Diagnostic powers

- What a new diagnosis tells us about current workings of medicine

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Abstract

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This essay researches current workings of medicine in relation to contested, female diagnoses. This is made by looking at the construction of the new psychological diagnosis Premenstrual Dysphoric Disorder (PMDD) in Swedish media, and relating it to a current trend seen in medicine; to medicalize women’s underperformance. A qualitative content analysis of 19 articles is conducted, showing that PMDD is constructed as; a biomedical fact and individual problem; a serious disease owned by the sufferers; and as something written out of the women’s self-image as a “not me”. These constructions are analysed with a theoretical framework built around the concept biomedicalisation, which we conceptualise as an exertion of biopower that shapes subjects in line with neoliberal ideals. Biopower is a concept from the Foucauldian notion of Governmentality, and describes power working on micro levels, through for example truth discourses, to make individuals understand and work on themselves as biological subjects. Our analysis shows that biopower can be seen to work through the different constructions of PMDD to shape self-managing, healthy subjects that are willing to biomedically change themselves in accordance with an ideological normal, but that this normal differs from that seen in research on other contested female diagnoses. To conclude we suggest that it would be more fruitful to look at biomedicalisation to understand current workings on female contested diagnoses, than to look at the trend on medicalisation of underperformance.

Keywords: Premenstrual Dysphoric Disorder, PMDD, biomedicalisation, biopower, contested diagnoses
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1 Introduction

The 14th of April 2014 comedian Karin Adelsköld appeared on Swedish television talking about her grave form of PMS (premenstrual syndrome), namely PMDD (premenstrual dysphoric disorder). She described how she started feeling bad after her second child, experiencing fits of rage and suspecting becoming mentally ill, only to realise that it was all due to this knew, still little known diagnosis PMDD. The response after was enormous, Karin describes how she got a “tsunami of emails” (Södermalmsnytt 2015) from women relating to the disease and wanting help, medicine, recognition. In other words, Sweden has a new diagnosis, being related to, diagnosed with, fought for and taught about (see also features in for example Expressen 2015 and Amelia 2015).

Sociologically, diagnoses can be a lot of different things and fill several functions. It is a structuring element in the relationship between social institutions such as employers and health insurance companies (Johannisson 2006: 29), it is an allowance not to live up to societal norms as it is an accepted form of deviance, and it is an ordering element for a wide range of complaints (Jutel 2009: 280). It gives the individual access to services, but also statuses as it offers an identity and social role (Johannisson 2006: 29). It is thus functional, labelling and enabling. It is a societal organisation, and an individual identity.

Durkheim highlighted long ago how sociologists must look at what other fields of research do not – social phenomena, or social facts (Tarde, Durkheim and Weber 2012: 88). That is, the ideas and actions that exists outside singular individuals, and which’s foundation is not the individual but the society (ibid.). We argue that diagnoses are always social facts. That does not meant that they do not have a biological, psychological or in any way aetiological cause or side, it simply means that the way we arrange, give them meaning and function and relate to diagnosis is always social. They exist outside of singular individuals, as a written down framework and as certain expectations and statuses. They exert power by being a labelling tool, but also by being an identity position, resulting from societal organisations, actions, morals and ideologies (which we will develop further throughout the work).

Despite aetiology, what becomes a diagnosis is a result of what we deem needs to be treated. Jutel (2009: 279) has called it “a cultural expression of what society is prepared to accept as normal” and several authors have been concerned with the moral and ideological functions of diagnoses (see for example Conrad and Schneider 1985, Conrad and Potter 2000 and Lassinantti 2014). Johannisson (2006: 29) has called diagnoses a “dynamic mirroring system for shifts in norm and value systems in the bigger societal body”, also suggesting that it reflects the current knowledge and status position of
the medical establishment. Diagnoses such as alcoholism (Conrad and Schneider 1985), antisocial personality disorder (Brante 2006) and DAMP (minimal brain dysfunction) (Kärfve 2000) have been questioned for their moral judgement. This way of looking at diagnoses is what initially sparked our interests, as it suggests that diagnoses can tell us something about medicines position and norm and value systems in society in general. This also suggests that looking at a new diagnosis, like PMDD, is especially relevant as it can tell us something about how we organise diagnoses and what we normatively allow now. Or, as Jutel (2009: 282) expresses it “The emergence of specific diagnostic labels provides a heuristic to the student of diagnosis”.

Researchers have long looked at the normative and moral workings of diagnosis, often so within writings on medicalisation (see Zola 1972 and Conrad and Schneider 1985), referring to the process where deviances are pathologised and becomes a matter for the medical world. Latter research has suggested that rather than pathologising deviance, today diagnoses can be seen to shape “better than well individuals” by pathologising underperformance (Conrad and Potter 2000). Thus medicalisation becomes a way to enhance performance, rather than manage illness (Clarke et al. 2003). Research on female diagnoses in particular has suggested that there is a trend to medicalise female behaviour that does not live up to a high productive norm in western societies (see Lassinantti 2014, Blum and Stracuzzi 2004 and Winter, Moncrieff and Speed 2015), which has been called to medicalise women’s underperformance, and seen to be done in line with neoliberal ideals (ibid.). Similar notions have been suggested in literature on PMS. Susan Markens (1996: 53) argue that discourses on PMS shapes a norm that serves a post-industrial society. She does not analyse this in relation to any other diagnoses or conditions however, but looks at it as something specific for PMS.

The problem, as we see it, is partly that PMDD so far has been analysed for its specificity, and not in relation to general trends in the workings of medicine. And partly, that very little research has gone into trying to understand the trend mentioned although several scholars are suggesting similar notions. Someone who has tried to understand and analyse this trend is Kitty Lassinantti (2014). In her study on women with ADHD (Attention Deficit Hyperactivity Disorder) she analyses medicalisation of women’s underperformance by looking at biomedicalisation as an exertion of biopower (power over bodies through biological subjectification) which works to shape individuals in line with neoliberal ideals. Inspired by this way to conceptualise the trend, and by the way Lassinanntti gives analytical value to what others only touch upon - we deem it fruitful to take these ideas further.

We believe that PMDD can be a window into current norms, trends and workings of female diagnoses, and that the concepts of biopower and biomedicalisation will offer ways to analyse these
workings. We are not saying that PMDD is representative of other diagnoses, but rather that relating what we find on the construction of PMDD to what has been seen in relation to other diagnoses could give us valuable insights into workings of medicine.

1. Purpose of the study

The purpose of this study is to develop a broader understanding of current workings of medicine in relation to female, contested diagnoses. We will do so by analysing the way PMDD is constructed with the concepts of biopower and biomedicalisation, and relate it to a current trend suggested; to medicalize women’s underperformance. In order to conduct this analysis, we must first see how the diagnosis is constructed (what themes are drawn upon, what is it created to be, what meaning is it given?) and will do so by turning to Swedish media. Our research questions reads thusly:

- How is PMDD constructed in Swedish media?
- Can the construction of PMDD be understood as part of a trend to medicalise women’s underperformance?

1.2 Limitations

PMDD is a diagnosis that falls under the category contested diagnoses, this refers to diagnoses that; have an uncertain or disputed medical explanation; often are surrounded with debate; and are diagnosed based on their symptoms (Jutel 2009: 290-291). ADHD and DAMP are examples of other diagnoses in this category. Thus when referring to workings of medicine – it is workings in relation to contested diagnosis that we refer to.

As is common for contested diagnoses, there is a debate surrounding the existence of PMDD, or the legitimacy of it (see for example Epperson et al. 2012 and Wakefield 2013), mostly concerning the aetiology and the quality of psychological research (see also Caplan 2004 and Ussher 2008). We do not take side in this debate. Aetiology is irrelevant to the study we are conducting as we are looking at the social construction of it. Some of the literature we are referring to question the way women ascribe some feelings and events to PMS (such as Cosgrove and Riddle 2003), as will we. This is by no means saying that the condition or feelings women are experiencing are any less real – we are simply looking at how they are constructed, attributed and given meaning.

2 Literature review

Several concepts, theories and previous study results have been of influence and use to this study. This chapter servers to present how other sociologists have conceptualised diagnosis; what research about diagnosis in Sweden has shown; how medicalisation and biomedicalisation can be
conceptualised and seen working; what role media plays in the construction of diagnosis; how PMDD became a medical phenomenon; what others have shown about the construction of this diagnosis; and lastly how the trend to medicalise women’s underperformance has been conceptualised and seen working. We will also problematise looking at social construction, and the use of value-laden terms such as underperformance and better-than-well.

2.1 Sociology of diagnosis

As mentioned, diagnoses can be seen to be a lot of different things and fill several functions. Annemarie Jutel (2009) together with foremost Phil Brown (1995), both following the notions of Mildred Blaxter (1978), is pushing what they call sociology of diagnosis to become a subfield to medical sociology – seeing its integral part in relation to illness and disease. Diagnoses have been what Jutel calls an absent presence in medical sociology (Jutel 2011: 793). That is, present in much literature, especially on medicalisation, yet not highlighted enough for its own specific features. Sociology of diagnosis suggests a few conceptual tools that will be presented here.

A common conceptualisation of diagnosis is that of diagnosis as both category and process (Blaxter 1978, Brown 1995 and Jutel 2009). It is a category by being a label assigned to a decided set of complaints (Jutel 2009:280), and it is a process by being “the thing that the physician does” (Blaxter 1978: 9). There seem to be a slight difference in the interpretation of what diagnosis as process entails, whilst Blaxter hints that this is something carried out by the doctor, Jutel and Brown sees it more as a process involving also the patient - an interaction leading to diagnosis. Brown’s description of the process also includes “the set of interactions which leads to the definition of the category” (Brown 1995: 39), a far broader conceptualisation. He then goes to suggest a theoretical framework that describes the social process of how a diagnosis comes to be, or the social construction of diagnosis (ibid.: 43). Relevant to mention here is the first step of disease’s discovery; when a diagnosis is discovered, this is often lay initiated (also highlighted in Conrad and Schneiders writings on medicalisation of deviance, 1970). Social movements commonly play a part, together with professional factors such as research or professional expansion, as well as organisational and institutional factors (ibid.). We mention this to highlight the socially constructed nature of diagnoses, stemming from various social interests.

Jutel has also suggested that diagnosis can be seen as the link between the illness and the disease narrative. There is an important difference between the terms illness and disease, she concludes, highlighted by some medical sociologists (see Jutel 2011 who does, yet Brown 1995 who does not). Illness can be understood as the personal experience of sickness, the narrative of the sick person, highly influenced by culture. Disease on the other hand “is framed by the biological, rather than the
personal” (Jutel 2009: 287), and is the medical narrative shaped by what medicine considers sick. Illness can become disease by being presented to the doctor and given a medical narrative (through a diagnosis) (Jutel 2009). These ideas reflect the power element that Jutel ascribes doctors and medicine. Having the power to diagnose, to turn disease into illness, ascertains the doctors and medicines authority (Jutel 2009: 284). A view shared by Brown (1995) and Blaxter (1978). Also writers on medicalisation share the view that medicines power in society lies partly in the relation between doctor and patient, and in the power to diagnose (Conrad and Schneider 1985).

Some diagnoses are the cause of more debate, contest and controversy than others, in sociology of diagnosis these are conceptualised as contested diagnosis - a central term for our work, which we have already presented and used. Contested diagnoses are characterised by being medically unexplained, having explanations that are disputed (Brown and Zavetosky 2004: 685) or by being surrounded by debate regarding them being “social, psychiatric or biologically in nature” (Jutel 2009 quoting Dumit 2006: 290). These diagnoses are ascribed based on their symptoms, and are many times disputed (Jutel 2009: 290-291). PMDD is a contested diagnosis as its aetiology is uncertain (Åkerman 2014), it is ascribed based on symptoms and it is disputed.

Sociology of diagnosis has stressed the role of diagnosis in medicine, and offered the field of medical sociology a set of concepts. According to the scholars of this field, diagnosis is both a category and as a process, it can turn something personal into general (disease and illness) and entails a power structure in the relationship between the doctor and patient, ascertaining medicines power. The critique that can be directed towards the field is that there seem to be a slight division as to what purposes this “new sociology” should attain. Whilst it seems that Jutel (2009, 2011) wants to contribute to the understanding of patient-doctor relationships and the diagnoses’ role, Brown envisages a sociology able to explain the broader societal movements in relation to diagnoses. This need not be a problem per se, but it becomes somewhat problematic as the process concept is hard to understand due to the different applications - is this something the doctor or the doctor and patient is engaged in, or all actions leading up to the diagnosis being made?

We also see a lack in the way the scholars present the concept of contested diagnosis, without exploring how these differ practically from other diagnoses.

2.2 Swedish research on diagnoses

Diagnoses, and especially contested diagnosis, have also been a concern for Swedish researchers. Looking at especially ADHD and DAMP, they call for a greater social contextualisation and criticises the hegemonic biomedical understanding of diagnoses.
Thomas Brante (2006: 73) calls our attention to the important role of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychological Association (APA), in the western world – dominating the clinical and theoretical workings of psychology. This is where PMDD is labelled a diagnosis, as we will explore further below. Through the example of ADHD (in which he takes special interest) he problematises the paradigm-shift seen in this manual, and in the workings of psychology in general, and criticises it with several concerns. The paradigm shift (also highlighted by several others, see for example Horwitz 2002 and Brown 1995) can be said to mirror a psychological trend away from psychoanalysis and towards neuropsychiatry. Brante describes how the psychoanalytic tradition used to look for reasons to ADHD in the child’s relationships, often subscribing therapy which could be combined with medications (ibid.: 91). As neuropsychology has become the dominant way to analyse and explain psychological conditions, social factors are treated as possibly reinforcing or inhibiting, but not causal, which he criticizes (ibid.).

Another Swedish sociologist that criticises the lack of contextualisation is Eva Kärfve (2000) who looks at the diagnosis DAMP. The behaviours described as caused by DAMP are also behaviours typical for children in underprivileged schools and family situations (Kärfve 2000. 11). In other words, the behaviours could be explained by a social structure, but this is not looked at. Brante (2006: 88) concludes that diagnoses make other explanations than biomedical invisible (see also Johannisson 2006: 40).

Brante also notes an increase in diagnoses – although focusing on ADHD he also mentions an increase in diagnosing depression and how diagnostic categories are increasing in general with every new version of the DSM – and gives possible explanations as to what can be seen to cause this (ibid.: 82-83). He mentions for example that biological explanations are gaining popularity in our culture; the biomedical model’s high status as it deals with hard facts; and that media and self-help books adapts the neuropsychiatric model. Most attention he gives to the influence of active pharmaceutical companies. These companies have an economic interest in medication, and financially support lobby groups and those researchers that are for an increased medicalisation of, for example, ADHD. In Sweden Riksförbundet Attention, an association for ADHD patients, is sponsored by four international pharmaceutical companies (ibid.: 82-84).

The notion of pharmaceutical companies playing a much larger role in medicalisation today is a common theme (see for example Clarke et al. 2003). Yet we must criticise Brante for not given any example or evidence of its actual influence, and although supported by other researchers (ibid.) it should be seen as a speculation.
Both Brante and Kärfve take a very critical stance in relation to the biomedical and neuropsychological trend seen in relation to diagnoses, and one should be aware of their research being critical. As most research on these diagnoses assumes a biomedical framework, however, this critical perspective is needed. And ss their critique consists of informed aspects, mostly criticising the research behind the diagnoses (see Brante 2006: 75-81 and Kärfve 2000: 43-75), and the conceptualisation, we deem their research relevant. One should mention that Brante is not against the diagnosis ADHD as such, but the way it is treated and diagnosed, whilst Kärfve criticises the very existence of the diagnosis DAMP.

To conclude; there is a trend seen in Sweden, as well as internationally, to adapt the biomedical understanding of disease and diagnosis, leading to an ignorance of social contexts and an increase in diagnoses.

Social constructionism somewhat divides the field, explicitly so in Sweden. Even though this is less explicit in other literature we are referring to, there is a difference in the degree to what is perceived ad socially constructed. Brante (2006: 74) sharply concludes that he is “not a social constructionist”, and explains that he does not deny that there are children with the symptoms described as ADHD and that it is the research behind the condition he criticises (ibid.). We do not see that this necessarily opposes a social constructionist viewpoint, depending on what you refer to with the term. As we have mentioned, we see that all diagnoses are socially constructed, but that does not negate aetiology. We agree with Johannisson (2006:37) who suggest that a diagnosis is always socially created (is a result from negotiations and social activities), and that there is a social aspect to every diagnosis. She writes that “this does not mean that anything can be called disease nor that disease does not exists “in reality”, it rather points to that the identity a disease has is never a neutral consequence of biological factors” and that “the laboratory does not decide the social part of the diagnosis’ success and circulation” (ibid.). To talk about social construction in relation to diagnoses is a sensitive matter, easily causing irritation and sometimes interpreted as a way to oppose diagnoses’ “real” existence (ibid.). Yet, relying on Johannisson’s notion that there are parts of diagnoses that are social, we see no problem in looking at diagnoses as social constructs.

2.3 Medicalisation and biomedicalisation

Medicalisation is a prevalent theme in medical sociology (Lassinanntti 2014: 62), and refers to the process of medical categories expanding (Conrad and Potter 200?). We do not intend to give a comprehensive review of the field of medicalisation here, with its controversies and interpretations (Conrad 2007). Rather, we aim to introduce the scholars and lines of thoughts that we are relying on in this study, define the concepts we will be using and mention current trends and controversies.
One of the most prominent writers on the phenomena, Peter Conrad, defines medicalisation as when “a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or ‘treated’ with a medical intervention” (Conrad 2007: 5). Following this definition it is evident that the term is neutral in value, and simply describes a process. It can be seen as a natural progress in medicine and health care (ibid.). It has many times been used in critical ways, however, and as synonymous to over-medicalisation (Conrad 2007: 5). We are, following Conrad (2007) and Lassianntti (2014), referring to it as neutral in value, although recognising that it can serve ideological purposes.

Conrad and Schneider (1985: 266) writes that the medicalised phenomena are often deemed deviant or immoral before any medical discovery (Conrad and Schneider 1985: 266), and that medicalisation shapes an ideological “normal” by giving deviant, morally unwanted phenomenon a medical status (ibid.). As examples they mention opium addiction and alcoholism being treated as medical conditions (ibid.).

If something is diagnosed, it is by definition medicalised, but as Jutel (2007) points out, this is not synonymous, and in recent years scholars have seen the medicalisation concept being applicable on a wider range of phenomena than diagnoses or deviant behaviour, such as for example childbirth, menopause and aging (Conrad 2007).

Pharmaceuticalisation is often referred to in relation to medicalisation, defined by Abraham (2010) as “the process by which social, behavioural, or bodily conditions are treated, or deemed to be in need of treatment/intervention, with pharmaceuticals by doctors, patients or both” (Abraham, 2010: 290). This can, similar to medicalisation, be seen as something neutral in value and as a progress in medicine and health care. This has seen a greater use in recent years, as medication and pharmaceutical companies’ interests are becoming of increasing concern to medical sociologists (see Conrad 2007, Clarke et al. 2003, Brante 2006 among others). Some however, deem the changes in medicine and the medicine’s increasing role requiring a whole new concept: biomedicalisation.

Biomedicalisation is a term suggested to update the medicalisation concept, seen to be needed because of the changing, and more encompassing nature and workings of medicine in society (Clarke et al. 2003). There is an increase in psychological diagnoses (Brante 2006), thus an increase in medicalisation, in society. This has been seen to be caused by “an increased influence of the biomedical paradigm” (Lassinantti 2014: 60, see also Brante 2006). It is now biotechnological advancements, the pharmaceutical industry and commodification of health that are the factors behind medicalisation (Lassinantti 2014, Conrad 2007) rather than professionalisation of the medical profession (Friedsson 1970, referenced in Lassinanttti 2014).
Biomedicalisation has been explained to work through creating discourses that put focus on health, rather than illness, making “health become an individual goal, a social and moral responsibility”, leading to subjects being responsible to *manage* illness and bodily states, rather than *recover* from them (Clarke et al. 2003: 170). Biomedicalisation also works by pushing the transformation of bodies, by creating a discourse placing the body as “flexible, capable of being reconfigured and transformed” (Clarke et al. 2003: 181). This serves to commodify health, as to biomedically change one’s body becomes sought after and paid for (ibid.).

Biomedicalisation then encompasses both the new workings of medicalisation (by biomedical discourses) and new mechanisms of power behind the medicalisation (biotechnological advancements and influence of pharmaceutical companies rather than the medical profession).

Not everyone sees the need for this updated term. Conrad (2007: 5) agrees on many of the suggested “new workings” of medicine, and pharmaceutical companies’ bigger influence on medicalisation, but deem a new term unnecessary. This should not be seen as a conflict, rather as two different lines of thought within the medicalisation literature.

Medicalisation and pharmaceuticalisation have been presented here as neutral in value, solely describing a process. Biomedicalisation on the other hand has been used in a more critical way to describe certain ideological workings (see Lassinantti 2014 and Clarke et al. 2003). Even though it is not value-laden as in suggesting “bad” or “good”, it suggests *certain* power mechanisms and cannot be seen as neutral. We understand biomedicalisation more as a theory than a concept, which we will explore in next chapter.

Similar to social constructionism, medicalisation has controversial connotations, and some prefer not to use it as they relate it to certain critical standpoints (Conrad 2007: 10-12). It is clear however, that for example Brante (2006) and Brown (1995) talks about very similar workings when noting a paradigm shift in psychology and several new diagnoses, yet not labelling this medicalisation or biomedicalisation.

Concludingly, we can establish the relevance of medicalisation concepts (medicalisation, biomedicalisation and pharmaceuticalisation) in relation to diagnoses’ normative and ideological functions. We will use medicalisation and pharmaceuticalisation in our work to relate to some processes and actions seen in the constructions, and then talk about medical, pharmaceutical or biomedical agency. Biomedicalisation will be the basis in our theoretical framework. This is a relatively new concept (put forward in Clarke et al. in 2003), and we see the need for more studies adapting these thoughts to evaluate its utility in the field. Medicalisation and pharmaceuticalisation
are concepts that do not offer much explanatory value or tools for analysis, which biomedicalisation can be seen to do to a greater extent.

2. 4 Diagnoses and media

Year 2003 Clive Seale wrote an article encouraging medical sociologists to study the media more, seeing its importance in creating and shaping disease. To do so, however, is already common within the medical sociological field, and several of the studies mentioned in this chapter have looked to media for seeing constructions and discourses on diagnosis (see for example Markens 1996 and Winter, Moncrieff and Speed 2015). Conrad and Potter (2000) also highlight the relevance of media, showing that media can play an active part in promoting diagnoses. This is partly done by dramatic storylines, extreme anglings (Conrad and Potter 2000: 563) or by “life and death” narratives (Seale 2003: 518). He also notices the way it can be seen to increase, or enable, self-diagnosis (ibid.: 570). In Conrad and Potters (ibid.) study on the expansion of the medical category ADHD, media was seen to play an integral role.

Prosser stresses that one cannot look at media channels as just “advocates driven by the agenda of the medical profession and pharmaceutical industry” (Posser 2014: 600), as there are what he calls internal logics of these fields with resistance and appropriation (ibid.). As our analysis is concerned with analysing power, this critique is of relevance. The constructions, which are our main focus, are the same regardless of power dimensions, yet we will take this notion into consideration in our analysis.

2. 5 PMDD

The diagnosis PMDD is our study focus in this report. This section will give a brief background on PMDD as a diagnosis and present what other researchers have shown on the construction of this phenomenon.

2.5.1 Background

PMDD is a diagnosis that gained full legitimacy when it was included as a full category in DSM in 2013 (Wakefield 2013). It is a grave form of PMS that affects between three to five percent of women (Åkerman 2014). Symptoms of PMDD include emotional distresses, such as irritability and malaise, as well as physical, such as breast tension and swollenness, and it is described to liken a depression. The symptoms are understood only to occur between ovulation and the onset of menses, but the aetiology behind the condition is unknown (ibid.). PMS is not a medical category, and is commonly associated with a far broader set of symptoms than PMDD (ibid.).
PMDD was first mentioned in medical literature in 1931 (then called Premenstrual Tension), yet not until in the 1980’s did it become a question for diagnostic status (Rittenhouse 1991). PMDD was included in the appendix for conditions requiring further study in the DSM-III-R and DSM-IV, and gained status as its own category in DSM-5 (Wakefield 2013). The question whether PMDD should be legitimised as a psychological disorder caused immense debate, engaging researchers from several fields, public discussion and activists and social movements (Wakefield 2013). The debate concerned primarily whether the existing research actually proved the conditions existence or not. In 2013, however, a special workgroup for the DSM considered that there was enough research to support the condition and it was included as its own category (ibid.).

Except for the critique concerning the reliability and validity of the research, concern of a more social character has also been raised. Psychologist Paula Caplan (2004) claims that what cause PMDD are natural reactions in the female body, and should not be pathologised and treated. She also argues that most women who say they are experiencing PMS or PMDD have other underlying social issues which are not taking seriously if this becomes a diagnosis. Ussher (2008) stresses that PMS has long been used to sustain stereotypes about women as exaggeratedly emotional, labile and in need of “taming”. To medicalise women’s anger or socially deviant behaviour is to marginalise women, she concludes, also common in relation other conditions related to the female body. She also means that a diagnosis is negating women legitimate reasons for anger. We will see concerns similar to those raised by Caplan and Ussher in the research on PMDD’s construction, which will be presented below. The difference is that these are not negating PMDD as a diagnosis, but questioning its construction.

There is also controversy around the pharmaceutical company that patented the medication for PMDD being part of the workgroup deciding on the final inclusion in DSM-5, which has been widely criticised (See Caplan 2004 and Örn 2013).

Sweden rely more on World Health Organisations (WHO’s) International Classification of Diseases (ICD) framework than DSM (Örn 2013), however DSM is seen to be influential on the medical conception of diseases in Sweden as well (ibid., Brante 2006). The fact that women are diagnosed with PMDD and given prescript medication for it supports this (Åkerman 2014).

2.5.2 The social constructions of PMDD
We will now introduce research that has looked at the social construction of PMDD and PMS. The research on PMDD is still scarce, the diagnosis being relatively new, and we have included research that has PMS as its main focus. Many times PMS and PMDD is used synonymously (see Swann
1995), and many times PMS is used to refer to the symptoms that are caused by the condition PMDD (see our result). The research presented below will be related to in our own result.

Susan Markens (1996) has looked at the way PMS is constructed discursively in in magazines and self-help books. She shows that women’s experiences are essentialised, and treated as constitutive of what PMS is. These discourses obstruct the fact that other social and political factors influence subjective experiences. She further shows that the pathologising of PMS symptoms serves to create a “normal woman” in line with “the ethos of discipline and productivity on which our post-industrial society is built” (Markens 1996:53).

Markens further shows that PMS is portrayed as negative, causing a wide range of negative emotions (such as ager, feeling bitchy, snapping) and life problems (such as “impair ability to function at work”) (Markens 1996: 46). There are reports of positive experiences such as increased energy, sensitivity, and creativity, but the discourses are primarily negative. PMS is portrayed as an individual problem, and the remedies suggested focus on women’s bodies and individual life-styles. This positions PMS as a medical phenomenon, and takes away focus from social or structural factors.

The suggestion that pathologisation of PMS can be seen to create behaviour or identities in line with post-industrial ideals, and the way she sees a medicalisation taking away focus from social factors, is very similar to what researchers on diagnoses have suggested (see for example Brante 2006, Conrad and Potter 2000, Clarke et al. 2003 and Lassinantti 2014). Yet at the time of Markens research PMDD was not an official diagnosis, and is not compared to such.

Another researcher looking at the meaning and construction of PMS is Catherine Swann (1995) who conducted a discourse analysis of interviews with 14 women attending a PMS-clinic in London. Her study shows that four main discourses can be seen in how the women are constructing and relating to PMS. Firstly, there is a biological discourse adapted, as the women understand their symptoms as deriving from a biological cause and relating their problems to “reproductive life events” (Swann 1995: 361) such as menarche. Secondly, she saw a tendency to attribute behaviour that do not fit into the archetypal notion of femininity to PMS – giving loss of control and being a bad mother as examples. She argues that this attribution makes whoever steps outside the ideals of femininity is deemed “mad or bad” – a notion earlier suggested by Ussher (1991). Thirdly, there is a dualist discourse, in two different aspects. Partly by a biological discourse that puts the problem within the body, making it a “not me”. This can be seen to represents a mind-body-dualism concurrent in western culture, and allows the women to “retain her feminine identity” (Swann 1995: 361). Partly, a dualist discourse is created as the premenstrual woman is contrasted with the “normal” woman. Fourthly, there is a romantic discourse of everything in the women’s lives being perfect except for
the PMS, although many of the interviewed women mention stressful life events that would contradict such a statement (ibid.: 363). Swann interprets this as PMS being a way for the women to try and control things that are hard for them to control; such as a violent partner or poverty (ibid.).

Swann relates the discourses to current female ideals and norms, yet does not offer any analysis of this notion. One could also criticize the fact that all women interviewed were attending the same PMS-clinic. The fact that these women are attending a clinic suggest that they have a medical understanding of their problems, and also that they are likely to have received similar information and thus developed a similar understanding of the phenomena. Maybe women not attending this clinic would have framed their experiences differently.

Cosgrove and Riddle (2003) have researched if there is a relationship between femininity and PMS, and argues that those that identify and try to live up to “idealized constructions of femininity” (Cosgrove and Riddle 2003: 47) are also those who report higher experience of PMS. This is suggested as they show statistically significant correlations between high test scores for PMS (measured through the Menstrual Distress Questionnaire) and high scores for femininity (measured on the Bem Sex Role inventory) (Cosgrove and Riddle 2003: 44). A clear lack of their research is that they fail to mention what this idealised femininity entails. They do mention that the antithesis of a socially sanctioned femininity is being angry, tense or irritated or irritable (ibid.: 48).

In a discourse analysis of interviews Cosgrove and Riddle (2003) also show a “not me”-construction, seen in Swann’s (1995) research. They suggest that such construct enables women to live up to the ideals to which they measure themselves with, as the deviant behaviours are placed as not being part of the persons “me”. She further suggests that PMS offers the sufferers a broader range of emotions that is normally granted women (Cosgrove and Riddle 2003: 50), but as these are constructed and understood as a physiological defect they are not taken seriously, nor do they challenge the narrow norm in which they are not included (ibid.). In conclusion she suggests that PMS can be a method for women to deal with contradictory demands, and that “PMS discourses functions to sustain idealized representations of femininity” (ibid.: 45).

None of these studies negate physiological causes of PMS, but they share a focus on PMS as socially constructed, and criticise positivist unidimensional research on the phenomenon. Common for the mentioned studies is also that they all suggest normative and ideological workings of PMS, or of the constructions of PMS. It is suggested to sustain an idealised femininity, and as a way to keep this ideal free from negative emotions. It is also suggested that PMS can be seen as a coping mechanism for feeling out of control, or for sustaining a normative self-image.
As we have mentioned, diagnoses and medicalisation are often looked at for their normative functions (see previous sections). The findings on PMS are not related to any other medical phenomena, however, but looked at for its specificity. Medicalisation is hinted, but no analysis is conducted of such. This might be explained with the fact that PMDD was not an admitted diagnosis at the time of these studies, but is still a big gap in research. There is also no research on the construction of PMS or PMDD in Sweden.

2.6 Medicalisation of women’s underperformance

We have mentioned that there is a trend to medicalise women’s underperformance in line with neoliberal ideals. In this section research suggesting this will be presented.

To “medicalise under-performance” is an expression first coined by Conrad & Potter (2000) in relation to adult ADHD, and then not analysed as gendered. In a study on the expansion of the medical category ADHD to include adults, they conclude that what is seen as problematic with adult ADHD is not related to behaviour but to performance. Quoting Diller (1997) they give examples such as procrastination, disorganisation and inability to complete tasks (Conrad and Potter 2000: 573, quoting Diller 1997: 277). The diagnosis lets the diagnosed understand their experiences as “difficulties are caused, not by a lack of self-discipline, but by an inborn neurological condition” (Conrad and Potter 2000: 573). The diagnosis exists as there is a perception of underperformance and “Individuals feel that they could/should be doing better and seek help in improving their performance” (ibid.). Medication for adult ADHD (Ritalin is mentioned in their study) becomes a way to improve underperformance, and has been credited to having saved marriages and careers (Conrad and Potter 2000: 574).

Underperformance is a value-laden word, and thus somewhat problematic in research. We gather from Conrad and Potters presentation of the word that it entails not living up to self-perceived norms about performance. Thus what is deemed as underperformance is measured by societal norms, but perceived by the self. The fact that it has to do with performance highlights the most important notion of the concept; that it has not got anything to do with curing illness but is a way to enhance certain performance. To medicalise underperformance is used somewhat synonymously to shape “better than well” individuals (see for example Blum and Stracuzzi 2004). Surely better and well are value laden words too, yet it indicates the same thing – it is not curing, it is enhancing. It is clear that this concept, also closely concerned with medication which becomes the way to enhance, is similar to the notion of biomedicalisation.
Several authors concerned with female diagnoses have highlighted a trend to medicalise women’s under-performance, and this is seen to be done in line with neoliberal ideals (see Lassinantti 2014, Winter, Moncrieff and Speed 2015, and Blum and Stracuzzi 2004). Blum and Stracuzzi (2004: 269) summarises the trend well in their study of discourses on Prozac (an antidepressant that has seen great popularity in America) in popular media, by stating that the discourses sends the message that there is a

[…] need to discipline elite female bodies, to enhance their productivity and flexibility. This new form of female “fitness” mirrors demands of the New Economy and indicates how psychiatric discourse contributes to the historically specific shaping of gendered bodies.

Lassinantti (2014) similarly shows how women with ADHD optimise themselves as they adapt their bodies to fit normative expectations. This is done through biomedicalisation and pharmaceuticalisation in line with a neoliberal ideology that shapes independent, responsible subjects (Lassinantti 2014: 207), and leads to an unrealistic female norm remaining, as deviances from it are medicalised and treated (ibid.).

Winter, Moncrieff and Speed (2015) have given attention to how this trend can be seen to work. In a discourse analysis on the construction of ADHD by female sufferers they note how the diagnosis is constructed as sought after, as it has “life-improving qualities” (by gaining a diagnosis women can get medication and enhance their performances career-wise, and home-wise). They show that the diagnosis is treated almost as a commodity, something women “happily have” or are seeking (Winter, Moncrieff and Speed 2015:424-425). She further shows that it is difficulties with every-day life that is positioned as problematic, such as having a hard time to manage home-chores such as doing the dishes, but also finding it hard to be efficient at work (ibid.), and that medication is constructed as common, positive and as something that increases potential (that for example enables women to be able to run their own business and working as an administrator among other things) (ibid.). They conclude that both obtaining the diagnosis and medicating can be seen as a medicalisation of underperformance, which she suggests is a response to an increasingly demanding female role that “can be perceived as consonant with the consumerist and competitive values of late capitalist society” (ibid.:430).

To conclude we see a trend within female diagnosis that is said to shape better-than well individuals through medicalisation and pharmaceuticalisation. This trend has been seen to discipline and optimise female bodies in accordance with “demands of the new economy” (Blum and Stracuzzi 2004) or neoliberal ideals (Lassinantti 2014). Neoliberal ideology can, and has been described differently by different authors. Our conceptualisation of neoliberal ideals will be made drawing on
how others concerned with medicalisation and biomedicalisation have defined it. We see it entail: productivity and flexibility (Blum and Stracuzzi 2004:269), independent individuals responsible for their own success or failure (Lassinantti 2014:109), competitiveness and self-control (Lassinantti 2014: 110 quoting Gustavsson and Hörnqvist 2003: 56-61).

As mentioned, the literature on PMS has suggested similar notions. Markens (1996: 53) noted how pathologisation in relation to PMS shapes a norm that serves a post-industrial society, which highlights the relevance to analyse this trend in relation to PMDD.

3 Theoretical framework

We will use biomedicalisation as the basis in our theoretical framework and conceptualise it as an expression of biopower, serving neoliberal ideals. This way of conceptualising biomedicalisation has been inspired foremost by Kitty Lassinantti’s (2014) study on women with ADHD, but also seen relevant as similar themes have been suggested in literature on diagnosis, yet not analysed under the same framework. In this chapter we will present the biopower notion, explain its connection to biomedicalisation and outline how these concepts will be used and in our study.

3.1 Biopower through biomedicalisation

Biopower refers to power that works on a micro level to make individuals understand and manage themselves as biological subjects (Foucault 1988, Lassinantti 2014, Rabinow and Rose 2006). Biopower was first coined by Michel Foucault (2002) and part of his Governmentality concept, a broader concept which entails several “kinds of power often guided by expert knowledges that seek to monitor, observe, measure, and normalize individuals and population” (Carke et al. 2003: 165). It is a concept with which Foucault links self-subjectification with societal regulation (Bunton and Petersen 1997: xi). The health of the population is an economic interest, and he describes biopower as an integral part of capitalism (Foucault 2002: 142). Lassinantti (2014), who suggests that biopower is executed through biomedicalisation, sees it today serving neoliberal ideals, and thus still connected to economic interests.

We have presented the concept biomedicalisation in the previous chapter, and described it working to make health a goal and responsibility, and placing the body as flexible and subject to transformation. We have also explained it as describing the “new” workings of medicine, enabled by advances in biotechnology. It is evident that this is closely related to the Foucauldian notion of biopower – making subjects understand and manage themselves biologically - although biomedicalisation is describing a process and biopower suggesting a power element behind this process. At a closer
reading it becomes evident that the concept biomedicalisation more or less has sprung out of these ideas. Clarke et al. (2003) repeatedly refer to governmentality when describing the power elements behind these new ways of medicine; as when biomedical discourses make individuals wanting to change themselves in line with a neoliberal consumerist ideal (see for example Clarke et al. 2003: 181). They do not develop this much, it is simply integrated in the biomedicalisation concept. In our study, similar to Lassinantti’s, the biopower as the driving force of biomedicalisation, plays a more central role.

To understand Foucault’s notion of biopower one should acknowledge that he saw power and knowledge as interconnected, “so that any extension of power involved an increase in knowledge and every elaboration of knowledge involved an increase in power” (Bunton and Petersen 1997: xiii). We should also acknowledge that he has developed the biopower concept partly as a critique to Marxist ideas of power as executed by macro-structures such as the state working through public institutions like the police and the law (ibid.: xii). Instead Foucault “saw power as a relationship which was localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local and covert level” (ibid.)

Latter interpretations of Foucault and the biopower concept have given more tangible examples of what this could entail. Ranibow and Rose (2006:195) writes that biopower can be seen working through “truth discourses about the ‘vital’ character of living human beings” and through subjectification making individuals work on themselves and their own health and lives in relation to these truth discourses. Ranibow and Rose (2006) do not use the term biomedicalisation, but we see that their description of biopower’s workings is similar to the way biomedicalisation is suggested to work. Lassinantti (Lassinantti 2014: 73), who does conceptualise biopower as working through biomedicalisation, sees it being reproduced as one “understand and explain oneself in relation diagnostic criteria, changes ones identity through pharmacological treatment or describes ones functionality as located to the biological body”. However, as she highlights, biopower is not solely an oppressive force that individuals are helpless before. As the power works on micro levels it is individuals who reproduce it through their actions, as can they chose to resist it through their actions – mainly done by referring to competing discourses (ibid.). Lassinantti shows this well in her study as individuals are at times questioning biomedical explanations of their experience and diagnosis, and offers alternative interpretations (see for example page 172). In this way, individuals are ideological actors (ideology referring to that of the discourse being pushed), and when they reproduce biopower it can be seen as ideological agency (ibid.).
Similar to Lassinantti, we will conceptualise biomedicalisation as an expression of biopower, working to create individuals in line with neoliberal ideals. Biopower can work in more ways than through biomedicalisation (see examples in Rabinow and Rose 2006), but it is on this medium we put our focus.

3.2 Application and relevance

We have explained how we see it problematic that several researchers suggest similar notion in relation to current trends of medicine—such as enhancement, new biotechnologies causing paradigm-shifts in knowledge and organisation of disease, enhancement, the biological understanding as central, and medicalisation in line with neoliberal ideals—without much effort to understand or explain this. We have been inspired by Lassinantti’s way of giving this explanatory value by suggesting biopower as central to biomedicalisation, and analysing it with one and the same framework. Our theoretical framing allows us not only to point to existing workings, but to offer an explanation of such in terms of power, and thus insights to how power elements works in the construction of diagnosis. We also believe that taking this relatively new line of thought further—biopower through biomedicalisation—would benefit the development of such a theorisation.

We will first present the results on PMDD’s construction, and then offer an interpretation in line with our concepts. We will also relate the constructions of PMDD to that of other contested diagnoses and look at this through biomedicalisation.

4 Research design

To answer our research questions we conducted a qualitative content analysis of media material, namely 19 articles about PMDD published in Sweden between 2012 and 2015.

Previous research has shown the relevance of looking to the media for getting to know what PMDD is constructed to be (see for example Markens 1996), and for seeing constructions of diagnoses in general (see Seale 2003 and Conrad and Potter 2000). We chose printed material - over radio, TV and internet-pages - partly as it offered the broadest material, and partly as it offered a greater diversity in the producers of the media. We also wanted material that reached the general public, rather than for example Youtube-videos which need to be sought out by the media consumers in a more intentional way.

4.1 The material

Our material consists of 19 articles printed between 2012 and 2015. These were retrieved using the key word “PMDS and jag” (PMDD and I) in the Swedish media bank Mediearkivet. This search was
motivated by us wanting articles that included personal narratives, seen highly relevant in previous research on PMS (see Markens 1996 and Cosgrove and Riddle 2003). The result from the search was comprehensive, allowing us to go through it all, and choosing those articles that had PMDD as their main theme and that featured at least one personal narrative – that is one person with the diagnosis talking about her (it was all women) experience of it. All articles that lived up to these two criteria between 2012 and 2015 were taken as ground for the analysis. We chose to include articles from all four years to have material enough for a reliable study, see below how the amount of articles was methodologically informed. We chose not to take material from further back in time as we want to do a current analysis of what PMDD is constructed as “now”, rather than analysing the development of the phenomena or conducting a comparative study.

The articles used consisted of eight printed in local newspapers, one in a national free newspaper, one in a weekly local newspaper, four in national evening tabloids, four in monthly magazine and one in a weekly magazine. 15 were in the format of personal portraits, one in the format of four long quotes where different women described their experience of PMDD, two were news articles and one was a column and thus written by the same person who’s narrative was being depicted. See references (8.2) for a list of the articles.

There can be seen to be an imbalance as to where these papers are published, what recipients they have and in what format they are. One could argue that this study would be more representative had the media outputs had a greater diversity, or the opposite; had one focused on only one type of paper or magazine. This is not due to sampling however – as we have included all that has been published in Sweden and matched our criteria. For that reason we deem it representative for our research question. The fact that our analysis is not focused on the recipients and their interpretation, but on the production and construction in the texts, also makes this less relevant.

4.2 Qualitative Content analysis

The method used to analyse our material was a qualitative content analysis, especially inspired Altheide and Seneider’s description of Ethnographic Content Analysis (2013), designed specifically for media material. This has entailed a constant revision of the emerging themes in an iterative process between noted categories, the material and theory (ibid.). Altheide and Schneider suggest, after having come familiar with the field of study, to choose a smaller number of documents (six to ten) to study in more detail. After outlining themes and categories in these and making a protocol for further analysis - which is also theoretically informed – they recommend to collect further documents to which the initial themes and categories can be tested by applying the protocol (ibid.: 39-45). This procedure was followed. First, an initial coding of ten text was conducted, coding every sentence. A
second, focused coding organised these in to what was seen as the main themes, after which a schedule for analysis was drawn up, informed by the themes seen in the material but also by previous research themes and our theoretical framework. We then collected 9 more articles and conducted a third analysis of all 19 articles, applying our schedule for analysis. We believe that this method has allowed us to both to stay true to the material, through the two initial codings, but at the same time conduct a theoretically informed analysis, through the third coding.

Qualitative thematic analysis has been criticised for a tendency to lose context (Bryman 2008: 553). To ensure that this did not affect the validity we also conducted a narrative reading of our material (ibid.). An outcome of this reading was that it made us aware of the dramatic ways the texts were built up, and made us question the reliability of constructions of women ascribing serious life events as *only* due to PMS - could this rather be seen as part of the dramatic narrative?

We have also been aware of the subjective element inevitable in qualitative research (Fejes and Thornberg 2009: 17), and conducted contra-readings to ensure reliability and intersubjectivity. An example of what has come from such contra-readings is a problematisation of the reasons for taking medication. Before the contra-reading we saw medication to be taken in line with what other researchers have shown – for enhancement (for example Conrad and Potter 2000 and Winter, Moncrieff and Speed 2015). But when putting this theme to the test we found several parts of the texts indicating that medication was taken for reasons that could not be described as for enhancement. These readings have helped us gain a more complex understanding of our material.

4.3 Ethical considerations

As this study has no active participants we face slightly different ethical issues than the ones traditionally applied in sociological research (such as guidelines on giving information, consent, confidentiality and using the data) (Vetenskapsrådet). It is hard to talk about these requirements in any relevant way, yet the issue of consent has troubled us somewhat. The authors, publishers and the women interviewed have not given their consent to their stories being analysed for research. However, as all the material we have used is public, we have not deemed it necessary obtaining consent, often the way in social research (Bryman 2008: 130).

Another ethical concern is the possible effects or consequences of this work - could anyone be affected by it, or might it be misused? (British Sociological Association 2002: 2) There is, as mentioned, a current debate about the existence of PMDD, where some argue that the current research is no enough to prove the existence of PMDD aetiologically and that PMDD should not be seen as a “real” diagnosis (see for example Caplan 2004). Such statements can be very offensive for
the women depicted in the papers, explaining very serious life events and feelings, and can be used to campaign against women getting diagnosis and help for their troubles. We have already mentioned that social constructionism is a debated term and sometimes associated with opposing diagnoses’ existence (Johannisson 2006: 37), and the way we analyse PMDD as socially constructed might be seen as a way to take the “against-side”. A more thorough reading of our text should reveal that this is not the case. We stand outside the debate of PMDD as real in any aetiological sense, and we recognise that the women are both suffering and experiencing the problems mentioned. What we analyse is how these sufferings are understood, given meaning and constructed, and whether this can be seen to be similar to other diagnoses. In line with Johannisson (ibid.) we believe that parts of a diagnosis being social do not negate parts of it being aetiological.

Lastly in this section, we must mention the issue of translation. This is written in a Swedish context, at a Swedish university, and responding to a need seen in a Swedish context (although also seeing it having a wider and more far reaching relevance, this is where the focus, and case example is placed). Yet we write in English, which means that all the quotes in our material have been translated by the undersigned. The choice to write in English was made due to personal reasons for the undersigned, together with a hope for readers outside a Swedish context. This is indeed an ethical concern, as a translation will always slightly twist or change the meaning of the texts, also making it a question about validity. To do the texts, authors and quoted justice, our translations have been consulted with two peers. As the analysis we have conducted has been concerned with underlying themes, and not for example language constructions (compare with for example Winter, Moncrieff and Speed 2015), we deem that our study still can be seen as valid. Had we rather been interested in semiotics, or even hermeneutics, which would entail more textually close readings (Bryman 2008: 533-534), translating would have been a greater issue. However, we do encourage the reader to keep in mind that it is the themes to be focused on in reading our quotes, rather than specific uses of words. In regards to intersubjectivity, we believe that if someone else studied the same material they would uncover the same themes, regardless of whether they would translate every word the same.

5 Result and analysis

In this chapter we will present our result and answer our two research questions. First, we will show how PMDD is being constructed in Swedish media; as a biomedical fact and individual problem; a serious disease owned by the sufferers; and as something written out of the women’s self-image as a “not me”. The results and a short analysis in relation to previous research will be presented together, and after every section there will be an analysis in line with biomedicalisation. In such analysis we will argue that the way biopower makes individuals understand themselves and their diagnosis in
biological terms which leads them to work on themselves in line with neoliberal ideals. We will also show how parts of the construction cannot be seen to reflect such workings.

Secondly, we will analyse whether the construction of PMDD can be seen as part of a trend to medicalise women’s underperformance. Here we will argue that even though there are features to the construction that can be interpreted as part of this trend, it might be more fruitful to look at this as an expression of biomedicalisation in general.

5. 1 PMDD’s construction in the media

5.1.1 A biomedical fact and individual problem

5.1.1.1 The reproductive body
All articles treat PMDD, as well as PMS, in a very factual manner. A biological discourse, and medical and biological “facts”, are used in the texts to explain the phenomenon for the readers, and used by the women quoted to explain their personal experiences. PMDD is constructed and explained in biomedical terms, and as to be understood as connected to a reproductive body – as for example in relation to giving birth, having their period and breastfeeding. Biomedical here refers to biological and medical, and is not equivalent to biomedicalisation as a power exertion - although we will show it can be seen as part of it. Five articles refer to “women of fertile age”, and the excerpt below from Oskarshamnştidningen shows a woman understanding her PMS-feelings in relation to giving birth:

For years she suffered from her troubles without knowing what they were caused by. It went so far that she was on sick leave because she thought she was depressed. – The problems started after I had my second child. I started to feel my confidence run short, I was easily annoyed and had outbursts of crying.

Having given birth, first second or third, is a commonly mentioned as central for the PMDD-experiences theme, but also other things connected to a reproductive body are of matter. Sydsvenskan writes:

For Sara, who today is 41, it started when she had stopped breast feeding her second child. – Everything felt meaningless, I felt incredibly unhappy. She felt like she had no skin on and was without protection from happenings in the world.

The two quotes are examples of premenstrual experiences being connected to a reproductive body. Sometimes PMDD is simply described in a biologically termed language. This is the case in Västerbottenkuriren:

We meet at her place on a day off to talk about PMDD, the hormonal state that strikes Jenny one week a month.
Here it is clear that whatever Jenny is experiencing as PMDD, is due to hormones. We see a similar notion in Södermalmsnytt:

Lisa becomes a monster each month due to her grave PMS. She finally had enough of the neglecting of female hormones and started a PMS-alliance.

In this exert PMS and female hormones become descriptive of the same thing, and the experiences are described as biomedical states. This is also the case in more informative parts of the texts, such as in Norrbottenkuriren:

PMDD is the oversensitivity to hormones that lasts between 10 to 14 days during the menstrual cycle and should not be confused with the milder (but still devilish) version PMS.

This last quote also goes to show the factual and enlightening manner adapted in the texts. Here we also see how PMS and PMDD is seen as variations of the same thing. Throughout the texts they are used either interchangeably or as referred to as mild or grave forms.

5.1.1.2 A concern for the doctor

Drawing on this understanding of PMS as being a biological concern, the relevant place to seek professional help is at the doctor or at a gynaecologist. Only three articles mention a psychologist or therapist. These are from 2012 and 2013, since 2014 such has not been mentioned. PMDD is constructed as a bodily disease, not a behavioural such. This is also evident as the quoted women liken it to having diabetes or the flue. As in Expressen:

I initially felt a resistance, but the doctor explained to me that this medicine is for me like insulin is for someone with diabetes.

The same way insulin is seen to “regulate” balances in the diabetic body, or functions, medication for PMDD is seen to adjust bodily imbalances. And in Södermalmsnytt we see similar notions:

All the emails resulted in the PMS-alliance that started this autumn. And now we’re sitting here talking about PMS. Three women around a table, all in the PMS alliance and all with the grave sort of PMS. Cecilia Dolk, Karin Adelsköld and Kristin Björnsdotter. They want the alliance [a PMS alliance started by the three women quoted] to normalise PMS. That everyone will know what PMS is. That the healthcare takes women seriously, that it becomes the same thing as having the flu.”

Here we also see a call for society to acknowledge PMDD as the serious disease it is (according to the women quoted). When calling upon workplaces and the health care to recognise PMDD, it is a biomedical understanding they are calling upon to be accepted.
5.1.1.3 An individual problem

This biological construction also serves to place what is problematic with the PMS-experiences’ as an individual, bodily problem. Following the placement of the problematic within the reproductive body, the problem is constructed as being situated within the woman, and seemingly only there; the way of understanding the PMS-experiences as due to the body, also entails as understanding it as not caused by other things. An example of how social situations are stripped of explanatory value for feeling bad, if the woman is suffering from PMS, is the following exert from Huddiksvalls Tidning:

Many women probably don’t even understand that they have PMS. They might think that something is wrong at work, [with the] partner or at home, and miss that it is the hormones playing tricks on them.

We see here a way of constructing it as either or; if these things are due to PMS, then they are not due to the other things. This, together with the notion that a lot of women have this can be seen to send the message; if you have problems at work, with the partner or at home then you might have PMS. This can also then be seen as medicalising these problems, as problems at work and problems with the partner becomes described in medical terms – caused by hormones. Thus to manage oneself and ones hormones, is a way to solve the PMS-problematic, such as problems at work. It is clear here how the biomedical understanding of oneself makes self-management the solution to social problems.

Other examples on how the texts construct PMS as an individual problem are the following exerts. This one from Vi Föräldrar:

- It was hard for the children to catch up with my mood. One week we’re playing and having fun, and the next I’m grumpy and there is more fights. I experience both Anders [her husband] and the children as annoying that week, but in reality it is me who is tricky, says Veronica.

In Sydsvenskan:

Laura often tells her children that are ten and twelve years old that she is having a really hard week and that it is not because of them if she is snappy, loose her temper, is angry or sad […] -It felt completely wrong and unfair towards my husband and my children that I was feeling like this.

Note also how they “are” sad or tricky. They do not become it, which would have suggested that it was something in their surrounding causing it. Evident in these quotes is also the gendered nature of the problems. We have shown that PMDD is constructed as a gendered problem by being connected to a female, reproductive body. Here we also see how it is constructed as such by constructing the problematic experiences as connected with what has been seen to be typically female concerns (see Winter, Moncrieff and Speed 2015 and Cosgrove and Riddle 2003), namely family and home. We see here that children and partner are the main concerns for women’s distress. Other examples on how such themes are constructed as central for the experience PMS is by headlines such as “Karin
36: ‘I couldn’t take care of my children” in Aftonbladet and “The children called me PMS-witch” in Må Bra.

5.1.1.4 Ignoring social context
We have touched upon these constructions medicalising problems such as *having troubles at work*, by placing it as due to PMS or PMDD. In accordance with what has been seen by several other researchers on diagnosis (see for example Johannisson 2007), we see that this leads to the ignorance of social context. As the quotes above show, by placing the problem within the woman, social situations hold no explanatory value for feeling bad. Aftonbladet, writes that:

[…] the problems [mood swings, apathy, excessive crying and break-downs] got worse after a tough separation from the children’s dad – it took a long time before she could connect the problems with PMS.

The article then goes to explain how things are now much better for the woman (that she no longer has such severe PMS), and quotes the woman saying:

[…] and as an extra bonus I have moved back together with my ex.

In this example social situations are mentioned, but not given explanatory value for the distressed feelings. It is not our purpose to evaluate what is a stressful situation, or what is a legitimate reason for anger, irritability and the like. We mention this to exemplify what is not given explanatory value, when PMS is.

Thomas Brante (2006) and Eva Kärnve (2000) have both raised concern over how a biological explanations of diagnoses makes it impossible for social factors to be causal. We can interpret this as a result of the paradigm shift Brante sees in psychology (from psychoanalysis to neuropsychiatry), and see it as an example of what this shift leads to in practice.

To locate the blame for external problems within the woman has been suggested in previous research on PMS to be a way for women to gain a sense of control over situations they experience hard to control (Swann 1995). To interpret problems as individual problems and not give social situations any explanatory value can be interpreted as such a strategy.

5.1.1.5 A biomedical fact and individual problem in relation to biomedicalisation
We have shown how the articles create PMDD as something biological, connected to the female body and thus an individual problem. This can be interpreted as biopower making individuals understand themselves as biological subjects. In coming sections it will become evident what this understanding enables and leads to, in this section we have seen how it takes away explanatory value from social context.
We also see here, what would go against this being an expression of biomedicalisation, and that is the depharmaceuticalising agency which can be seen when some women quoted call for society to change (for PMS to be normalised and for workplaces to adapt), instead of the individual having to adapt (and change themselves by medication). Although this is depharmaceuticalising agency, it is not demedicalising agency, as the acceptance called upon is that of the biomedical discourse. What we see then can be interpreted as a will for depharmaceuticalisation, but an inability as an individual to resist an already pharmaceuticalised context. We can also relate this to what Lassinantti (2014: 73) has called ideological agency, and see that there are individuals resisting the hegemonic discourse of women needing to manage and adapt themselves. The concurring discourse they draw upon then is one of women’s situations and experiences needing to be taken seriously in society. It is important to note that there is also resistance to biopower, or to biomedicalisation making women changing themselves.

5.1.2 A serious disease owned by the sufferers

5.1.2.1 A serious condition

Throughout the literature, PMDD is univocally constructed as something very serious. This is done through quoting women’s serious depictions of their experiences. Following quotes serves to exemplify this. A rubric in Amelia reads:

PMDS controlled Julia’s life for twenty years.

In Huddiksvalls Tidning:

Two years ago she felt worse than ever. – My partner was going on a business trip to Paris and I was home alone. I fell to the floor and thought that life was over. Everything felt worthless and I couldn’t manage to live anymore. I got scared of myself.

In Femina:

Once, I was so maddened by a messy butter knife on the kitchen counter that I jumped on the open the dishwasher so that it broke. It happened several times that I threw porcelain and I think all of our kitchen cupboards have gotten a dent. Karin’s mood swings lastly caused her marriage to end and not until long after did she find out that her behaviour was caused by an extreme form of PMS.

These exerts represents the way the papers establish PMDD (and PMS) as something very serious. This also seems to be a way to legitimise this as a “real disease”, which is also made through comparing it with other “real diseases” seen above. Winter, Moncrieff and Speed (2015) has shown in a discourse analysis of women with ADHD that the construction of the disease as real is central for the women, the importance lying in establishing it as a real biomedical disorder, also evident in our
material. They analyse this being a way for the women placing themselves beyond moral judgement for the behaviours, also seen in Lassinantti’s (2014) study on women with ADHD in Sweden.

PMDD is described solely as negative. To question such an “extreme” result, we have tried to find positive representations of PMDD in counter-readings, but to no avail.

5.1.2.2 PMDD is owned by its sufferers

PMDD is constructed as something owned by the women experiencing it, them being the only ones able to know what it entails. This is evident through the fact that all but two of the quoted women have diagnosed themselves, and through the way the papers encourage women not to rely on doctors but to take the matter in to own hands. Only two of the portrayed women had been diagnosed by a doctor without having suspected the diagnosis themselves. In an informative section under the rubric “Get help” in Södermalmsnytt it reads:

Read up! Then try to get help. ‘It is a struggle, beware that you probably have to change gynaecologist several times before you find the right one. Trust yourself - you have interpretive prerogative when it comes to your own body

The “right one” which is referred to is the one who is willing to diagnose them with PMDD. Two other articles made similar claims, where the readers were encouraged to keep on seeing people until someone gave them the diagnosis, and six articles explained the contact with healthcare as problematic. In Amelia it reads:

A few years back Frida started to suspect that her problems were due to PMS, but it wasn’t until half a year later, when she saw the comedian Karin Adelsköld talk about her PMS on TV, that it all made sense to her. […] She did a PMS-test online and got top score. Then she went to the doctor. – Now it says in my medical record that I have PMS, but I am convinced that it is the more serious form, PMDD, that I have.

Clear in this exert is that Frida diagnosed herself (with the help of an online test) before she went to the doctor, but also after (with the more serious PMDD). The doctor can be seen as a gatekeeper, not so much for the diagnosis anymore (as suggested by Jutel 2007) as for medication, suggesting a changing role or power of the doctor.

We also see that what is the ground for Frida’s self-diagnosis is someone else’s personal experience – or what we can call illness-narrative. We thus see how it is the other woman’s “expertise” that is more important, or influential than the doctors. Jutel (2007) has conceptualised diagnosis as being the link between illness and disease, illness referring to the personal narrative of the sick, and disease referring to the medical narrative given by the medical world (by diagnosis). Seen in our material through self-diagnosis is that the line between illness and disease being blurred, and the illness (self-
perceived experiences) becomes equal to the disease. Marken’s raised concern over personal experiences being given the power to define what disease is (which she sees always will be cultural products). Our material shows that this is the case for PMDD.

A medical vocabulary is still used, however, suggesting some influence of the medical world. And doctors are still gate-keepers for medicine.

The self-diagnosis and construction of PMDD as owned by the sufferers can be seen as a result of the women being constructed as fully responsible of their health. Clarke et al. (2003) have seen that self-diagnosis can be part of commodifying health, and we might interpret our result of a sign of this. Other signs of commodification are the ways diagnosis and medication are constructed as sought after in a consumerist manner, and taken when seeing a need.

5.1.2.3 PMDD is manageable
The portrayals are not solely depicting a negative image of the situation for women with PMS or PMDD. They also have parts in a more positive tone, encouraging the readers who suspect they have PMDD to take action. The message seems to go along the lines: this is serious, but manageable. The help that is suggested can be divided in to the three categories; medication, knowledge and what we have chosen to call “general well-being”.

Medication is described in an overall positive manner and as very helpful. All women cited but two have taken some sort of medication. One decided to stop because of complications, the rest take some substance for PMDD. Most commonly mentioned are anti-depressants such as Premalex, a few mention specific contraceptives, and two taken vitamins. A few times complications are mentioned, such as hard to sleep or tiredness, but this is described as “worth it”. To give examples on how medicine is depicted, this exert from Hallandsnytt:

“Up to 90 000 Swedish women suffers from such grave PMS, so called PMDD, that their life quality and ability to function is affected. – I started to have suicidal thoughts, says Linda, 29 years old. But anti-depressant medicine can help almost everyone.”

And in the same article:

Compared to treatment for depression, the women who suffer from PMDD only need to take medicine when they experience the troubles. – The effect comes already after one or a couple of days, which indicates that PMDD should not be seen as a form of depression, says Elias Eriksson [professor in pharmacology]. - Already the second day it was as if the world cleared up. I feel now that I can handle my PMDD and take medicine the days I feel the need.

Similarly in Västerbottenkuriren:
Maja noticed the effect straight away [from the anti-depressants]. Today she starts to take her medication as soon as the first signs of PMDD appear, such as when her patience runs short and the tiredness is noticeable. There are some side effects, such as hard to sleep, but that passes after a few days. As soon as the period comes she stops taking the medication.

The benefits are described as to being able to handle themselves and their direct situations. We see here that medicine is constructed as something very helpful, being able to help “almost everyone” and turning around very serious feelings and states. We see also that the benefits are constructed as being able to handle the problems caused by PMS, and that women can take the medicine when they feel the need.

We suggest the term “general well-being” to describe the all-encompassing health and lifestyle tips that are described as a help for PMS. An example of this is this exerts from Amelia:

There is no cure for PMS/PMDD. If you have a milder form a lifestyle change can be enough. Avoid stress, train regularly, sleep enough, think about your diet, avoid alcohol, tobacco, coffee, sugar and too salty or fatty food. Make sure to keep a PMS-diary – a lot of women don’t necessarily connect their problems with their menstrual cycle.

Another example on how encompassing this can be is from Huddiksvalls Tidning:

How you become friends with your PMS: […] Track your menstruation cycle and grade your troubles. Start with mental training. Talk about your PMS and share what you’re feeling. Eat regularly and never skip a meal. Lessen the amount of triggering substances such as sugar, salt, caffeine, alcohol. It inhibits the bodies uptake of estrogen, affects your blood sugar and can worsen the accumulation of water. Eat a lot of fibres and greens. Start training. Adapt your training to your menstrual cycle. The phase between menstruation and PMS is perfect for intensive training. The week your menstruating, give yourself time for reflection and a few days of calm, through for example yoga.

Women are encouraged here to understand themselves, and their health in accordance with their cycle. These exerts also show how it health and control are constructed as the “solution”.

Also, “just to know” (that it is PMDD that one has) is described as a solution. In Metro:

By telling people around her how she works, the problems have become easier to deal with - To know what this is caused by makes me ready in a different way now and that has helped a lot.

And in Hallandsnytt:

When Linda found out that her feelings were due to hormones it was enormous relief

We have previously shown that women are encouraged to take matters into own hands and “read up”. This too, can be interpreted as a way to gain control (being the one who has the knowledge and thus
know how to handle oneself), closely related to the self-diagnosing and shrinking, or changing influence of the doctor we have suggested.

5.1.2.4 A serious disease owned by the sufferers in relation to biomedicalisation

Biomedicalisation has said to focus on enhancement of bodies (Clarke et al. 2003). We have seen here that PMDD is constructed as a “serious” illness, and states such as falling to the floor with feelings of worthlessness and doubting life have been seen. When women are described taking medication for states like these, it cannot be interpreted as enhancement, and would suggest biomedicalisation not being at work. There are however also depictions of women taking medication for short patience and tiredness, which would suggest enhancement and biomedicalisation. Discourses focusing on enhancement rather than curing has also been seen in research on women with ADHD (Winter, Moncrieff and Speed 2015, Lassinantti 2014), suggesting this being common for contested diagnosis. To say that PMDD simply is or is not an expression of biomedicalisation is clearly an oversimplification, and this ambivalent result goes to show that we can interpret parts of the media constructions as part of this, and others not.

The “help” described (healthy living, medication or knowledge and self-diagnosis), can be seen as ways to create responsible, healthy subjects (in line with neoliberal ideology) through biomedicalisation. It is the understanding of oneself and ones illness as biologically caused and thus an individual problem, that makes the solution to the illness-problematic being to manage oneself. Neoliberal values can be seen in the creation of a responsible subject who needs to manage her own health, and in the creation of an ideal that is healthy and without short patience and tiredness- an ideal to which women adapt. This can serve as an example of how biopower’s subjectification (Rabinow and Rose 2006) works in practice.

5.1.3 PMS, me and the normal

5.1.3.1 PMS is “not me”

The PMS is constructed as something other than the self, and constructed with agency, as something actively doing and causing things. It is constructed as a reason for bad and unwanted feelings and behaviours, and as a contrast to “the real self”. In Sydsvenskan:

    When Clara started to keep a diary it became evident that this was grave PMS, also called PMDD. To finally see the reason for her anxiety was a relief. It helps her to think that PMS is not a part of her personality. – It’s not me. I’m a happy person.

And in Sydsvenskan too:
Clara tells the big kids that she has hormones in her head fighting. How the two-year-old experiences her dips she thinks a lot about. – He is too little to see any patterns, but of course he is affected. I never cry otherwise.

Here, anxiety is written out of Clara’s “real self” who is understood as happy. By applying feelings such as anxiety and crying to the PMS, they PMS-sufferers can sustain their self-image as happy individuals. The way Clara states that she never cries if it is not for the PMS can be interpreted as what Swann (1995) has called a romantic discourse, where everything in the women’s life is said to be perfect except for the PMS. Swann suggests that this can be a strategy to gain a sense of control.

The “not-me” constructed here has been seen in previous research on both PMS and diagnoses (See Swann 1995, Markens 1996 and Winter, Moncrieff and Speed 2015,), and can be understood to do several things. To trivialise anger and deem the women’s angry feelings meaningless (Swann 1995), to take away blame for these unwanted behaviours from the individual (Winter, Moncrieff and Speed 2015) and to give women access to a wider range of emotions – not otherwise fitted in the female normative behaviour (Cosgrove and Riddle 2003).

By PMS and PMDD being the agent behind negative feelings and behaviours, it is also constructed as the cause to life events caused by these feelings and behaviours – such as divorces and quitting ones job – sometimes explicitly, and implicitly at others. An example is evident in in Metro:

Today she takes contraceptives and vitamins to lessen the hormonal troubles. But PMDD has also affected her dear ones - All my relationships have ended because of this.

In Sydsvenskan:

Stina tries to keep a low profile the problematic week. – I’d rather say too little than too much and don’t go in to situations where there is a risk for disagreements, because then I can fire up and become rabid. She has bad experiences, once she quit a job in ire/rage.

And in Södermalmsnytt:

After Karin appeared on the TV-sofa she got a ‘tsunami of emails’. After a while she realised that she couldn’t manage on her own. – Women write that they are on their way to divorce, that they are yelling at their children. That they can’t manage to get out of bed. They’re desperate, says Karin.

PMS and PMDD is constructed, as we can see, as the reason for these un-wanted life events. It does not say that explicitly that this is only because of the PMS, but that is still the way it is constructed. One can interpret it (and then again one might not) that the women don’t want to divorce at all, or that there is no reason to yell at the children.

It might be that the women do not think that these events are solely due to the PMS. Media has been prone seen to sensationalise health stories (either being overly positive or negative, in both cases
angled for dramatic purposes) (Seale 2003). What we are interested in here is what the texts construct and give meaning, why even if this might be exaggerated it is still part of the construction.

5.1.3.2 PMDD constructing normalcy
Most research agrees on diagnosis and medicalisation having normalising, idealising functions (see for example Conrad and Schneider 1985, Johannisson 2006, Lassinantti 2014 among others). We see that normal is a reoccurring theme in the texts, but that normal also is constructed in many ways less explicitly.

A text in Västerbottenkuriren contrasts having PMS to living like anyone else:

Three weeks every month Jenny is living like anyone else. She is working as a nurse at the oncologist in Umeå and plays guitar and sings both in a band and in solo projects. But then it comes, the day when it feels like someone pulls a blind down in front of her joy of living, when anxiety and tears take over for a week and she wants to just lock herself in with her cat Hjördis as only company and plough through TV-series. – I’m a stress-tolerant and ambitious person. This does not match my personality, says Jenny

Here, it is clear that normalcy does not include anxiety and tears, wanting to be on one’s own and watch series. In Oskarshamns tidning:

I have cried, screamed, pulled away and avoided situations where I’ve had to be social and nice. I couldn’t live a normal life, the mood swings controlled everything

This excerpt shows how the feelings caused by PMS are positioned as something opposing the normal. By referring to something as PMS or PMDD (or caused by that), and having an understanding of this as a serious disease, which we have shown, is to also say that what is caused by PMS or PMDD is caused by a disease, is sick and thus not normal. Thus, the things positioned as PMS or PMDD, can be seen as a medicalisation (making them a matter for the medical world) of these things and thus serves to take them out of the concept of “normal”. To see what “normal” is being constructed in our material, we must then look at what is being attributed to PMS or PMDD.

In our empirical data we have shown that what is being positioned as PMS signs of PMS or caused by PMS (or PMDD) is: to be easily annoyed, to cry, to be anxious, to have feelings of unhappiness, wanting a divorce, being unhappy with ones relationships, being angry at ones children, being angry in general, being irritated and grumpy, being easily annoyed, “losing it”, having severe mood swings, to have failing relationships, to quitting ones job in rage, yelling at ones children, not getting out of bed.

The normal then, is an absence of these feelings.
A creation of normal is made in more ways than just by positioning things as due to PMS, we argue. A more subtle way to do so, is through the “ought to be happy situations” most articles describe. For example in Västerbottenkuriren:

Frida was newly married, the daughter had just turned one and life ought to be fantastic. Despite that Linda lay in bed, under the cover, and thought for the first time about taking her life.

The message sent is that if someone is newly married and has a one year old daughter, one is supposed to be happy, not to be happy in such a situation serves as proof of PMS – of a disease. Even though these are surely happy occasions for many, what the discourse does is making it deviant, diseased, not to enjoy these things. We must mention that our analysis might seem to take lightly on someone thinking about taking her life. This is not the case. Clearly the woman is experiencing very stressful feelings, and this ought to be taken seriously. This said, the construction of what is ought to make her happy is the same. Here we also see how family and children that ought to be a happy situation, two themes very often featured in the women’s “normal”.

Not all articles describe these “ought to be happy”-situations so explicitly, but most constructs such. Three article mentions “questioning ones friends and family”, and another “questioning ones partner and career-path” as “proof” (they use it to legitimise having PMS, and as an explanation of what it entails) of PMS.

Taken out of its context, to have mood swings, to divorce, to yell at ones children can be seen to just describe normal occasions in women’s lives, although maybe not pleasant ones. We do not mean to define a “real” essence of normal here, but rather want to contrast the way these behaviours are constructed (as signs of PMS) with how they are not constructed (as normal life events).

As we have touched upon, PMS and what is ascribed to PMS is gendered – as does the normal need to be understood as gendered. The gendered nature has been evident mainly in two ways, firstly by PMS and PMDD being connected to a female, reproductive body, and secondly by the problematic experiences being constructed as connected with what has been seen to be typically female concerns such as children, partner and house-chores. Partners and children are mentioned in every article as affected by the PMS, friends and work only sporadically. Even the two women quoted who do not have children, mention such as potentially problematic. In Norrbottenkuriren:

The thought of children in the future both excites and scares. To not function properly and be sufficient as a parent would be a nightmare, and she paints up possible horror scenarios – What if my abilities to calm down wouldn’t work anymore?
What these notions goes to show is that the main concern for most of the quoted women seem to be not being able to be a good mother and partner.

Cosgrove and Riddle (2003: 50) have suggested that it is women who try to live up to typical cultural role on femininity that more often position themselves as PMS-sufferers, as this stereotypical role simply do not offer behaviours such as anger and “losing it”. PMS then offers them a wider range of emotions, whilst still constructing the “impossible” ideal. It is evident that it is problems with typically female chores that are being medicalised in our material, suggesting women are trying live up to ideals that do not include the negative emotions.

5.1.3.3 PMS, me and the normal in relation to biomedicalisation

We have in this chapter seen how a “normal” is constructed in the texts, and how women try to live up to this normal through medicalising behaviours that do not fit it. Once again we will highlight how this is enabled by a biomedical understanding of PMDD and the problematic experiences, enabling women to understand their problems as biologically caused and thus part of the “me”.

The “not me”-construct can be seen to contradict the self-managed subject we claim is being created through biomedicalisation, as it can be seen as a way to not being held responsible for certain behaviours (Lassinantti 2014: 207). We will argue though, that it is rather a way for the women to avoid blame than responsibility, as it becomes clear that the one responsible to manage this problematic “not me” is the woman. Previous research (Cosgrove and Riddle 2003) has suggested it being a coping mechanism for not living up to narrow norms or ideals, yet the way medicine is constructed as a solution (and taken even by those ideologically opposing having to adapt themselves) makes living up to these ideals expected still.

Biomedicalisation has been seen making individuals enhance themselves in line with neoliberal ideals, or what has been called to create “better than well” individuals (Blum and Stracuzzi 2004). Previous research have found this creating productive, competitive and highly performative individuals (see Blum and Stracuzzi 2004 and Lassinantti 2014) and Winter, Moncrieff and Speed (2015) have shown how the normativity is created by women medicalising for example not being efficient at work. The normal that is being created in our material, however, is rather a calm, happy, good wife and mother than a productive career-woman. Surely the ideal not to get angry at ones children or ever cry is also a “better-than-well” individual, however it is not completely in tune with what previous research has described as such.
5.1.4 Summary of PMDD’s construction in the media

In our material, several things on the construction of PMDD and the exertion of biopower have been evident. This serves to conclude what we have seen so far.

PMDD is created as being PMS, but a graver version. It is understood as a serious biomedical condition that is caused by functions in the reproductive body, and as a matter for the medical world. We have shown that this biomedical construction of PMS works to place PMS as an individual and not a social problem and responsibility, also leading to social contexts being stripped of explanatory value for women’s distress. We have shown how the women are constructed as the owners of the disease, responsible for as well diagnosis as treatment, and supposed to manage their condition with several forms of self-control and adjustments. We have seen also how the doctors role can be seen to be changing from gatekeepers to diagnosis to gatekeepers of medication, and how the line between illness and disease being blurred when the personal narrative becomes the medical narrative. We have seen how PMS is constructed as a “not me”, something outside the women’s self-perception responsible for their distress, enabled by the biomedical understanding of the problems. We have seen how to the medicalisation of PMS-attributed behaviours and feelings serves to create a female norm that does not include anxiety and distress, failed relationships and anger at children. We have also highlighted how this norm is gendered.

By applying our theoretical framework we have been able to see several examples of how biopower can be seen to work through biomedicalisation in the construction of PMDD. We have seen PMDD being constructed as something to be understood in biomedical terms and thus making the body something to be managed and adapted. We have seen how enhancement is encouraged and constructed as something positive, and how parts of our material suggests that a process of commodification is in progress in relation to PMDD as a diagnosis. We can interpret the workings of biopower creating healthy subjects who understand themselves in bodily terms and are highly responsible of their own health and wellbeing.

We have also seen things that cannot be said to part of biomedicalisation. In some exerts the women are described to seek help and medication for very serious states, such as doubting their lives, which does not support the way biomedicalisation is said to encourage enhancement, and which contradicts the focus on health just mentioned. The way some women, through the texts, are calling for societal change can be seen as a resistance to biomedically having to change themselves. We can also see that the normalcy constructed not so much reflects neoliberal ideals as much as more classical female ideals such as a happy, calm partner and mother.
5.2 PMDD in relation to the medicalisation of women’s underperformance

This section will outline an answer to our second research question:

- Can the construction of PMDD be seen as being a part of a trend medicalising women’s underperformance?

We will draw on what has been shown in our analysis so far, and argue that parts of the PMDD construct can be interpreted to be part of this trend, but that it might be more fruitful to look at the diagnosis in relation to the more general trends of biomedicalisation.

To medicalise women’s underperformance has been described to discipline and optimise female bodies in accordance with “demands of the new economy” (Blum and Stracuzzi 2004) or neoliberal ideals (Lassinantti 2014). It has been seen to shape responsible, independent subjects and to create individuals who optimise, and pharmaceutically change, themselves in accordance with normative expectation. It is suggested that this is done through biomedicalisation, medicalisation and pharmaceuticalisation (Lassinantti 2014), and that it leads to an unrealistic female norm from which deviances will be medicalised.

We have seen in our material that women are being created as the full owners of the disease; PMDD or PMS is caused by their biology and it is helped by their management. This can be seen to create responsible, independent subjects responsible for managing the behaviours and feelings that are being positioned as PMS and PMD and for diagnosing it. This is also evident in how the quoted women talk about how they manage and control their PMS, rather than cure it. This would support the construction being part of the mentioned trend.

Further, we see a willingness among the women to change themselves, mostly through medication but also through training and diet. As mentioned there is ambivalence as to what reasons women change themselves. Some take medication for what is described as very serious feelings of hopelessness (such as doubting life) which cannot be seen as a sign of women enhancing themselves, and not as part of the trend. Others take medication not to feel tired and not to get irritated, and many take it when they “feel the need to”, which can be seen as a way of choosing to optimise behaviour and thus in line with the trend. Women can also be seen to optimise themselves by actively seeking the diagnosis and medication.

We have shown that there is a norm created by medicalisation and that women are willing to change themselves in accordance with this norm. This too would suggest the medicalisation of PMDD being a way to create better-than-well individuals. However, the norm that the PMS-sufferers are creating
is rather different to the norm seen in previous research and said to be in line with neoliberal ideals (for example being efficient at work and in school, seen in Winter, Moncrieff and Speeds study from 2015). It is that of a calm, happy partner rather than a productive career woman. A norm to never cry or being unhappy in ones relationships is surely also a way of medicalising underperformance, but not in accordance with a norm that suit the market economy in the same direct way as seen when women with ADHD take medication to be more efficient at work (Winter, Moncrieff and Speed 2015).

To conclude, the PMDD diagnosis, as constructed in media, can be seen to medicalise women’s underperformance and it can be seen to shape better than well individuals, but not fully in accordance to the suggested trend as the normal is not as closely connected to neoliberal values as has been seen in previous research. The way that women are constructed as responsible, individual subjects indicates the trend, but could also be interpreted as reflecting workings of biomedicalisation in general.

We will argue that parts of the construction of PMDD can be seen as influenced by such a trend. PMDD cannot be seen as a result from such a trend however, but needs to be seen rather in relation to previous research on PMS and in relation to the history of the PMS-concept. If we, for example, put it in relation to how Rittenhouse (1991) has seen PMS becoming a social concern at times when the female role is shifting in society, bringing about a public discussion on women’s “appropriate role”, the more “traditional” themes of good mother and partner suggested in our material gains a different perspective.

6 Conclusion

The purpose of this study was to develop a broader understanding of current workings of medicine in relation to female, contested diagnoses. We have done so by analysing the way PMDD is constructed and relating it to a current trend suggested; to medicalise women’s underperformance. We saw it as a problem that PMDD so far only had been analysed for its specificity, and have throughout the work attempted to relate it to constructions and workings of other contested diagnoses. We also saw it as problematic that there were several hints in previous research to similar notions – that of medicalisation of behaviours that serves to shape an enhanced individual in accordance with a neoliberal ideology – but without bigger attempts to understand such. Inspired by Lassinantti’s study on women with ADHD (2014), we have offered explanations through an analysis with the concepts of biopower and biomedicalisation.
In relation to the research questions, our research has shown that that PMDD is constructed in media as a serious biomedical disease to be handled and controlled by the individual. We have seen also that PMDD is constructed to be something fully owned by the women experiencing it as they both diagnose and treat themselves. We have also seen that constructing PMDD as something bodily enables a construction of the PMS as something different from the women’s “selves”, a “not me” that is the cause of unwanted feelings and behaviours.

Our result does not fully support PMDD being part of a trend to medicalise women’s underperformance, as the normative woman created in our material is different than what has previously been conceptualised as in line with neoliberal ideals. However, the fact that women are willing to change themselves in accordance with normative expectations and the way they are created as responsible and self-managed subjects suggests that that parts of the construction of PMDD can be seen as influenced part of this trend.

6.1 Current workings of medicine

By looking at PMDD as a contested diagnosis and applying a theory of biomedicalisation, we have been able to put the construction of PMDD in relation to the construction of other contested diagnoses and to general trends of medicine. What, then, can our results tell us about current workings of medicine in relation to contested female diagnosis?

A biomedical understanding of one’s diagnosis, of one-self and of ones problems has been noted in medicine in general, reflecting new biotechnological knowledge (Clarke et al. 2003), and a paradigm shift towards neuropsychiatry (Brante 2006). This has also been seen in our research. Similar to Brante (ibid.) and Kärfe (2000) we have seen how this takes away social causation. We have also seen, similar to Conrad and Potter’s (2000) in relation to ADHD, that this leads to a medicalisation of not only bodily conditions and behaviours, but of social scenarios such as divorce. Also concurrent with other research is a generally positive attitude towards changing oneself biomedically.

The “not me”-construct can also be seen to reflect a more general trend in the social construction of diagnosis, also highlighted by Winter, Moncrieff and Speed (2015) Lassianntti (2014) and (in other wordings) Brante (2006) and Kärfe (2000). We have offered explanations of this trend being that it allows subjects to live up to a narrow norm by placing divergences form it as a “not me”, and that it can be seen as a way for the women to remove blame for the behaviours not concurrent with this norm. Another construction that also can be seen to reduce blame is the construction of the disease as very serious, suggested in research on females with ADHD (Winter, Moncrieff and Speed 2015). We must mention that this construction also is made as the women truly are suffering.
Lastly, we have seen how personal narratives are highly constitutive of how the diagnoses are understood. We have shown that the personal narrative becomes the medical narrative through self-diagnosis and how women diagnose themselves based on others personal depictions. Winter, Moncrieff and Speed (2015) described how other women’s explanations of their own experiences of ADHD became central in other women’s experience of the diagnosis, and many mention self-diagnosis as currently common (Winter, Moncrieff and Speed 2015, Lassinantti 2014, Clarke et al. 2003). This also suggests a shifting role or power status of the doctor, at least in relation to contested diagnoses.

There are also several constructions that cannot be seen as part of any general trends. The way PMDD is connected to a reproductive body is one example of this. Also, as we have mentioned, the female ideal created in relation to PMDD can rather be seen to reflect a more classical female norm as mother and partner, than high-performing career-women suggested in other literature (see Blum and Stracuzzi 2004 and Winter, Moncrieff and Speed 2015).

Something that has not been specifically highlighted in the research on other contested diagnoses we are relating to, but seen in our material, is a focus on overall health. This is however mentioned by Clarke et al. (2003) who suggest that it is part of the new workings of medicine. We see it thus possible that this is something we will see more of in discourses on contested diagnoses in the future.

Most of our comparative material is on female contested diagnosis, and we can only predict workings on such. Yet further research might show that our results are valid for contested diagnosis in general. The fact that we have seen similar workings to what to Brante (2006), Kärfe (2000) and Conrad and Potter (2000) have seen in studies on diagnoses that are not solely female (rather the opposite) would suggest this.

To conclude, we also need to stress that PMDD as a diagnosis should not be seen as caused by trends in medicalisation or biomedicalisation. Rather, we are suggesting that parts of how the diagnosis is constructed can be seen as caused by this.

6.2 Our contribution

Our material shows that the understanding of one-self in terms of biology is foundational for many of the other constructions seen in the material. Biopower is thus a powerful tool enabling and leading to several things – such as making individuals biomedically changing themselves to live up to productive norms, disregard social situations and blame big life events on bodily functions. The way we have seen this exemplified in our material can serve as an example of how biopower works in practice; through individuals adapting to and reproducing the overreaching biomedical discourse.
Our work can be seen to contribute to the field of medical sociology, by exploring current trends of medicalisation and constructions of contested diagnoses. We encourage further research to look more in to the specifics of contested diagnoses, and explore the different norms constructed by different diagnoses (see our discussion).

7 Discussion

We have conducted a qualitative content analysis on articles published in Sweden between 2012 and 2015. Qualitative analyses will always have an element of subjectivity (Bryman 2008). The themes we have seen are strikingly unison despite the media material being of shifting genres, which would suggest reliability. The fact that our findings are very similar to what other research has shown on the construction of PMS, further suggests validity and a reliable result.

The interpretation and analysis of our findings have been made in line with the concepts of biopower and biomedicalisation. This theoretical viewpoint has shown fruitful as it has allowed us to analyse the construction of PMDD in relation to trends and general workings of medicine. It has also offered an understanding of power elements working through the constructions; how such are expressed, to what this might lead and what purposes it might serve. We have been able to look at reproductions of power, and the outcomes of this power exerted, yet the conceptualisation of biopower as working through biomedicalisation does not help us analyse who exerts this power in the first place – or where it comes from. Foucault (2007: 2) stated that biopower is not “self-generating”, so it must originate from somewhere. Taking in to consideration that Foucault saw power as interconnected with knowledge (Bunton and Petersen 1997: xiii), we might need to look at the producers of knowledge to find the executers of power. This would suggest that the power is in the hands of big medical institutions, where research is conducted. It also leads us to believe that pharmaceutical companies are executing a great deal of power, as they fund much research and thus have the power to fund what type of research they see fit (Brante 2006: 73). They also support information groups, and broadcast the results of these through advertisement (ibid.). The media are also producing knowledge, but maybe they are more mediators and co-producers than the executors. If we understand the power being executed on macro levels by big institutions such as medical institutions and pharmaceutical companies, then our research can be seen to exemplify how this power works, or is reproduced, on the micro level.

We see the need, lastly, also to criticise labelling things as “typically female”, and only referring to “women”. We have throughout the thesis referred to what other studies classified as “typically female”. This is not a problem per se, but we want to notify the reader that we have tried to be careful.
in labelling what is “typically female”, and have not related to any behaviours as gendered or typically female nor male (remember that it is the social categories we are referring to) that previous research has not already. One could argue that it is unnecessary to keep doing research that divides men and women, female and male. Because of this being a central theme in our material and previous research, it would have been inconsiderate not do to so. We can highlight however, that queer-perspectives would benefit the research on PMS. Ussher found interesting results by challenging the hetero-patriarchal nature of PMS (1995), and more could be done here. It would also be interesting to see if men with a uterus experience PMS, or if women with no uterus experience it. This could give valuable insights on the social nature of the matter.

7.1 Suggestions for further research

Our research has focused on the construction of diagnosis in media. Further research could benefit from looking at more contextual elements. Who are the women that diagnose with PMDD? Are there patterns in socioeconomic status, age or geographic? This would be interesting in relation to several contested diagnoses. Are there socioeconomic patterns to whom diagnose with certain diagnoses? Is ADHD a middle class diagnosis, and PMDD a working class such (this is only an example, not based on any facts or previous research)? And can this then be seen to explain women measuring themselves to different norms? Following on this, it would also be interesting to look more into whether different female diagnoses create different norms on femininity.

Seeing that a lot of research look to media for the construction of, or discourses on, diagnoses, it would also be interesting to analyse media’s role more explicitly, which Seale suggests (2003). A more hermeneutic approach could for example give a bigger understanding of the producers and recipients of the text (Bryman 2008: 533).

Sociology of diagnoses have stressed the important role of diagnoses and offered several conceptual tools to understand such, for example the term contested diagnosis which we have relied on. Yet they do not explore how contested diagnoses work differently to other diagnoses. We suggest that further research try to update this line of sociology by exploring more explicitly the workings of contested diagnoses, and maybe develop conceptual tools to understand such. In our research we have noticed a few things seemingly particular to contested diagnoses, such as a changing or different role and power of the doctor, illness-narratives becoming disease-narratives through self-diagnoses, and a “not me”-construct.
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