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PERPETUATING PMS:
WHAT SUPPORTS THE STEREOTYPE?

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SUBMITTED TO SCRIPPS COLLEGE IN PARTIAL FULFILLMENT OF THE
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Abstract

This study investigated how the problematic construct of premenstrual syndrome (PMS) is sustained and perpetuated in our culture. A main effect of gender priming on the number of PMS symptoms recalled from a description suggests that priming activates relevant stereotypes, leading to selective attention to stereotype-consistent information, reinforcing the held stereotypes. An interaction between gender priming and type of description (a woman experiencing PMS, a woman experiencing headaches, or a man experiencing headaches) on the number of pathological conditions ascribed to the woman or man described was found. This suggests that gender priming has a restrictive effect on pathologizing, but further research needs to address how pathologization may function to perpetuate PMS.
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Introduction

“What is the stereotype of the premenstrual woman? She is portrayed in popular culture as a frenzied, raging beast, a menstrual monster, prone to rapid mood swings and crying spells, bloated and swollen from water retention, out of control, craving chocolate, and likely at any moment to turn violent” (Chrisler, Rose, Dutch, Sklarsky, Grant, 2006, p. 371).

Given that most women do not resemble this description, how is the stereotype of premenstrual syndrome (PMS) maintained? What mechanisms support and perpetuate it? How do aspects of the way women are socialized into specific gender roles influence and perpetuate the construct of PMS? What might stereotype maintenance processes reveal about its existence?

A Brief History of PMS as a Social Construct

What is PMS, and how has this construct come into existence? Dr. Robert T. Frank, a gynecologist, first introduced the diagnostic category of “premenstrual tension” in 1931. In his definition, he emphasized cyclical disturbances in the latter half of the menstrual cycle, which range from those manifested physiologically, such as headache, backache, abdominal and back pain, water retention, weight gain, fatigue, and nausea, to those manifested psychologically, such as depression, difficulty concentrating, nervousness, irritability, and restlessness (Frank, 1931). In 1953, Greene and Dalton proposed the term “premenstrual syndrome” as a way to include somatic and behavioral components in addition to psychological ones. This broader definition explains PMS as “the presence of recurrent symptoms in the premenstruum or early menstruation with complete absence in the postmenstruum,” (Greene & Dalton, 1953) and reflects contemporary definitions, seem to primarily include irritability, depression, anxiety,
breast swelling and pain, headaches, abdominal bloating, poor concentration, food cravings, lethargy, weight gain and change in libido (Richardson, 1995). However, defining PMS is a point of contention among researchers; definitions of PMS regarding the symptoms, timing, and duration vary greatly among researchers.

**Problems with PMS as a Diagnostic Category**

For such a well-established and commonly known phenomenon, PMS as a diagnostic category is problematic for several reasons. For one thing, more than 150 symptoms have been associated with PMS, and some have even labeled it has a “wastebasket diagnosis.” (Corney & Stanton, 1991; Minkin & Wright, 1996) Another issue with the diagnosis of PMS is reflected in the wildly varying reported prevalence rates, which have been estimated as low as 5% and as high as 97% (Ussher, 2003; Corney & Stanton, 1991). Researchers such as Marván & Trujillo (2010) have suggested that erratic prevalence rates may be explained by several methodological issues: (a) lack of uniformly accepted operational definitions for categorizing premenstrual symptoms, (b) different sample characteristics, (c) the use of prospective or retrospective protocols, (d) different instruments used for assessing symptomatology, (e) different methods used for evaluating changes in symptom severity, (f) and participants’ awareness of menstrual cycle focus of studies.” (Marván & Trujillo 2010)

The instability of PMS prevalence rates is also reflected in a common research finding, which shows that 60-70% of adult women report experiencing some symptoms over their menstrual cycle, “but only 20-50% of those who retrospectively report having PMS show a PMS pattern in prospective reports collected over one cycle and only about
5% do so in two consecutive cycles.” (McFarlane & Williams, 1994, p. 340)

Retrospective studies, which rely on women reporting their symptoms and moods at various phases of their last menstrual cycle, are largely useless because retrospective accounts are unreliable and have not been demonstrated to correlate with other indicators of premenstrual symptoms (Marván & Cortes-Iniesta, 2001). Prospective studies, which use daily self-reports, have often shown lower mean symptomatology scores than retrospective reports. McFarlane and Williams (1994) a 4-month study in which they compared mood ratings recorded prospectively (daily) and retrospectively (one time, at the end of the 4 months). The participants consisted of women on hormonal birth control, women who were not on hormonal birth control, and men. The researchers found that women in the study did not actually experience the classic menstrual mood pattern in prospective mood reports, but when they were asked to recall their moods retrospectively, they reported the typical menstrual mood pattern. In addition, no significant differences were found among groups at any phase of the menstrual cycle, and no significant changes in mood were found over the menstrual cycle for any group. In fact, participants’ moods fluctuated less over the menstrual cycle than over the days of the week. This discrepancy between prospective and retrospective mood reports suggest that perhaps the presence of PMS as a stereotype is more of a cause of PMS than a fundamentally biological explanation.
Alternative Explanations for PMS as a Construct – Social Variables

In light of the problems with PMS as a diagnostic category, alternative explanations become necessary, and several have been explored and proposed by researchers.

Menstruation makes salient that a physiological change is occurring, and it is the deviance from the supposedly stable, constant self that becomes pathologized into the diagnostic category of PMS. Ussher (2004) articulates this idea:

The aim is to rid women of variability in symptomatology over the menstrual cycle. Implicit in this assumption is the notion that subjectivity is consistent, that there is a core that should remain constant, and that any fluctuation in mood, in sensation, in reaction to others, or in bodily experiences, is a failing or a pathology. This is something that features very strongly in women’s accounts of their premenstrual symptoms where change is positioned as a sign of illness. (Ussher, 2004, p. 136)

If the cultural standard is to be emotionally stable and unchanging, it is evident that change in affect is seen as an illness. Because fluctuation in mood is central to the definition of PMS, perhaps the pathologization of emotion in our society helps to explain the perpetuation of this supposed syndrome. Pugliesi (1992) uses a sociological framework to put forth a concept that may explain PMS: the medicalization of emotion. Pugliesi states that women who receive treatment for PMS are generally the most concerned with emotional symptoms, and this trend (of emotion as central to PMS) is also reflected in the frequency that emotional symptoms are reported in the literature with comparison to the frequency that cognitive/behavioral and physical symptoms are mentioned. Emotion takes place within cultural and social constraints, and Pugliesi asserts that

…women and intimates become concerned when emotional experience and/or conduct violates normative expectations and disrupts the fulfillment of role
obligations…The availability of the label and concept of PMS encourages a medical interpretation of these normative transgressions: the medicalization of emotion. (Pugliesi, 1992, p. 137)

According to Pugliesi, women’s social roles often revolve around expressing emotions of nurturance, so when a woman transgresses this and expresses anger, hostility, or other similar emotions, explaining the behavior as out of the woman’s control becomes necessary. A biological explanation such as PMS may function as such. This is performed by both men and women and is perhaps best shown in patterns of attribution that are often made: “…inconsistencies between the environment of conduct and negative mood tends to elicit internal attributions (i.e., biological or psychological explanations) versus external attributions (explanations focusing on the environment or circumstances), as done emotionally expressive behavior in general.” (Pugliesi, 1992, p. 141) Similarly, Slade (1984) found that women experience fluctuations in both positive and negative emotions throughout their menstrual cycles, but patterns of attribution connect only the experiences of negative emotions to PMS and menstruation. Finally, Pugliesi argues that emotional deviance is “an important cue leading to the labeling of others as mentally ill” (Pugliesi, 1992, p. 140), and this type of process may be occurring in the labeling of PMS. Pugliesi asserts that PMS may serve as an explanation for emotional deviance among women, and that this justification enables it to be a medical rather than a moral or behavioral problem.

Why might women label themselves as sufferers of PMS? By doing so, women may reap the benefit of living up to the stereotypical feminine ideal and be able to express anger or other emotions (inconsistent with the feminine ideal) at the same time. PMS is believed to have medical causes, which shifts the responsibility for a woman’s
behaviors during the premenstrual phase from the woman to the biology of women’s bodies, enabling the woman to transgress the constraints of the female gender role.

Cosgrove and Riddle (2006) illustrate this idea eloquently:

Because it is virtually impossible to be both ‘feminine’ and irritable, positioning oneself within the PMS category has a clear psychological advantage: one can continue to live up to an idealized representation of femininity and occasionally fall short of the ideal as long as falling short is the result of an illness. The ‘real me’ or non-PMS self is the one who lives up to the ideal, whereas the PMS self is the disordered aberration. (Cosgrove & Riddle, 2006, p. 48)

Although positioning oneself in this diagnostic category seems beneficial because it may enable a woman to transgress her gendered social role, it in fact prevents a woman’s emotions or behaviors that fall outside of the gender norm to be legitimately considered. In this way, the maintenance of the stereotype of PMS may serve to maintain gender stereotypes and norms. Even when a woman is socially allowed to cross gender norms (by claiming victim to PMS), her actions taken while using a socially sanctioned explanation are often perceived as symptoms of a temporary biological dysfunction, rather than a legitimate product of the environment and the woman’s feelings. This “makes it impossible to take seriously women’s concerns, complaints, and feelings… despite the increased opportunity to express affect, the legitimacy of the affect will always be suspect when it is expressed under the guise of a PMS outburst.” (Cosgrove & Riddle, 2006, p. 51).

Ussher (2004) proposed a similar idea as to why women might self-label themselves as PMS-sufferers. She suggested that women engage in self-policing processes in order to stay consistent with the female gender stereotype, and that this self-policing plays a role in PMS. Self-policing is a mechanism that individuals use to ensure they do not waver from the norm, and Ussher argues that “PMS is the outcome of self-
policing practices, which function to ensure adherence to hegemonic constructions of femininity…which include “the positioning of women as emotional nurturers of others…the juxtaposition of the ‘good’ and the ‘bad’ woman…and the positioning of the woman as closer to nature, with subjectivity tied to the body…” (Ussher, 2004, p. 256)

She argues that women are socialized to sacrifice their own needs for others, and PMS is a way to express that their needs are not being recognized.

Based on these ideas of self-policing and self-surveillance, McKinley (1996) developed a construct called objectified body consciousness (OBC), which reflects feminist theory regarding how the female body has been constructed as an object to be looked at. McKinley uses the concept of OBC to label the experience of one’s body as an object. Higher levels of OBC have been theorized to lead to negative body experiences for women, and three facets have been shown to be important in women’s negative body experiences: body surveillance, internalization of cultural body standards, and beliefs about appearance control. These three components correlate with worse reported symptoms of PMS (Ussher 2004), so although no studies have been done on the relationship between OBC and PMS, it will be hypothesized in the current study that high levels of OBC will also correlate with greater recollection of PMS symptoms that are embedded in descriptions of various targets.

**Alternative Explanations for PMS as a Construct – Stereotype Maintenance Processes**

Stereotypes consist of the knowledge, beliefs, and expectations associated with various groups (e.g., Sherman & Hamilton, 1994; Mackie & Smith, 1998), and a vast
amount of research has been conducted on how and why stereotypes are maintained. An important, well-researched phenomenon is that individuals attend to and encode consistent behaviors more thoroughly than inconsistent behaviors (see Frey, 1986, for a review), maintaining their held stereotypes. This may shed some light on why the stereotype of PMS is sustained and perpetuated—consistent details (for example, experiencing mood swings the week before menstruation) may be attended to and encoded, whereas inconsistent details (for example, feeling happy and energized the week before menstruation), may be left unobserved and unencoded.

In addition to the selective attention and encoding for stereotype-consistent details, research has examined other cognitive biases that may result in the perpetuation of stereotypes. In examining how PMS is sustained despite a lack of medical consensus, Chrisler et al. (2006) have postulated that social cognition maintains the social construction of PMS. More specifically, they have proposed that cognitive biases such as the "illusory correlation (we easily associate random events when certain relationships are expected), illusory optimism (we believe that we are less vulnerable or luckier than other people), the fundamental error of attribution (when explaining the behavior of others, we underestimate situational factors and overestimate dispositional factors)…" (Chrisler et al. 2006) play a role in the belief perseverance of PMS.

While a stereotype is a set of traits or behavioral patterns that all members of a group are assumed to possess, a schema is a conceptual framework that influences the organization and interpretation of information. Researchers have found that people tend to observe and encode information that fits with a schema they have, and disregard or distort information that does not fit with their schema. Seta J., Seta C., and McElroy
(2003) investigated how schemas are maintained through cognitive compensatory processes, and they found that perceivers compensated for an inconsistent action of the target person by altering their attribution concerning the target’s action. They also found that perceivers were likely to compensate for an inconsistent behavior by making extreme stereotypically consistent attributions regarding related group members or by deeming the target an exception and maintaining their general view of group members. For example, in one of the experiments Seta et al. (2003) conducted, there were four groups of participants: one group which read about a minister who sexually molested a young boy and sold heroin to a teenager, who later volunteered to help the March of Dimes; a second group who read about the same inconsistent behaviors of the aberrant minister but were told that another minister, unrelated to the inconsistent actors, volunteered to help the March of Dimes; and finally, two control groups, which were not exposed to inconsistent information about ministers. All four groups were asked to rate the reason why the minister volunteered on a Likert scale, with 1 being “to make a good impression” and 7 being “he is totally concerned about the March of Dimes.” The results demonstrated that participants who read about the aberrant behaviors of the ministered attributed his generosity in volunteering to the dimension that was more consistent with the dispositional attribution of ministers—impressing others—in contrast to the same target control participants. On the other hand, participants in the fellow group member condition (reading about one minister’s aberrant actions and another minister’s generosity) attributed the second minister’s generosity to the dimension that was more consistent with the disposition of ministers in contrast to the control participants. These findings reveal that even in the face of disconfirming evidence, people are likely to
engage in compensatory processes to preserve their schemas, or the set of stereotypes about others that they hold.

Rudman and Fairchild (2004) also investigated the maintenance of stereotypes, focusing on the backlash effect (Rudman, 1998), the phenomenon that violating stereotypes can result in social and economic reprisals. Backlash can be severe for individuals who transgress gender bounds, such as when female leaders exhibit a directive style rather than a participatory style, with the former receiving more negative evaluations from peers (Eagly, Makhijani, & Klonsky, 1992). In one experiment, Rudman and Fairchild (2004) had men and women compete against (and lost to) a same- or opposite-sexed confederate on a computer game task that was either masculine (football knowledge) or feminine (knowledge of children’s developmental skills). After the competition, participants were given the chance to sabotage the confederate. As predicted, individuals who lost the competition to counter-stereotypical targets were more likely to sabotage the confederate, or the winner who deviated from gender stereotypes. In a different experiment, Rudman and Fairchild (2004) found that gender deviants who feared backlash resorted to strategies in order to avoid it, such as deception or gender conformity. This suggests that individuals who deviate from stereotypes, those who may in fact have the greatest potential to challenge stereotypes, may be the least likely to do so due to a fear of backlash from others. Therefore, on both the side of the actor (the one deviating or not deviating from a stereotype), and on the side of the perceiver (the one determining if another is deviating or not), schemas are strongly maintained and reinforced through separate processes. In other words, perceivers punish individuals who do not fit stereotypes, and actors, out of fear of backlash, line up their actions in order to
be consistent with stereotypes. Both parties contribute to this reinforcement, making it
difficult to break the maintenance of stereotypes.

These cognitive biases and related stereotype-maintenance processes have been
well-researched within broad categories, such as gender or race, but little research has
been done on such phenomena with regards to PMS in particular, which is why the
current study aims to investigate which processes preserve the stereotype of PMS.

**Theoretical Basis for Gender Priming**

Semantic priming is a procedure used to examine automatic information
processing, and in particular, to analyze the strength of a relationship between two
concepts. (Mahzarin and Hardin, 1996) For example, priming can reveal the extent to
which beliefs about gender (i.e., gender stereotypes) operate automatically. Researchers
have found that priming a social category, such as the elderly, can elicit stereotype-
consistent behaviors on participants who may not even fit the social category to begin
with. For example, priming for the category of the elderly by showing participants words
associated with old age, such as “gray hair,” or “cane” can result in slower walking in
participants who are not considered to be elderly. (Bargh, Chen, & Burrows, 1996) This
is likely due to people’s propensity to imitate others (Dijksterhuis and Bargh, 2001). The
ideomotor perspective proposes that people’s schemas of social categories contain
behavioral representations that can automatically and unconsciously become behavioral
effects, demonstrated in the subject’s actions, when the schema is activated (Kawakami,
Young, and Dovidio, 2002). A number of studies have demonstrated that subtly priming
participants for a social category influences participants’ behavior and performance
across various tasks. For example, Shih, Pittinsky, and Ambady (1999) found that when
participants were primed for their Asian American identities, they performed better on a
mathematics test, consistent with the stereotype of Asian Americans’ math ability. In the
same study, another group of participants were primed for their identity as women, and
they performed worse on the mathematics test, in comparison to the group primed for
their Asian American identities, as well as a control group. This result also demonstrates
the behavioral effect of priming: participants primed for their identities as women
performed worse on a math test, consistent with the stereotype of women’s lack of
mathematical ability. In the current study, half of the participants will be primed for
gender in order to investigate how gender priming influences the recollection and
interpretation of descriptions of different targets (a man, a woman, and a woman overtly
described as experiencing PMS).

The Current Study

By using the existing research on social variables and stereotype maintenance
processes, this study aims to investigate what mechanisms may function to perpetuate the
construct of PMS. In particular, the current study will analyze the relationship between
people’s sex role internalizations and their schemas related to PMS, as well as the degree
to which individuals attend to information related to PMS depending on the type of target
described.

The purpose of this research is to examine if priming for gender and labeling a
person in a description as experiencing PMS interact. In particular, the research will be
focused on if these two variables interact to influence two things: first, the number of
PMS-related symptoms that were recalled from a description of a person, and second, the number of pathological conditions ascribed to various targets described.

It is hypothesized that there will be an interaction between priming and description on number of recalled PMS symptoms, such that:

(a) Participants who were primed for gender will recall a greater number of symptoms than control participants.

(b) Participants will recall the greatest number of symptoms from the description of a woman experiencing PMS (i.e., the PMS-Woman condition) in both the priming and control conditions.

It is hypothesized that there will be an interaction between priming and description on the number of pathological conditions ascribed to targets, such that:

(a) Participants who were primed for gender will ascribe a greater number of pathologies to targets across all descriptions as compared to control participants.

(b) Participants will ascribe the greatest number of pathologies to the PMS-Woman as compared to the woman described as experiencing headaches (i.e., the Headaches-Woman condition) and the man described as experiencing headaches (i.e., the Headaches-Man condition).

It is hypothesized that scores on femininity will be positively correlated with:

(a) Recall of PMS symptoms.

(b) Assignment of pathologies across all conditions.

It is hypothesized that scores on objectified body consciousness (OBC) will be positively correlated with:

(a) Recall of PMS symptoms.
(b) Assignment of pathologies across all conditions.

Methods

Participants

I recruited 118 participants (16% male, 84% female) through email and Facebook, an online networking site (www.facebook.com). The mean age was 23 with a standard deviation of 7.01. Participants were not personally identified.

Materials

The survey was created using SurveyMonkey (www.surveymonkey.com). Two scales were used in the survey. The first was the short form of the Bem Sex Role Inventory (BSRI; Bem, 1974), which is a self-report measure of sex role orientation. Bem based the BSRI on gender schema theory (Bem, 1981), which proposes that sex typing is derived in part from gender-schematic processing, that is, interpreting information about the self and others through a lens influenced by cultural definitions of masculinity and femininity. There are three sub-scales: Femininity, Masculinity, and Androgyny. The Femininity Scale consists of traits traditionally viewed as more desirable for a woman, the Masculinity Scale contains traits traditionally viewed as more desirable for a man, and the Androgyny Scale includes filler items that are considered neutral traits. Bem has emphasized that the BSRI assesses how people identify themselves psychologically. It has a seven-point Likert scale, with 1 being “never or almost never true” and 7 being “almost always true.” The scale consists of items such as: “Acts as a leader,” “Understanding,” and “Adaptable.” The long form contains 60 items, but the short form, which is the one used in this study, consists of 30 items (10 masculine items, 10 feminine
items, and 10 neutral/androgynous items). The reliability and validity of the BSRI short-form have been explored and established. For example, Holt and Ellis (1998) found strong internal reliabilities of the BSRI for the masculinity scale ($\alpha = .95$) and for the femininity scale ($\alpha = .92$). Masculine adjectives were rated as significantly more desirable for a man than for a woman, and feminine adjectives were rated as significantly more desirable for a woman than for a man, demonstrating the validity of the BEM short-form. The second scale in the survey was the Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996), which measures the degree to which people view their body as an outside observer, or objectify their bodies, rather than thinking about how their bodies feel and what their bodies can do. The OBCS consists of three subscales: Body Surveillance, Body Shame, and Control Beliefs. Body surveillance, a constant self-surveillance to make sure that one’s body conforms to feminine or masculine standards, consists of items such as, “During the day, I think about how I look many times,” and, “I often worry about whether the clothes I am wearing make me look good.” Body shame addresses the shame one feels when he or she does not measure up to cultural standards of beauty that have been internalized by the individual. This subscale consists of items such as, “I would be ashamed for people to know what I really weigh,” and, “I feel ashamed of myself when I haven’t made the effort to look my best.” Finally, Control Beliefs reflect the idea that individuals believe they can control their appearance and can achieve cultural standards of beauty given enough effort. The Control Beliefs subscale contains items such as, “I think a person can look pretty much how they want to if they are willing to work at it,” and, “I can weigh what I’m supposed to when I try hard enough.” Participants rated their agreement with each item on a Likert scale ranging from
1 (strongly disagree) to 7 (strongly agree). The OBCS consists of items such as: “I often compare how I look with how other people look” and “I feel ashamed of myself when I haven’t made an effort to look my best.” The OBCS has been established as a reliable and valid measure. For example, McKinley and Hyde (1996) found that the internal consistencies of the OBCS were moderate to high: Surveillance Scale, .89; Body Shame Scale, .75; and Control Beliefs Scale, .72. In addition, there were strong negative correlations between body esteem and both Surveillance ($r = -.39, p < .001$) and Body Shame ($r = -.51, p < .001$), demonstrating the scale’s validity. Finally, OBCS had a strong positive correlation with both the Appearance Orientation Scale, $r(79) = .64, p < .001$ and the Public Body Consciousness Scale, $r(79) = .46, p < .001$, demonstrating good concurrent validity. In addition to these two scales, the survey had one of three descriptions: a description of a woman experiencing PMS; a description of a woman experiencing frequent headaches; or a description of a man experiencing frequent headaches. The descriptions were created based on pre-testing, which consisted of 10 participants ranking various behavioral/emotional symptoms as more consistent or less consistent with the stereotype of PMS. The traits presented were taken from a list of emotional/behavioral symptoms in a PMS overview on the Mayo Clinic’s website (www.mayoclinic.com), as well as symptoms listed on beinggirl.com, a website dedicated to educating women about their bodies. The participants ranked 10 out of the 20 symptoms listed as being most associated with the stereotype of PMS. Symptoms that at least 6 out of 10 participants believed to be in the top 10 symptoms associated with PMS were used, including: irritability, mood swings, oversensitivity, tearfulness, sad, and out-of-character. These six symptoms were embedded into the descriptions of the woman
with PMS, the woman with headaches, and the man with headaches. All three
descriptions were identical except for the target’s name (Hannah, Lauren, or John), and
except for the first sentence, which stated one of the following: “Lauren (or John), a
student in college, has been experiencing frequent headaches over the past few days” or
“Hannah, a student in college, has been experiencing premenstrual syndrome (PMS) over
the past few days.” The complete descriptions are given in the Appendix. After reading
one of these three descriptions, the participant completed a distractor task, the Faces Test
(Baron-Cohen, Wheelwright, Jolliffe, 1997) in order to prevent rehearsing of the
information they read. The Faces Test is a series of 20 photos, asking the participant to
select the emotion that best represents the face shown (in a forced-choice response
format). After completing this distractor task, participants were asked to do free recall of
any details they could remember about the person described. This was to assess the
number of PMS symptoms that were recalled, one of the dependent variables of the
study. In addition, participants were asked, “Do you believe the person described
exhibited any of the following? (Check as many as apply.”) The response choices
include: “self-absorption,” “drama,” “paranoia,” “anxiety,” “depression,” “bipolar
disorder,” and “none of the above.” This was used to observe differences in the number
of pathological conditions ascribed to the various targets described. Finally, the survey
contained demographic questions regarding age and the gender with which the participant
identifies. The participant then read a debriefing page and was thanked for participating
in the study.
Procedure

Participants were randomly assigned to one of two priming conditions. In the first condition, the gender-priming condition, participants filled out the two scales (the BSRI and the OBCS), priming them for gender, and they then completed the description and recall sections. In the second condition, the control condition, participants completed the description and recall sections and then proceeded to fill out the BSRI and OBCS scales. For the description section, there were three conditions: a woman experiencing PMS, a woman experiencing headaches, and a man experiencing headaches. Participants were randomly assigned to one of these three conditions so that each participant read and performed recall for only one description. Lastly, all participants answered demographic questions regarding the age and gender with which they identify. These questions were at the end to avoid gender priming in the control condition.

Design

This was 2 (gender priming, control) x 3 (woman with PMS, woman with headaches, and man with headaches) between-groups design. The independent variables were gender priming (yes, no), femininity score (high, low), masculinity score (high, low), and Objectified Body Consciousness Scale score (high, low). The dependent variables were symptoms recall score (high, low) and number of pathological conditions ascribed to the target (high, low). All of the variables that were separated into high and low categories were split at the median score, with scores above the median categorized as high, and scores below the median categorized as low.
Results

A 2x3 ANOVA was carried out to determine the effects of priming (priming and control) and scenario description (PMS-Woman, Headaches-Woman, and Headaches-Man) on the number of recalled symptoms. As hypothesized, there was a significant main effect of priming condition, $F(1, 112)=6.48$, $n^2=.055$, $p=.012$, such that participants who were primed for gender ($M=2.31$, $SD=0.96$) recalled a greater number of symptoms than control participants ($M=1.91$, $SD=0.89$). However, there was no significant main effect of scenario description, $F(1, 112)=1.13$, $n^2=.024$, $p=.255$, and, contrary to hypothesis 2, part a, there was no significant interaction between priming condition and scenario description on the recall of symptoms, $F(1,112)=1.97$, $n^2=.034$, $p=.143$. The interaction is shown in Figure I.

![Image](priming_x_description_on_recall.png)

*Figure I. Interaction between priming and description on recall of symptoms.*

A 2x3 ANOVA was also carried out to determine the effect of priming (priming and control) and scenario description (PMS-Woman, Headaches-Woman, and
Headaches-Man) on the number of pathological conditions ascribed to the target. There was no significant main effect of scenario description on the number of pathological conditions assigned to targets, $F(1,112)=2.32$, $n^2=.040$, $p=.040$, such that participants reported a similar number of pathologies across all three descriptions – PMS-Woman ($M=1.07$, $SE=0.16$), Headaches-Woman ($M=1.31$, $SE=0.19$), and Headaches-Man ($M=1.67$, $SE=0.19$). There was, however, a significant main effect of priming, $F(1,112)=7.82$, $n^2=.065$, $p=.006$, such that participants in the control condition ($M=1.55$, $SE=0.14$) assigned a greater number of pathologies to the target than participants in the priming condition ($M=1.04$, $SE=0.15$). There was also a significant interaction between priming and description, $F(1,112)=6.08$, $n^2=.098$, $p=.003$: participants in both the priming ($M=1.26$, $SD=1.13$) and control ($M=0.87$, $SD=1.14$) conditions reported a similar number of pathologies in response to the PMS scenario, $p=.25$; however, participants in the control condition ($M=1.73$, $SD=1.03$) as compared with those in the priming condition ($M=0.64$, $SD=1.15$), reported a greater number of pathologies for the Headaches-Woman description, $p=.006$; participants in the control condition ($M=2.10$, $SD=1.13$) as compared with those in the priming condition ($M=1.07$, $SD=0.88$) also reported a greater number of pathologies for the Headaches-Man description, $p=.006$. The interaction is shown in Figure II.
A bivariate correlation was carried out on femininity, recall score, and number of pathologies ascribed to targets, but no significant correlation was found between femininity and recall, \( r(116)=.044, p=.633 \), nor between femininity and number of pathologies, \( r=.067, p=.472 \). A second bivariate correlation was carried out on OBC, recall score, and number of pathological conditions ascribed to targets. No significant correlation was found between OBC and recall, \( r=.136, p=.141 \), nor between OBC and number of pathologies, \( r=.112, p=.225 \).

Several independent t-tests were carried out to determine the effects of gender on OBC scores, femininity scores, masculinity scores, and recall scores (i.e., recall of PMS-related symptoms). There was a significant mean difference for gender in OBC scores by participants of different genders, \( t(116)=3.26, p=.001 \), such that female participants (\( M=4.22, SD=0.57 \)) scored higher than male participants (\( M=3.75, SD=0.64 \)). The gender differences in OBC are shown in Figure III. There was no significant difference in
femininity scores by participants of different genders, $t(116)=0.86$, $p=0.39$, such that female participants ($M=5.40$, $SD=0.90$) and male participants ($M=5.19$, $SD=0.70$) had similar femininity scores. In addition, there was no significant difference in masculinity scores by participants of different genders, $t(116)=1.00$, $p=0.31$, such that female participants ($M=4.85$, $SD=0.83$) and male participants ($M=4.71$, $SD=0.60$) had similar masculinity scores. Finally, there was a significant mean difference in recall scores by participants of different genders, $t(116)=2.92$, $p=.004$, such that female participants ($M=2.19$, $SD=0.94$) recalled a greater number of symptoms than did male participants ($M=1.53$, $SD=0.69$). Gender differences in recall are shown in Figure IV.

![Figure III. Difference in OBC scores by gender.](image1)

![Figure IV. Difference in Recall scores by gender.](image2)
Discussion

It was hypothesized that there would be an interaction between priming and description on recall, such that primed participants would recall a greater number of PMS symptoms than control participants. A main effect of priming was found, supporting the hypothesis: primed participants did in fact recall a greater number of symptoms than control participants. As found in previous research, priming is an implicit memory effect that elicits stereotypical thoughts or behaviors associated with the category or group that was made salient (Roberts & Gettman, 2004), so participants who were primed for gender may have interpreted the description of someone with PMS-related symptoms in a more gendered way than those who were not primed. In other words, the priming of gender may have activated participants’ gender schemas, and participants may have construed the symptoms presented in the descriptions as gender-related, subsequently recalling a greater number of PMS symptoms.

Contrary to the hypothesis, findings revealed no significant main effect of description and no significant interaction between priming and description on recall. This may be explained by a memory mechanism that appears to function in two different ways, as represented by a discrepancy in the literature regarding whether perceivers recall more stereotype-consistent or stereotype-inconsistent details. Although many studies show that individuals recall details consistent with schemas or stereotypes that they hold (Fyock & Stangor, 1994; Chatard, Guimond, and Selimbegovic, 2007; Frawley, 2008), other studies demonstrate the opposite (Sherman, Lee, Bessenoff, & Frost, 1998; Sherman, Stroessner, Conrey, & Azam, 2005; Wyer & Srull, 1989). Todd, Galinsky, and Bodenhausen (2012) address this incongruity: “…numerous studies have demonstrated a
memorial advantage for inconsistent information (especially on recognition-memory measures that minimize the influence of retrieval strategies and response biases; Sangor & McMillian, 1992).” (Todd et al., 2012, p. 95) It is possible that this discrepancy in type of detail recollection is represented in the current study. Because the targets in the PMS-Woman description and the Headaches-Woman description are both female, the PMS-related symptoms presented are likely consistent with participants’ schemas regarding the female gender role. The same PMS-related symptoms embedded in the Headaches-Man description are likely inconsistent with participants’ schemas regarding the male gender role, since such negative emotional indicators violate cultural ideas of maleness. In other words, participants in the PMS-Woman and Headaches-Woman description recalled an equal number of details, which were consistent with both targets’ gender, and participants in the Headaches-Man description recalled the same number of details, although they were inconsistent with the target’s gender.

It was hypothesized that there would be an interaction between priming and description on the number of pathological conditions ascribed to the target, such that primed participants would ascribed more pathologies to targets than would control participants. In particular, it was proposed that primed participants who read the PMS-Woman scenario would assign the greatest number of pathologies to the target as compared with all other conditions. Findings did not support the hypotheses, and instead demonstrated that control participants ascribed more pathologies to targets than primed participants. This implies that the priming that was executed had a limiting or constrictive effect on participants’ assignment of pathologies to the targets. Completing the OBC scale and BSRI prior to reading one of the descriptions may have made participants more
cognizant of gender pressures and expectations that people face, making participants less likely to pathologize, and more likely to be more lenient towards the targets. Primed participants may have also been more likely to view the targets’ issues as related to gender pressures or expectations, rather than to pathological ailments, explaining why they were less likely to ascribe depression, anxiety, or another condition to targets. Another potential explanation for this finding is that schemas related to gender and PMS were not activated within the control group, and so participants looked for an alternative explanation for the targets’ behavior. For example, a participant may have been more likely to attribute a target’s behavior to depression or anxiety because gender and PMS were not salient in the participant’s mind.

In addition to the hypothesis that primed participants would assign more pathologies to targets than control participants, it was proposed that there would be an interaction between priming and description on total number of pathologies ascribed to targets, such that primed participants who read the PMS-Woman scenario would assign the greatest number of pathologies to the target as compared with all other conditions. Results confirmed that there was an interaction between priming and description on number of pathological conditions; however, it was found that participants in the priming and control conditions reported a similar number of pathologies in response to the PMS scenario. A probable explanation for this finding is that the diagnosis of PMS, as stated in the PMS description, is sufficient to explain the target’s emotional and behavioral symptoms, and no other pathological conditions are necessary to explain the target’s behavior. In the absence of an explanatory basis for the symptoms, people are more likely
to pathologize, but when such an explanation is readily available, no further reasoning is necessary.

Contrary to the hypotheses, no significant correlations were found between femininity, OBC, recall score, and pathologies score. Femininity and recall score were expected to be positively correlated because it was believed that participants high on femininity would have stronger PMS schemas, and therefore would recall more symptoms consistent with those schemas. Similarly, it was predicted that femininity and number of pathologies would be positively correlated. This was postulated because research has shown that women who are more likely to view premenstrual experiences as a pathology are also more likely to engage in self-policing and self-surveillance, which have both been linked with femininity (Ussher 2004). However, neither of these hypotheses was supported, perhaps because the dependent variables, recall of symptoms and number of pathologies ascribed to targets, are not accurate representations of the complexities of individuals’ PMS schemas, or of people’s tendency to view PMS as a pathology. In addition, the pathology question did not assess the degree to which participants viewed PMS as a pathology; rather, it gauged how many other pathological conditions participants assigned to targets. In other words, the number of pathologies participants ascribe to targets does not reflect how much participants perceive their own premenstrual experiences as pathological. In addition, the concepts of self-policing and self-surveillance have been linked in both OBC and PMS, so it was expected that OBC would correlate with recall of PMS symptoms, as well as pathology score. This was not supported by the results, which may be because the dependent variables (recall of PMS symptoms and pathology score) are not synonymous with individuals’ reporting of PMS
symptoms. It is also possible that the construct of OBC has a relationship with PMS that was not captured by the design of this research study. Because no prior research has been done on OBC with regards to PMS, it is difficult to explain this finding conclusively; future research should address this relationship.

Although no predictions were made regarding relationships between gender and other variables in the study, gender differences in femininity and masculinity scores were investigated. Findings showed that femininity and masculinity scores did not differ between female and male participants, which is not consistent with literature on the BSRI (Bem, 1976). Although participants’ education level was not collected, it is reasonable to assume that most participants are currently enrolled in liberal arts colleges (the majority of participants invited to the Facebook event for the survey are Claremont Colleges students), and it may be that such students are less likely to embrace extreme stereotypical gendered traits. A meta-analysis of 63 studies that used the BSRI revealed that women's self-ratings on masculinity have been increasing steadily, and gender differences on the masculinity dimension have been decreasing over time (Twenge, 1997). The desirability for certain traits in men and women may be changing over time, and it is possible that these changes are reflected in the high-achieving sample in this study.

Gender differences in OBC and recall scores were also investigated. There were significant differences between genders in OBC scores and recall scores. Female participants had a higher mean score on OBC than male participants, which is consistent with the literature on OBC (McKinley & Hyde, 1996). In addition, female participants recalled a greater number of PMS stereotype-consistent details than male participants. A
possible explanation for this is that women may be more familiar with what is
stereotypically associated with PMS, particularly because they may experience related
symptoms, which could strengthen the stereotype about PMS that they hold. When
reading a description of someone who is experiencing symptoms associated with PMS,
the female participant’s strong schema about PMS is likely activated, resulting in high
recall of stereotype-consistent details. In contrast, a male participant is likely to have a
weaker schema about PMS because he may not experience the symptoms himself, so he
may be less likely to recall as many stereotype-consistent details as female participants. It
may be that when male participants think of PMS, one symptom, such as “mood swings,”
comes to mind, whereas when female participants consider of PMS, a grouping of
symptoms comes to mind, such as “moody,” “sad,” and “tearful.”

A limitation of this study is that the descriptions may not have been complex or long
enough, and they may not have included all major symptoms that are associated with
PMS. There were six PMS symptoms embedded in the description, and 2.5% recalled
zero symptoms, 25.4% recalled one symptom, 39.8% recalled two symptoms, 25.4%
recalled three symptoms, and 6.8% recalled four symptoms. None of the participants
recalled greater than four symptoms, and the majority of participants clustered around
recalling two to four symptoms, which shows the limited variability in this data variable.
If the descriptions had been longer or more detailed, it is possible that there would have
been more variation in the number of details recalled, which could have influenced
differences between the various conditions. Another limitation is that priming did not
have the expected effect on outcomes, and perhaps this is due to the nature of the priming
process used. Instead of using the BSRI and OBC scales as priming tools, a more
conventional priming technique, such as presenting participants with sentences or images of individuals engaging in gender-stereotypic behaviors may have elicited results more consistent with research on gender priming. A final limitation was that due to the composition and size of the participant sample, some analyses were not utilized because they placed such a few number of participants in each cell. A much larger sample with an even split between female and male participants would have been ideal.

The results found in this study suggest that priming for gender leads to a greater recollection of PMS symptoms, suggesting that it may play a part in perpetuating PMS. Because people are primed for gender in various ways on a daily basis, these findings support the idea that individuals encode information consistent with their held stereotypes (for example, encoding the experience of mood swings prior to menstruation), and disregard information that is inconsistent with their held stereotypes (for example, not attending to experiences of happiness prior to menstruation). Activating stereotypes people hold about PMS by priming them for gender may function to reinforce those stereotypes. The findings regarding ascribing pathologies to targets are fairly inconclusive in terms of implications for how PMS is perpetuated. One interesting finding was that individuals who were primed for gender pathologized less than control participants. This may suggest that priming individuals for gender may make them more cognizant of gender pressures, leading to greater leniency of deviation from social norms that may be unreasonable or unhelpful to individuals’ well-being. However, this finding does not reveal much about how the construct of PMS is sustained, so more research could be done on the relationship between pathologizing and PMS.
Future research should address the many other variables that may play a role in the sustainment of PMS as a social construct, expanding the literature and knowledge about PMS, stereotypes, and schemas. In particular, cognitive biases (such as the illusory correlation and the fundamental error of attribution) have been theorized to play a role in perpetuating PMS, but no research known to the author has been conducted to test this theory. If plausible, it would be interesting and worthwhile for future studies to examine such cognitive biases. Finally, this was the first study known to the author to examine the relationship between OBC and PMS, so future research should further investigate how these variables relate (or do not relate) to one another.
References


Slade, P. 1984. Premenstrual Emotional Changes in Normal Women: Fact or Fiction?


Appendix A

Objectified Body Consciousness Scale (OBC-S)

Please rate your agreement with the following statements on a scale from 1 (strongly disagree) to 7 (strongly agree).

1. I rarely think about how I look.
2. I think it is more important that my clothes are comfortable than whether they look good on me.
3. I think more about how my body feels than how my body looks.
4. I rarely compare how I look with how other people look.
5. During the day, I think about how I look many times.
6. I often worry about whether the clothes I am wearing make me look good.
7. I rarely worry about how I look to other people.
8. I am more concerned with what my body can do than how it looks.
9. When I can’t control my weight, I feel like something must be wrong with me.
10. I feel ashamed of myself when I haven’t made the effort to look my best.
11. I feel like I must be a bad person when I don’t look as good as I could.
12. I would be ashamed for people to know what I really weigh.
13. I never worry that something is wrong with me when I am not exercising as much as I should.
14. When I’m not exercising enough, I question whether I am a good enough person.
15. Even when I can’t control my weight, I think I am an okay person.
16. When I’m not the size I think I should be, I feel ashamed.
17. I think a person is pretty much stuck with the looks they are born with.
18. A large part of being in shape is having that kind of body in the first place.

19. I think a person can look pretty much how they want to if they are willing to work at it.

20. I really don’t think I have much control over how my body looks.

21. I think a person’s weight is mostly determined by the genes they are born with.

22. It doesn’t matter how hard I try to change my weight, it’s probably always going to be the same.

23. I can weigh what I’m supposed to when I try hard enough.

24. The shape you are in depends mostly on genes.

*Items that are reverse scored: 1, 2, 3, 4, 7, 8, 13, 15, 17, 18, 20, 21, 22, and 24*
### Bem Sex Role Inventory Short Form (BSRI – short form)

Please rate yourself on each item, on a scale from 1 (never true) to 7 (always true).

<p>| | | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Defends own beliefs</td>
<td>16.</td>
<td>Have leadership abilities</td>
</tr>
<tr>
<td>2.</td>
<td>Affectionate</td>
<td>17.</td>
<td>Eager to soothe hurt feelings</td>
</tr>
<tr>
<td>3.</td>
<td>Conscientious</td>
<td>18.</td>
<td>Secretive</td>
</tr>
<tr>
<td>4.</td>
<td>Independent</td>
<td>19.</td>
<td>Willing to take risks</td>
</tr>
<tr>
<td>5.</td>
<td>Sympathetic</td>
<td>20.</td>
<td>Warm</td>
</tr>
<tr>
<td>7.</td>
<td>Assertive</td>
<td>22.</td>
<td>Dominant</td>
</tr>
<tr>
<td>8.</td>
<td>Sensitive to needs of others</td>
<td>23.</td>
<td>Tender</td>
</tr>
<tr>
<td>9.</td>
<td>Reliable</td>
<td>24.</td>
<td>Conceived</td>
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<tr>
<td>10.</td>
<td>Strong personality</td>
<td>25.</td>
<td>Willing to take a stand</td>
</tr>
<tr>
<td>12.</td>
<td>Jealous</td>
<td>27.</td>
<td>Tactful</td>
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<tr>
<td>14.</td>
<td>Compassionate</td>
<td>29.</td>
<td>Gentle</td>
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<tr>
<td>15.</td>
<td>Truthful</td>
<td>30.</td>
<td>Conventional</td>
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Appendix C

Description 1

Please read the following excerpt.

Hannah, a student in college, has been experiencing premenstrual syndrome (PMS) over the past few days.

Hannah is outgoing, social, and cheerful. She is involved in many activities on her college campus, and generally performs well in school. She is dual majoring in biology and psychology, and enjoys relaxing and going to parties on most weekends. Her friends have a wide variety of interests, yet her main friend group is tightly knit. For a period of a few days, Hannah’s friends noticed that she was irritable and prone to quick swings in mood. There were one or two incidences where Hannah seemed oversensitive to comments her friends made to her, even leading to signs of tearfulness in Hannah. She appeared sad and acted out-of-character for about 3 or 4 days and then returned to her normal, happy, stable self. Hannah’s friends aren’t sure what to make of what happened.
Lauren, a student in college, has been experiencing frequent headaches over the past few days.

Lauren is outgoing, social, and cheerful. She is involved in many activities on her college campus, and generally performs well in school. She is dual majoring in biology and psychology, and enjoys relaxing and going to parties on most weekends. Her friends have a wide variety of interests, yet her main friend group is tightly knit. For a period of a few days, Lauren’s friends noticed that she was irritable and prone to quick swings in mood. There were one or two incidences where Lauren seemed oversensitive to comments her friends made to her, even leading to signs of tearfulness in Lauren. She appeared sad and acted out-of-character for about 3 or 4 days and then returned to her normal, happy, stable self. Lauren’s friends aren’t sure what to make of what happened.
Please read the following excerpt.

John, a student in college, has been experiencing frequent headaches over the past few days.

John is outgoing, social, and cheerful. He is involved in many activities on his college campus, and generally performs well in school. He is dual majoring in biology and psychology, and enjoys relaxing and going to parties on most weekends. His friends have a wide variety of interests, yet his main friend group is tightly knit. For a period of a few days, John’s friends noticed that he was irritable and prone to quick swings in mood. There were one or two incidences where John seemed oversensitive to comments his friends made to him, even leading to signs of tearfulness in John. He appeared sad and acted out-of-character for about 3 or 4 days and then returned to his normal, happy, stable self. John’s friends aren’t sure what to make of what happened.
Appendix F

Faces Test

On the following pages, you will see a series of faces. Please select the emotion you believe the face is expressing.
PERPETUATING PMS
Appendix G

Recall

Please list any details you can remember from the description you read.
Appendix H

Ascription of Pathological Conditions to Targets

Do you think the person described exhibited any of the following? (Check as many as apply.)

- Self-absorption
- Drama
- Paranoia
- Anxiety
- Depression
- Bipolar Disorder
- None of the above
Appendix I

Demographics Questions

1. How old are you?

2. With which gender do you identify?
Appendix J

Facebook Event Posting

Hi!

I am conducting a survey that examines how particular social variables relate to each other for my senior thesis in psychology, and I would really appreciate your help! If you would be willing and interested in participating in my study, please click the link below for more information about it.

[SurveyMonkey link to my survey]

Please feel free to email me at bbuhaly3181@scrippscollege.edu with any questions or concerns you may have.

Thank you for considering participating in my study!

Best,
Brianna Buhaly
B.A. Candidate of Psychology
Scripps College
Appendix K

Informed Consent Form

You are invited to participate in this research study about how particular social variables relate to each other. The following information is provided in order to help you to make an informed decision about whether or not to participate. If you have any questions please do not hesitate to ask.

This research is being conducted by Brianna Buhaly, a student and a candidate for a B.A. in Psychology at Scripps College. The purpose of this research study is to identify how unique social variables interact with one another in people’s lives. In particular, I am interested in how these variables affect impression formation.

Participation in this study will require approximately 10 to 15 minutes of your time. You must be 18 years or older to participate. You will be asked to answer questions regarding the way you think about yourself and characteristics you would use to describe yourself. You will also be asked to read a short piece describing a person, and you will be asked to identify emotions on the faces of people in a series of photos. The risks of this research are expected to be minimal. If you find that any questions or information make you uncomfortable, you are free to decide not to participate or to withdraw at any time. In the event of any problems resulting from participation in the study, you can seek counseling through a service to search for counselors provided by the American Psychological Association by visiting http://locator.apa.org.

The benefits to your participation in this research include that you may find it interesting to answer the questions provided. It is possible that you may experience no direct benefit from your participation. However, the information gained from this study will help us better understand how certain factors affect impression formations.

No identifying information will be asked for in this study. In the event that any information obtained could identify you, it will be kept strictly confidential. The information obtained in this study may be presented at scientific meetings, but your identity will be kept strictly confidential. You will not be asked to put your name on any of the responses you give during the research. Your responses to the questions we ask you will be anonymous.

Your participation in this project is entirely voluntary. You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigator or with Scripps College. Your decision not to participate will not result in any loss of benefits to which you are otherwise entitled. Your decision to discontinue participation at any time during the study will not result in any loss of benefits to which you are otherwise entitled.

You may ask questions concerning the research before agreeing to participate or during the experiment. If you have any questions regarding this research, you may contact Brianna Buhaly at bbuhy3181@scrippscollege.edu, or the supervisor of this study,
Judith LeMaster, at judith.lemaster@scrippscollege.edu. If you have any questions about your rights as a research subject that have not been answered by the investigator you may contact Pamela Rowland, the Administrator of the Scripps College Institutional Review Board at prowland@scrippscollege.edu.

You are voluntarily making a decision whether or not to participate in this research study. Your acceptance certifies that you have decided to participate having read and understood the information presented.

△ I am 18 years or older, and I have read and understood this information. I wish to participate in this study.
△ I do not wish to participate in this study.

Brianna Buhaly, Principal Investigator
Bbuhaly3181@scrippscollege.edu
Appendix L

Debriefing

Perpetuating PMS: What Supports the Stereotype?

Thank you for your participation in this study. This debriefing is given as an opportunity for you to learn more about this research project, how your participation plays a part in this research, and why this research may be important to society. Please do not discuss this study with anyone else who might also participate in the future. Knowledge about the study may influence their responses and, essentially, invalidate the information obtained from them. (For this same reason, it is important that you tell the experimenter if you knew details about this study before participating.)

As you may have observed, stereotypes about premenstrual syndrome (PMS) are widespread and powerful, despite little concrete evidence regarding its etiology and diagnosis. How is it that stereotypes of PMS are vehemently upheld in the absence of a foundation of medical evidence?

This study is designed to examine how gender priming affects the recall of details consistent with the PMS stereotype. In addition, it observes how the objectification of one’s own body and femininity/masculinity relate to the recall of details consistent with the PMS stereotype. Finally, this study investigates what types of pathological conditions people associate with different described targets, examining if there are differences across descriptions of a man, a woman, and a woman who is overtly described as experiencing PMS (each participant saw only one description).

I hypothesized that participants who were primed for gender would recall more stereotype-consistent details across all descriptions. I also hypothesized that the greatest number of stereotype-consistent details will be recalled for the description of a woman with PMS, the second greatest number of stereotype-consistent details for the description of the woman, and the fewest stereotype-consistent details for the description of the man. In addition, I hypothesized that the greatest number of pathological conditions will be ascribed to the woman with PMS, the second greatest number to the woman, and the fewest to the man. I think that the more people objectify their body and are characterized as feminine, the greater their recollection for stereotype-consistent details, and the greater their ascription of pathological conditions. This research is important in the fields of psychology because it may provide information about how stereotypes are sustained. In particular, this research will help us understand what mechanisms may be supporting the social construct of PMS, and how they may interact with each other.

It is likely that the results of this research will be presented at a senior psychology thesis conference at Scripps College. Again, your individual responses will be kept anonymous during this process. If you have any questions about your rights as a research subject that have not been answered by the investigator you may contact Pamela Rowland, the Administrator of the Scripps College Institutional Review Board at prowland@scrippscollege.edu. In the event of any problems resulting from participation in the study, you can seek counseling through a service to search for counselors provided by the American Psychological Association by visiting http://locator.apa.org. If you are
interested in the results of this study or if you have any additional questions or comments, please contact Brianna Buhaly by email at bbuhaly3181@scrippscollege.edu.

Thank you again for your participation!