

1994

Informational and Attitude Changes Toward P.M.S. as a Function of Viewing an Educational Video and Presenter Gender

Paula J. Kirk

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INFORMATIONAL AND ATTITUDE CHANGES TOWARD P.M.S. AS A
FUNCTION OF VIEWING AN EDUCATIONAL VIDEO AND PRESENTER GENDER
(TITLE)

BY

PAULA J. KIRK

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

MASTER OF ARTS

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1994

YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
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Attitude Changes

Abstract

Subjects were 61 volunteer college women and men randomly assigned to one of three conditions: condition A= viewed video presenting factual information about Premenstrual Syndrome presented by female; condition B= viewed video with identical dialogue, except presented by a male; condition C= control group. Pre and post measures were taken at a ten day interval and a presenter evaluation form was completed by subjects in conditions A and B after viewing the video.

Results indicate the following: First, participants who viewed an instructional video on PMS gained more educational information than those participants who did not. Second, Sex of presenter did not appear to influence the amount of information gained. Finally, an increased understanding of PMS did not influence a more positive attitude toward PMS. Suggestions for further investigation on the subject were to increase population size and diversity as well as using other women's health issues as variables.

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Acknowledgments

I would like to take this opportunity to thank the many people that have encouraged, supported, and stuck by me as I worked toward this goal in my life.

My Instructors at Lake Land College who helped me believe in myself and my abilities. If it had not been for that small Community College and the wonderful people that work there, I'm not sure I would have started this journey at all.

My many new friends (both students and staff) this experience has given me. You are all in my thoughts and I will cherish the good times we have shared. Your friendship, support, and encouragement kept me going through the rough times as well as the smooth.

My Instructors at E.I.U. who were always there when I needed help. You challenged me then gave me the tools to meet that challenge.

My Thesis Committee: Dr. Linda Leal, Dr. Russell Gruber, and Dr. Barbara Woike. You gave me advice and encouragement at all the right times. A special thanks to Dr. Leal for all your time spent proof reading all those papers and listening to my worries about this project. Your efforts are greatly appreciated.

My family who has put up with my hours of studying, calling out for

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dinner, awful moods at exam time, and everything else that changed when I went back to school. You have stuck by me, supported me, and loved me through all of this and I love you all. I know that I could never have succeeded in reaching this goal in my life without your help. A very special thank you goes to my husband, Garrett. Those late nights when you tried to help me understand stats, bringing dinner home, and taking on extra household duties so I could study. I know you were tired and just as busy, but you were always there for me, encouraging and supporting me through whatever I was doing. I love you.

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In 1931, R.T. Frank became the first person to use the term Premenstrual Tension to describe a cluster of symptoms being experienced, on a cyclical basis, by many of his female patients. Dr. Frank had become the first person in the medical community to view the cyclical symptoms of weight gain, water retention, and nervous tension experienced by his patients as a true medical problem. He believed that premenstrual problems were caused by poorly working kidneys and could be relieved if the patient drank more tea and coffee to help the water buildup, took calcium lactate to decrease tension, and magnesium citrate to help the kidneys and bowels work better (Kass-Annesse & Danzer, 1984). Fortunately, sixty years of research has resulted in a better understanding of PMS and more effective treatment methods. Many PMS practitioners advise a treatment program which includes diet changes (such as removing completely or at least reducing the daily intake of red meat, sugar, salt, and caffeine), adding a vitamin/mineral supplement, and, in the more severe cases, a natural progesterone therapy.

Since the publication of Frank's landmark article in the Archives of Neurological Psychiatry, there has been much confusion and controversy over the disorder now known as Premenstrual Syndrome or PMS (Dalton, 1978). Although Ames (1988) suggests there is no single precise definition for PMS,

most PMS practitioners and researchers agree that it is a cluster of physical and emotional changes that affects a woman on a cyclic, premenstrual basis.

Perceptions, complaints, degree of disabilities, and morbidity vary somewhat (Dalton, 1978; Norris, 1983; Yankausky, 1990). However, for diagnosis, the symptoms must be recurrent usually occurring in two of three cycles. There must also be an interval, either free of symptoms or with marked improvement, that usually occurs within the follicular (second half) phase of the cycle (Dalton, 1978; Neimeyer, 1988; Norris, 1983; Osofsky, 1988; Sampson, 1981).

Given the controversy around the precise definition of PMS, it is no wonder that the prevalence of the disorder is difficult to determine as well. Conservative estimates place the incidence of PMS in at least 25% of the female population (Reid, 1981; Wilhelm-Hass, 1984). Still others estimate the maximum numbers as high as 90%, with 5% to 15% having symptoms so severe that their lives are significantly disrupted (Bender, 1986). The inconsistencies in statistics are, in part, due to so many women believing it is "normal" to have complaints monthly so they fail to consider the importance of reporting symptoms in their medical history (Lauersen, 1983; Yankausky, 1990). In a study, by Brooks, Ruble, & Clark (1977), investigating women's expectations, attitudes, and knowledge about menstrual-related changes, 191 women were asked to complete

a questionnaire composed of four sections: 1. the Menstrual Distress Questionnaire was given twice with different instructions both times: (a) complete as if your period will begin in a day or two; (b) complete as if your period will not begin for another 7 to 14 days; 2. Forty-six statements (rated on a 7-point scale) representing five categories were presented and included: (a) beliefs about physiological and psychological concomitants of menstruation; (b) styles of dealing with menstruation; (c) menstrual-related effects on performance; and (d) general evaluation of menstruation; 3. Women were asked to name the two ovarian hormones, to describe the general pattern of hormone fluctuation related to the menstrual cycle, and to specify the effect of oral contraceptives on menstrual related physical and psychological changes; and 4. Questions about personal use of oral contraceptives, length of menstrual period, length and intensity of menstrual flow, and experience of psychological and physical menstrual distress.

Using factor analysis on the 46 statement questionnaire, five different attitude dimensions were identified. These were: 1. Menstruation as a psychologically and physically debilitating event; 2. As a positive event; 3. As a bothersome event; 4. As an event whose onset can be predicted and anticipated; and 5. As an event that does not and should not affect one's behavior. Factor

score means were then calculated by dividing the sums of items by the number of items in each factor. In general, although they did not deny that menstruation had some effects, the data suggested that menstruation was seen as slightly positive and was not perceived as very debilitating or predictable by the women sampled.

The previously mentioned study, however, does not take into consideration that many times women will have symptoms that they don't recognize or relate to premenstrual problems or as "menstrual-related changes" and often are misdiagnosed. Thus, many women would not be aware they are having troublesome premenstrual symptoms. These misdiagnoses are often labeled as thyroid disease, depressive disorder or even psychosis (Atkinson, 1988). Norris (1983) suggests that in extreme cases, the effects of PMS are so far-reaching that it may become difficult to separate the syndrome from the personality thus resulting in confusion of diagnosis.

Another reason for unreliable statistics could be our culture's somewhat negative attitude toward menstruation (Harrison, 1982). These attitudes are not new. Years ago Hippocrates blamed premenstrual tension on "the agitated blood of a woman seeking a way of escape from the womb" (Dalton, 1978).

Attitudes of women and men toward P.M.S. seem to be acquired at a very early age. In a study investigating the effects of menarche on adolescents, it was

found through questionnaires that even premenarcheal girls and young boys have a reasonably well-defined and mostly negative set of attitudes and expectations towards menstruation. Most believed that menstruation is accompanied by physical discomforts, increased emotionality, and a disruption of activities and social interactions. The authors suggest that the results are likely linked to specific aspects of the socialization processes in the menstrual experience (Clarke & Ruble, 1978).

In a study, using both males and females, Brooks-Gunn & Ruble (1986) investigated expectations for menstrual and premenstrual symptoms, attitudes about menstruation, sources of menstrual-related information, and effects of menstruation upon daily activities. Subjects were 239 students from three colleges who filled out a survey containing the Menstrual Distress Questionnaire (measuring expectations for menstrual and premenstrual symptoms and attitudes toward menstruation), the Adolescent Menstrual Attitudes Scale (discovering sources of menstrual-related information) and the Menstrual Attitude Questionnaire (measuring effects of menstruation upon daily activities).

The major findings were as follows:

First, although both males and females believed women experience certain cycle-related symptoms, females reported that women experience more severe

menstrual and premenstrual symptoms (when compared to intermenstrual ones) than males reported, while males believed women experience more severe menstrual than premenstrual symptoms than females believed.

Secondly, males learned less about menstruation from the majority of possible informational sources and rated most sources as being more negative than did the females. Third, males believed that menstruation had more of an effect on women's moods and had a more debilitating effect on women's lives than did females.

Finally, females rated menstruation as more bothersome than did males. It was suggested that men and women differ with respect to some of their attitudes and beliefs about menstrual-related changes because men's and women's sources of information are somewhat different. The majority of the female subjects reported getting most of their information about menstruation from their mothers. The males reported getting quite a bit of their information from female friends and not from their mother or father.

It was also noted that the males may receive menstrual-related information later than females. In addition, males rated their sources of information as more negative than did the females. The authors suggested that this may be because men are socialized to perceive menstruation as more debilitating and/or more of a

negative event than are women. Possible explanations for this were that both women and men may be more uncomfortable talking with men about menstruation and their discomfort may be perceived as, or translated into, negative feelings about menstruation, and/or males and females may have differential access to books or magazines on menstruation (traditional men's and women's magazines in all likelihood, treat menstruation differently).

It is possible that different messages concerning menstruation are transmitted to men and women in terms of the message itself or in the individual's perception of the message. In all likelihood, a combination of both is true and this, in turn, creates confusion and negativism. This being the case, it is no wonder that women are not likely to report symptoms of premenstrual distress to someone, particularly male physicians, if they feel that person would not understand (Ford, 1992).

The purpose of this study is to investigate the possibility of increasing knowledge of PMS by having subjects view a video of a woman or man presenting factual information about P.M.S.. Also, the study assessed attitudes and possible positive attitude changes toward PMS as a function of presenter gender. By increasing one's knowledge of PMS it is predicted that there would also be an increase in understanding of the disorder and this would possibly create

a more positive attitude toward the subject.

An attitude is an evaluation of some object about which an individual has some knowledge (Pratkanis & Greenwald, 1989). Attitudes and beliefs are formed through many routes (Deaux, Dane, & Wrightsman, 1993). Some are formed through direct, personal experience or direct reinforcement. They can also be learned through imitation or social learning and through the object's association with other objects about which attitudes have already been formed (i.e., classical conditioning). Attitudes can also be developed as a person acquires information on a topic (Deaux et.al, 1993).

Attitudes can be acquired from other people (Deaux, et al., 1993), and, as Hovland and his colleagues (1953) suggest, the more believable the source, the more likely there will be a change in attitudes. Since attitudes are learned from others and our own experiences, it is possible then that presenting positive, factual information about PMS could alter (increase positive/decrease negative attitudes) both women and men's attitudes.

It has also been found that communications from high-status people are also more memorable than communications from lower-status people (Holtgraves, 1991). For both of these reasons, it is possible that information about PMS that is presented by a man or woman may have different effects on

subjects in terms of persuasive power and positive attitude change.

Because the subjects will be viewing an informational video about Premenstrual Syndrome given by a woman or a man presenter, the results expected in this study are twofold: First, pretest/posttest difference scores of the group that viewed the video presented by the male are expected to indicate a greater increase of acceptance of information as fact, thus higher scores on the posttest than the group that viewed the video presented by the female; Second, pretest/posttest difference scores should also indicate more positive attitude changes in the group that viewed the video presented by the male.

Method

Subjects

Subjects were 61 students (22 men, 39 women) taken from an undergraduate subject pool and randomly assigned to three different groups. Mean age of subjects was 20 years with the mode being in the 18-19 years range. There was no significant differences in the mean age of the male ($M=20$ years) and female ($M=20$ years) subjects, as evident in Appendix A.

Instruments

The Menstrual Attitude Questionnaire (Brooks-Gunn & Ruble, 1980) was used in part, with additional questions about factual information on PMS. The questionnaire was used to assess the subject's basic information about and attitudes toward PMS. Answer choices were given on a five (5) point scale from "strongly agree" (5 points) to "strongly disagree" (1 point).

Two video tapes containing identical dialogue were made to be presented to the two experimental groups. The tapes contained educational information about Premenstrual Syndrome and were approximately 25 minutes in length. The main difference between the two tapes was that one had a female presenting the information and the other had a male presenter.

Participants in the experimental groups also evaluated the video presenters. Each subject was asked to answer 8 questions to evaluate (on a five point scale from excellent= 1 point, to very poor= 5 points) the presenter of the video they viewed on the basis of the presenter's credibility, influentiaity, likability, self confidence, knowledge about the subject presented, and what degree (Ph.D., MD., Ed.D., MA, R.N., Other) the presenter was thought to have acquired.

Procedure

Each subject in all three (3) groups were asked to fill out the modified information/attitude questionnaire, as a pretest, during the first session (see Appendix A). After filling out the questionnaire, the two experimental groups were told that a local medical facility was developing a new program for presentation to the community and needed "feedback" on their video presentation. The subjects were asked to view the educational video to assess the presentation of the presenter. Based on random assignment, group A viewed the video with the female presenter and group B viewed the video with the male presenter. Group C, the control group, was told there were technical difficulties and that the video could not be seen, but were asked to return in ten (10) days to continue the project.

After a ten (10) day interval, the subjects in all three (3) groups were asked to again fill out the modified information/attitude questionnaire, which was used as a posttest.

Results

Appendix A presents the PMS questionnaire completed by participants and includes mean pretest and posttest scores for each item. Appendix B presents

the presenter evaluation form completed by the subjects in the two experimental groups.

Educational Information

For the statements related to educational information, statements that were "true" were scored as correct if subjects indicated either "agree" or "strongly agree." False statements were scored as correct if subjects selected either "disagree" or "strongly disagree." Difference scores were calculated by subtracting each subject's mean pretest score from his/her mean posttest score (see Table 1).

Insert Table 1 about here

A 3 (Condition: female, male, and none) by 2 (Sex: female subject, male subject) analysis of variance of difference scores indicated a significant main effect for group, $F(2,55)=9.491$, $p=.0001$. Follow-up Tukey tests indicated no significant difference between the two groups that viewed the video. As evident in Table 1, both experimental groups gained significantly more educational information about PMS than did the control group. Neither the main effect for

Sex nor the Sex x Group interaction were significant.

Attitude Change

Difference scores were calculated for the items that assessed attitude toward PMS. These scores were calculated by subtracting each subject's mean pretest score from her/his mean posttest score (see Table 2).

Insert Table 2 about here

Even though it appears that the group that viewed the female presenter had more of an attitude change toward PMS, a 3 (Group) by 2 (Sex) ANOVA found only one significant finding for Sex, $F(1,55) = 4.798$, $p = .033$. Overall, men's attitude changed very little when compared to women. Even though it appears, in Table 2, that men in the control group as well as men who viewed the male presenter, changed their attitudes in a negative direction from the pretest to the posttest, the group by sex interaction was not significant, neither was the main effect for group.

Presenter Evaluation

Responses to the evaluation of the presenter were scored 1 (to indicate

excellent) to 5 (very poor). A low score, therefore, indicates a positive rating.

Mean ratings are presented on Table 3.

Insert Table 3 about here

A 2 (Condition: female presenter, male presenter) by 2 (Sex of subject) analysis of variance revealed a significant group by sex interaction, $F(1.36) = 4.23$, $p = .047$. As evident from Table 3, men who viewed the male presenter rated him more negatively than did the women in that group. The main effects for Group and Sex were not significant.

The majority of participants in both experimental groups, 16 for the group that viewed the female presenter and 15 in the group that viewed the male presenter, indicated that they felt the presenter was a medical doctor (see Appendix A).

Internal Reliability

Alpha coefficients indicated that the internal reliability for the educational information section of the questionnaire was low to moderate ($\alpha = .63$) for the pretest and moderate ($\alpha = .77$) for the posttest. Alpha coefficients for the

attitude assessment section revealed moderate internal reliability ($\alpha=.81$) for the responses to the pretest and good internal reliability ($\alpha=.87$) for the posttest responses.

An alpha coefficient of .83 for participant evaluation of video presenter suggests moderate to good internal reliability.

Discussion

Results of the present research indicate that participants who viewed an instructional video on PMS gained more educational information than those participants who did not. This indicates that it is possible to present realistic information about PMS to large audiences via a taped presentation.

Contrary to prediction, however, sex of presenter did not appear to influence the amount of information gained. One reason may be that, as indicated in Appendix B, the majority of participants in both groups viewed the presenter as a medical doctor and the credibility of the information presented may not have been questioned. Although no professional or educational information about the presenters was provided during introductions both female and male college students viewed the female presenter as a physician. It is an encouraging note this finding in that both the presenters were given equal status. Secondly, sex of

presenter also may not have mattered because factual, noncontroversial material was presented in a straightforward manner by both presenters. This may be why students in both experimental groups rated the presenter as very knowledgeable about PMS.

The prediction that an increased understanding of PMS would influence a more positive attitude toward the subject was not confirmed. Control group attitudes did not vary significantly from those of the experimental groups. Although male attitudes changed very little, there was a trend for more overall attitude change with the female presenter. More substantial support for this trend would require increasing the number of subjects to more clearly define this trend in future studies. Overall, the present results indicate that gaining factual information on one occasion was not enough to change male college student's attitudes about PMS.

Presenter evaluations indicated that males rated the male presenter lower. This further supports Brooks-Gunn & Ruble (1986) finding regarding males being more uncomfortable talking with other males about menstruation. The discomfort of men in the present sample may have been translated into negative evaluations of the presenter. The female subjects may not have been uncomfortable hearing a man talk about menstruation because they are likely used

to male physicians talking about female issues and did not see this as an unusual situation. Males may not be used to discussing this topic with other males and found this to be an unnatural and, therefore, uncomfortable situation.

Limitations of this study, such as a limited population (i.e., college students at one university) and a need for a larger sample size should be addressed in future research on this subject. Also, other health issues could be addressed in future studies to investigate whether sex of presenter is influential in causing men to feel uncomfortable when female issues are discussed. For instance, both female and male college students could view a presentation on an issue related to women (e.g., PMS) as well as another discussion by the same presenter on an issue that is gender neutral (e.g., diabetes).

The present results indicate that both men and women benefit from presentations on facts related to PMS. Further research is needed in order to determine how to effectively present this information so that it results in not only the learning of facts, but a positive attitude change as well.

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Table 1

Mean difference scores for Educational Information as a Function of Group and Sex

	Female	Male	Overall
Group 1	5.93 (14)	5.29 (7)	5.71
Group 2	6.42 (12)	3.71 (7)	5.42
(Control) 3	0.92 (13)	1.50 (8)	1.14*

*note. $p < .001$.

Table 2

Mean difference scores for Attitude Change as a Function of Group and Sex

	Female	Male	Overall
Group 1	2.34 (14)	2.14 (7)	2.28
Group 2	2.75 (12)	-1.14 (7)	1.32
(Control) 3	2.00 (13)	-0.75 (8)	0.95
Overall	2.35 (39)	0.05* (22)	

*note. $p < .05$.

Table 3

Mean scores for Presenter Evaluation as a Function of Group and Sex

	Raters		
	Female	Male	Overall
Presenter:	-----		
Female	2.72	2.55	2.67
	(14)	(7)	

Male	2.41	3.07*	2.65
	(12)	(7)	

Overall	2.58	2.81	
	(26)	(14)	

*note. $p < .05$.

Appendix A

Please read the following directions carefully before you begin! Read each question carefully. Mark all answers on the computer sheet only. DO NOT put answers on this test. Please answer all the questions honestly; all information will be kept confidential.

1. Please indicate:

a = female b = male

N=(39)N=(22)

2. Indicate your age group as:

scored (1) a = 18 - 19 yrs. (4) d = 24 - 25 yrs.

(2) b = 20 - 21 yrs. (5) e = 26 yrs. or above

(3) c = 22 - 23 yrs.

group A males=1.28

group A females=1.57

group B males=1.29

group B females=2.08

group C males=1.14

group C females=1.14

overall =1.24

=1.58

3. Indicate estimated family yearly income:

a = 15,000 or below c = 25,001 - 35,000 e = 45,001 or above

b = 15,001 - 25,000 d = 35,001 - 45,000

For remaining questions use the following answer choices:

a=strongly agree b=agree c=undecided d=disagree e=strongly disagree

****(Educational information scored: correct=1 incorrect=0)**

Educational Information mean pretest scores:

Condition	Condition	Condition	Women	Men
1	2	3		
9.52	9.95	11.05	10.95*	8.82

note*p=.01

Main effect for condition not significant.

Sex by Condition interaction not significant.

4. Premenstrual Syndrome (PMS) is a physical disorder with psychological aspects. **pretest= .69** **posttest= .89**

5. Anxiety, irritability, mood swings, and crying for no apparent reason are common symptoms of PMS.

pretest= .85 **posttest= .87**

6. Cold sores, migraine headaches, seizures, and asthma attacks are also symptoms of PMS.

pretest= .11 **posttest= .64**

7. Charting symptoms for 2 to 3 cycles (months) is important in diagnosing true PMS. **pretest= .46 posttest= .77**
8. There are over 150 individual symptoms associated with PMS.
pretest= .38 posttest= .70
9. "Premenstrual magnification" is a diagnosis used when a chronic illness seems to get worse premenstrually, but never really disappears.
pretest= .36 posttest= .48
11. The predominate theory accounting for the cyclical nature of PMS symptoms is the "Hormonal theory", which suggests an imbalance of the hormones estrogen and progesterone during the first half of the cycle.
pretest= .03 posttest= .08
12. Just because an individual may occasionally have premenstrual symptoms, it does not mean she will have PMS.
pretest= .66 posttest= .67
13. Self-help and lifestyle changes have been found to be successful in managing PMS symptoms.
pretest= .70 posttest= .87
14. A blood test can determine if an individual has PMS.
pretest= .41 posttest= .57

15. Which symptoms an individual has is more important than their timing in the menstrual cycle.

pretest= .34 posttest= .39

17. Hormones, in a woman's body, are produced every 20 minutes.

pretest= .23 posttest= .49

18. PMS is often misdiagnosed as a thyroid disorder.

pretest= .10 posttest= .43

19. The first step and foundation for treating PMS is self-education.

pretest= .87 posttest= .89

20. Eliminating fluctuations in blood-sugar levels is critical in managing many PMS symptoms.

pretest= .46 posttest= .70

22. An individual with PMS should drink lots of coffee and other caffeinated beverages. **pretest= .70 posttest= .72**

23. Alcohol has no effect on PMS symptoms.

pretest= .70 posttest= .80

24. It is sometimes necessary for an individual to undergo a hysterectomy to relieve symptoms of PMS.

pretest= .16 posttest= .31

25. Many physicians prescribe antidepressants or tranquilizers to control symptoms of PMS.

pretest= .56 posttest= .62

26. Taking oral contraceptives is often beneficial in managing symptoms of PMS.

pretest= .03 posttest= .26

28. Tubal ligation (having one's "tubes tied") has been found to actually trigger or exacerbate (make worse) symptoms of PMS.

pretest= .08 posttest= .33

29. To be considered true PMS, symptoms must disappear or dissipate with the onset of menstruation.

pretest= .28 posttest= .41

30. PMS usually gets more severe with age and each pregnancy.

pretest= .18 posttest= .41

31. Most women have some premenstrual symptoms.

pretest= .90 posttest= .92

Mean P.M.S. Attitude Pretest Scores:

Condition	Condition	Condition		
1	2	3	Women	Men
22.48	24.00	23.05	24.97*	19.91

note * $p < .001$

Main effect for condition not significant.

Sex by Condition interaction not significant.

Attitude scored: (a=1 b=2 c=3 d=4 e=5)

10. Men shouldn't have to know about female physiology
or problems that may arise during a woman's cycle.
pretest=4.38 posttest=4.43
16. Most women make too much of the minor physiological effects of
menstruation. **pretest=3.00 posttest=3.54**
21. Premenstrual tension/irritability is all in a woman's head.
pretest=3.90 posttest=4.11
27. Women who complain of premenstrual distress are just using that as an
excuse. **pretest=3.75 posttest=4.15**
32. A woman who attributes her irritability to her approaching menstrual
period is neurotic.
pretest=3.85 posttest=3.63
33. This questionnaire has no significance because "PMS" does not really
exist.
pretest=4.60 posttest=4.53

Appendix B

PRESENTER EVALUATION

Please indicate your answers to the questions below as:

a=excellent b=good c=average d=poor e=very poor

score= (1) (2) (3) (4) (5)

(group A= female presenter; group B= male presenter)

1. How believable was the presenter? group A= 2.29 group B= 2.16
2. How influential would the presenter be in the community?
group A= 3.10 group B= 3.21
3. How influential would the presenter be with peers?
group A= 3.14 group B= 3.05
4. How likable was the presenter? group A= 3.33 group B= 3.21
5. How knowledgeable was the presenter?
group A= 1.43 group B= 1.68
6. How self-confident was the presenter?
group A= 3.43 group B= 3.00
7. How trustworthy was the presenter?
group A= 2.19 group B= 2.37

8. What degree does the presenter have?

	group A= 2.43	group B= 2.53
	(female presenter)	(male presenter)
scored	<u>A</u>	<u>B</u>
1 a=Ph.D. (Doctor of Philosophy)	n=1	n=0
2 b=MD (Medical Doctor)	n=16	n=15
3 c=Masters Degree	n=0	n=0
4 d=R.N. (Registered Nurse)	n=2	n=2
5 e=Other	n=2	n=2