 months?

Thank you very much for answering these questions and for your time.

Questions for the partner who is NOT experiencing PMS:

1. Do you feel that your partner suffers from PMS symptoms?

2. If so, would you consider them to be mild, moderate or severe?

3. Have you been diagnosed with a clinical illness (for example, depression)? (If yes, go to question 4.)

4. Are you taking medication for this? If so, what?

Thank you so much for your time. (Go to 1 or 2.)

1. If participants do not meet the criteria:

Thank you for answering these questions; I appreciate your time. I'm very sorry but I'm afraid that you don't meet the criteria for this particular study at the moment. The study

is looking at [for example, heterosexual cohabiting relationships]. I understand you may feel distressed because of PMS; therefore, if you feel you need some support in terms of PMS or relationship issues I can email or post you some resources that may be of use. Alternatively, you can always speak to your GP. Thank you again for your time and for contacting me.

2. If participants do meet the criteria:

Thank you for answering these questions; I appreciate your time. If it's OK with you, I would like to either arrange a time to meet so that you are able to learn more about the study and fill in some forms and a questionnaire regarding PMS, or I can post or email these forms to you for you to complete and send back. Once these forms have been completed I will then contact you so that we can arrange a time and place for us to meet to conduct an interview. Do you have any questions? If you want to contact me at all with regard to the study, please don't hesitate to call me or email me using the details I have given you. Thanks again for your time.

Appendix J

Participant Information Sheet

Research into Relationships and Premenstrual Syndrome (PMS)

Background to the study

I am a trainee on the Professional Doctorate of Counselling Psychology course at the School of Social Sciences, City University, London and my research is examining couple relationships where one partner experiences PMS symptoms. There is currently limited research and, therefore, very little knowledge of this area, particularly from the perspectives of both people in the relationship. Therefore, a main aim of this research is to better understand the experiences of couples who experience PMS, how they relate to each other, how they give and seek support, and how they manage PMS symptoms within their relationship.

The information being collected for this research includes the perspectives and accounts of both members of couples experiencing PMS. This information will be collected from interviews with couples. This knowledge, in turn, will hopefully add to the existing treatments available to women and couples to help them better understand, accept, and manage their PMS symptoms.

Procedures for participating in the study

The study will involve an initial screening and an interview. The screening stage will involve a telephone interview to ensure you and your partner are both suitable for inclusion in the study. If you are interested in participating and you meet the criteria, you will be given (either in person, or by email or post) an information pack containing relevant information about the study, a demographic questionnaire, consent forms, and a PMS measure. The researcher will then contact you to answer any queries you may have about the study procedures and to schedule an interview with you.

The interviews will be conducted by the researcher and should take approximately 1½–2 hours. The researcher will ask about your experiences regarding PMS. All interviews will be recorded using an audio digital recorder and will be transcribed.

Confidentiality

Interviews will be digitally recorded and fully transcribed. The recordings will be stored in a secure location and only the researcher will have access. People's names or job titles will not be included in the reports and any identifiable details will be appropriately made anonymous. I hope you will be able to help with this important area of research. If you agree to take part, please complete the consent form. Please note: you are free to withdraw at any time and without giving a reason.

Possible benefits of participating in the study

This research will hopefully give an insight into how couples experience PMS in their relationship. This information will, therefore, hopefully lead to a greater understanding of how couples manage PMS symptoms and this will help to inform professionals working with couples who may experience distress/problems when one partner suffers from PMS.

Possible risks of participating in the study

There is minimal risk in participating in this study. Some interview questions asked in the study may lead participants to experience mild distress; however, if this does occur you can withdraw from the study at any time or choose not to answer certain questions.

How will the results be used?

The data from this research will be used for:

1. DPsych dissertation (including viva)
2. Academic research papers and presentations
3. A summary report to be circulated to all interested participants.

Please indicate on the consent form if you would like to receive a summary of the results.

Please contact me if you would like further information:

Zoe Starnawski – Phone: 07810331479; email: zoe.starnawski.1@city.ac.uk

Thank you.

Appendix K
Demographics Form

Name: _____ Contact (phone/email): _____

Age: _____

Occupation: _____

Current relationship status: _____

Do you have any children? Yes (Specify number: _____) No

What is your religion? (please circle the appropriate number)

1. Catholic
2. Protestant
3. Jewish
4. Hindu
5. Other (please specify): _____

What is the cultural/ethnic background to which you feel you most strongly belong? (for example, White-British, Caribbean, Asian)

Do you have any formal qualifications? If so, what are they?

Have you ever received any support for relationship difficulties (for example, counselling)? If so, please specify any details.

Appendix L

Interview Schedule

Thank you for agreeing to be here today. I am going to ask you both some questions and I would appreciate if you could answer them as honestly as you can. I am aware that it may be difficult for you to be open in front of your partner and that some issues may be raised today which might cause you some discomfort/distress. If for any reason you do feel distressed, please let me know, as you are free to discontinue at any time. Also, just to remind you that everything you say today is confidential. Do you have any questions or concerns that you would like to raise before we begin? If not, shall we start?

Meaning

I'd first like to ask each of you to answer individually:

- What does PMS mean to you?
- How do you feel about you / your partner experiencing PMS?

After each partner has answered:

What does PMS mean for you as a couple?

(Prompt: Were you aware that that is how your partner felt?)

Typical experience

Can you describe a typical PMS experience to me? (Prompt – a particularly bad or good/memorable premenstrual experience that normally happens at that time?)

Impact on couple and family relationships

- How does PMS impact on your relationship and family and parenting (if applicable)?
- What are the biggest challenges faced by you as a couple?

Communication

- How do you communicate with each other with regard to PMS?
- Does the experience of PMS in the relationship cause conflict?

(Prompt: have there been particular issues you tend to have disagreements about because of PMS?)

Coping

- As a couple, how do you cope with PMS symptoms?
- What works and doesn't work in the relationship to manage PMS symptoms?
- What problem-solving techniques do you use?
- How do you manage conflict?

Support

Ask to woman who experiences PMS:

- How do you experience support from your partner with regard to PMS?

Ask to partner:

- How do you provide support to your partner with regard to PMS?

To both participants:

- How have you utilised other sources of support outside the relationship regarding PMS? (for example, couple therapy, friends)
- What does PMS mean to you?

Appendix O

Cluster Theme Table Across Participant Couples

Couple 1 Elaine and Mark	Couple 2 Margs and Bob	Couple 3 Mary and James	Couple 4 Olivia and Joe	Couple 5 Samantha and Douglas	Couple 6 Rita and Maxwell	Couple 7 Denise and Dave
PMS as a negative/intense/overwhelming emotional experience	Making sense of PMS	Transformation during PMS	PMS as a confusing experience	PMS as a problem/negative experience	PMS as a confusing experience	Transformation– not normal
Desire to be in control/loss of control	Loss	Desire to be in control/loss of control	It's like the penny dropping – belated awareness of PMS	PMS as a struggle/challenge	Idiosyncratic experience of PMS	PMS as problematic/negative experience
PMS as a confusing experience	The negative emotional experience of PMS	PMS as a time of conflict	PMS as a battle/struggle	The difficulty of accepting the positive experience of PMS	PMS as a time of conflict	Social stigma
PMS as a lonely experience	PMS and self-image	Challenging vs accepting PMS	PMS as a problem	Privacy/secrecy	PMS as a negative experience	PMS as emotionally intense/ overwhelming experience
PMS as unpredictable/changeable	Difficulty being with a partner with PMS	PMS as a hassle	PMS as a 'thing' – a phenomenon not easily described	Coping with PMS	PMS as an anxiety-provoking experience	PMS as a relational experience
PMS as a problem/hassle	Privacy/secrecy	PMS as a confusing experience	PMS as a lonely experience	PMS as confusing	PMS as a relational experience	Relational dynamics
Ways of coping/not coping with PMS	Coping with PMS	The positive experience of PMS	Support	PMS as emotionally intense/overwhelming experience	PMS as a reminder of past loss/trauma	Difficulty of being supportive/helpful partner
Experience of support-importance of empathy and others understanding	PMS as confusing	PMS as an anxiety-provoking experience	Privacy/secrecy	Desire to be in control/loss of control	Negative/critical self-view	PMS as a battle/struggle
PMS as a precursor – to an unknown future	PMS as a time of challenges	PMS as a relational experience		PMS as a time of conflict	Lack of awareness/monitoring of cycle	Experience of trauma
Challenging medical intervention	PMS as a relational experience	PMS and motherhood	247	PMS as a relational experience	Coping with PMS	Feelings of guilt
	The support				Desire not to use	Support experiences

	experience					PMS as an excuse/name for distress	
PMS and identity	The experience of trauma					Social comparisons	PMS as a confusing experience
Privacy/secretcy/stigma						Desire to remain emotionally in control/not show vulnerability	Desire to fix PMS
PMS as a time of tension/conflict						Support experiences	PMS as a no-win situation/experience - hopelessness
PMS as a relational experience						Privacy/secretcy	Concern about losing control of emotions
Wider social implications of PMS/social norms/stigma						Family history of PMS	Feelings of anger/frustration toward self
Couple relationship dynamics						Treating PMS	PMS as having a positive impact on communication between couple
Being a parent						Illness	Desire for self-respect
						Social and personal expectations	Feelings of blame for others' anger
						Couple dynamics	Social comparisons
							Cultural/social expectations/norms
							Coping strategies
							Difficulty committing to plans
							Similarity of PMS to other mental health problems
							Privacy/secretcy
							Metaphorical expressions for PMS experience

Appendix P
Table of Master Themes

Participant Couple	Couple 1 Elaine and Mark	Couple 2 Margs and Bob	Couple 3 Mary and James	Couple 4 Olivia and Joe	Couple 5 Samantha and Douglas	Couple 6 Rita and Maxwell	Couple 7 Denise and Dave
Superordinate theme one: The “Curse” of PMS							
Subordinate themes							
PMS as a burden	953-957, 965, 925-938, (negative part of the relationship- a problem) 980-981, 934-936, 941-943 (eradicating PMS) 184-188, 212-21, 957-964, 378-38, 983-984, 137-140, 150-152 (impact on family)	689-702, 696-697, 667 (stress)	123-127, 27-28, (loss of control), 383-386, 396-400 (loss of freedom), 72, 80-81 (stress), 307-308 (the curse) 342-349 (lack of positive)	219-225; 375-378, 539	35, 356-362, 183-18, 1036-1037, 183-187 (guilt)	219-224, 236-240, 842-849, 883-889 (fear of depression recurring/relapse), 249-253 276-278 (lack of positive)	151-153, 2548-2551, 71-72, 99-103, 125, 2100-2106, 2172-2174 33-34 1085-1094, 246-251, 255-258 (stress), 908-918, 2261-2267, 276-293 (isolation), 65-68, 110, 637 (impact on family), 33-34 (stress) 27-34 (no-win situation)
Vicious cycles: the adverse emotional consequences	992-993, 928-930, 932-933, 937-938, 941-944, 624-630, 634-636, 631-632 (fear of menopause), 210-212, 19, 23-24, 380 381, 428, 435, 370-375, 49, 53-54 (anger)	84, 87, 143-144 204-209, 310-312	34-35, 72, 307-308, 338-339, 300-301, 288-290, 82-83, 221, 347-348 (negative part of self/relationship) 148-149), 325-326 (anxiety, menopause)	977-979, 572-584, 431, 853-854, 191-195 (body image) 391-398 (anger at loss)	572-578, 35-37 656-660 (overwhelmed by external stress), 104-110, 696-698, 603-610, 866-869	71-76, 269-272, 276-278, 298-301 (overthinking, increasing anxiety), 219-224, 236-240, 842-849, 883-889 (fear of depression recurring/relapse)	221-222 (sense of hopelessness), 46-51 (feeling on edge), 223-232 (anticipatory anxiety), 941-949, 2616-2617 (PMS similarity to depression), 298-299, 2273, 1254-1264, 466-471 (feelings of worthlessness/

									hopelessness), 472-497, 511-547
The unexpected deviation from “normality”	496-499, 350-355, 282-286, 208-210, 268-272, 202-203, 274-276, 201-202, 291-293, 623-624, 32-34, 22, 26, 217-218, 227 228, 224-225, 221-223, 291-293, 623-624, 32-34, 22, 26, (464-465, 363, 364, 948-949 self-talk strategies)	310-312, 240-242, 22-24, 71, 371-374 324-330, 122-126, 15-16	20-22, 26-28, 30-31, 466-469, 494, 525-527, 107, 452-458	312-313, 401-405, 477-478, 527-534, 547-548, 856-859, 500-502, 30-33, 739-745, 315-319, 419-423, 106-116 39-44, 50-53, 178-189, 178-185, 31-35, 148-152, 175 177, 465-466, 287, 143-144	234-252, 727-734, 962-973, 478-483 (idiosyncratic symptoms)	20-22, 26-28, 30-31, 466-469, 33-37, 44-46, 25-32, 816-820, 180-184, 155-160, 357-360, 163-171, 186-19, 596-601, 457-468, 905-910	35-36, 138-148, 169-171, 276-293, 367-370, 704-710, 2534-2537, 2796-2801		
Superordinate theme two: Connection and disconnection: the importance of communication and intimacy									
Subordinate themes									
The couple in conflict	520-522, 330-336, 96-97, 309-313, 314-315, 172-174, 167-169, 134, 112-115, 116-118, 92-94	455-459, 171-177, 161-163, 390-394, 517-519, 248-264, 472-475, 42-43	258-260, 263-264, 265 411-418, (loss of freedom), 437-440, 46-47, 199-203 (taking anger out on partner), 226, 113-114, 266-270, 261-264 (loss of control	111-116, 226-236, 649-651, 656-661 (unresolved relationship issues), 78-79, 913-914 (taking our anger on partner), 898-901 (regret)	150-151, 236-252, 958-973, 461-463, 427, 434-435, 211-215 (relationship boundaries), 373-375	52-53, 315-322 (triviality of arguments), 55-56, 134-141, (difficulty letting go), 345-352	27-34, 1208-1220, 1154-1179, 1636-1646		

				during arguments), 255-256					
Barriers to intimacy	128-130 (limited couple time) 455; 895-896; 414-418 (good communication, 996-1001 (isolation), 44-48 (isolation) 165-166, 152-153, 404-405 (withdrawal)	396-405 (abandonment)	480-483, 494, 525-527 (feeling as an outsider), 100-106, 480-483 (lack of empathy/ understanding)	30-33, 739-745, 417 (lack of understanding), 712-718, 728-731 (intimacy), 39-45, 161-163, 265-275 (differences in communication), 627-630, 97-99, 362-366, 279, 282-286, 241-243, 259-263 (abandonment)	23-30, 48-54, (communication difficulties), 502-511, 40-47, 124-127 (lack of understanding), 145-148 (emotional expression), 562-566, 999-1011 (abandonment), 1713, 1682 (lack of intimacy)	708-711, 717-722 (lack of intimacy/attraction)	644-648 371-377 58-65, 498-504, 1079-1084, 1066-1072, 78-83, 371-377, 2269-2275 (isolation)		
Superordinate theme: Beyond the Couple: Socio-cultural Influences on the Relationship									
Subordinate themes									
Turning the spotlight on gender norms and expectations	471-472, 561-563, 542-544, 551-555, 477-487, 978	132-140 (social expectations)	594-600 (gendered coping)	177-178, 292-299, 740-741, 749-751, 758-762 (cycle monitoring)	1343-1347, 797-801, 349-352, 885-888, 550-554, 339-347, 1230-1238 (male support)	537-542 (social expectations)	162-169, 1695-1698 (support expectations), 1487-1499, 1538-1544, 1553-1560, 1792-1804, 2317-2321, 2739-2744 (multiple expectations), 1497-1501, 548-553, 2806-2814 (acceptance), 364-366, 612-623, 2556-2558 (social expectations)		
Stigma and privacy	401-403, 562, 552-555, 977-980, 996-1001, 542-547, 68, 1005-1007	572-583, 549-562, 122-126 (confidentiality) 115-119	364-367, 449-450, 477-483, 502-504, 581, 589-598 (individualist society)	486-491, 699, 502-503, 616-622, 539 (guilt and shame)	1212-1213, 349-352, 353-356, 80-82, 1174, 1187-1196 (PMS and mental health),	474-479, 755-760, 482-485 (normalisation)	2404-2405 (confidentiality), 498-504 (secrecy)		

	(confidentiality)		299, 316-319 (guilt, shame)		572-584 607-611 (medical approach), 967-970 (acceptance), 100-104, 153-155, 208-211 (cathartic experience)	1366-1371, 529-532 (support from others)	361-363, 382-387, 388-392 (support difficulties), 104-112 (psychological tools), 745-754 (info seeking), 730-736 (acceptance), 399-405 (practical help), 423-433 (supplements)	1760-1781, (difficulty to support), 2806-2814 (acceptance)
The struggle for validation	288, 83, 494-497 291-293, 506-507, 32, 67, 318-319, 455, 895-896, 861-862, 490-491, 390-391, 64-66, 288-291, 293-294, 540-541, 233 (ways of coping) 531-536 (acceptance) 414-418, 458-459, 259-297, 826-827, 563-569 (partner interest in well-being)	334-340 (problem solving), 348-364, 429-438, 164-165, 317-318, 396-405, 520-525, 449-454, 481-485, 103, 640-642, 104-108, 321, 508-511 (self-compassion), 755-757, 160-165, 175-177, 273-279, 334-335, 742-749, 341-348, 334-340, 764-770, 405-410, 45-55, 500-505 (patience and love)	464-472 (humour), 509, 511-514 (partner's practical help)			871-874, 1230-1238 (difficulty to support), 710-719, 740-753, 777-788 (practical help), 862-864		

Section D: Journal Article for Publication

**The norms and expectations of Premenstrual Syndrome (PMS) in
heterosexual couples' accounts of experiences of PMS: An
interpretative phenomenological analysis**

The norms and expectations of premenstrual syndrome (PMS) in heterosexual couples' accounts of experiences of PMS: An interpretative phenomenological analysis

Abstract

Objectives. Previous qualitative research into the experience of Premenstrual Syndrome (PMS) has largely focused upon women's accounts and lesbian relationships. The current interpretative phenomenological analysis (IPA) aimed to explore heterosexual couples' experiences of PMS.

Design. Following IPA guidelines, a qualitative in-depth interview design was used, largely focusing upon shared aspects of the experience of PMS as reported by seven heterosexual couples.

Methods. Heterosexual couples who self-identified, or who identified their partners, as experiencing PMS distress were recruited and participated in joint 90–120 min interviews using a semi-structured interview schedule. Interviews were recorded, transcribed verbatim and analysed using IPA.

Results. Three significant superordinate themes emerged from an analysis of the couples' experiences: (1) The “curse” of PMS; (2) Connection and disconnection: the importance of communication and intimacy; and (3) Beyond the couple: social influences on the relationship. This study focuses on the third superordinate theme and its subordinate themes: ‘Turning the spotlight on gender norms and expectations’ and ‘Stigma and privacy’. This superordinate theme supports the conceptualization of PMS as a gendered experience confounded by cultural, societal, self, relational, and familial expectations. It also affirms that PMS is a highly stigmatizing experience for the couple.

Conclusions. Couples' experiences of PMS involved many social norms and expectations, which were felt as pressures. Most of the women discussed multiple self-expectations related to remaining “in control” and the majority of couples discussed specific gender expectations with regard to social behaviour and support efforts. PMS was also reported as a highly stigmatizing experience, leading to feelings of isolation. Directions for future research are explored and implications for the practice of counselling psychology are focused on.

Practitioner Points

- This study indicates the importance of considering the couple relationship when developing interventions for women experiencing PMS, in particular the potential usefulness of including the male partner.
- Practitioners should be encouraged to increase their understanding and awareness of PMS, such as common premenstrual symptoms and the potential distress they may cause to women, their partners, and couples. This is likely to enhance the level of support and increase the ability for women, their partners, and couples to self-manage distress.
- Attention should be directed by practitioners to the stigma around PMS and the problems this creates for the couple relationship, such as shame and fear. Practitioners should be encouraged to help challenge and decrease this stigma. Decreasing social and self-imposed stigma and isolation may lead to increased couple support.