

Pathologizing Your Period

Despite a lack of evidence, the psychiatric establishment has made extreme premenstrual distress a recognized disorder—and a boon to Big Pharma.

BY PAULA J. CAPLAN

ARE YOU UNHAPPY? BLOAT-ed? Is it hard to concentrate? Do you have food cravings? Breast tenderness?

If you read the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), you will find your symptoms listed under "premenstrual dysphoric disorder" (PMDD). In other words, because of those symptoms, a therapist or doctor could label you as having a mental disorder.

The DSM is the bible of psychiatric diagnosis, used by nearly every hospital, clinic, doctor and insurance company, as well as Medicare and Medicaid. Since PMDD first was mentioned in the DSM in 1987, people have received the mistaken impression that it's real and that it's an illness. With the manual's fifth edition currently in preparation, that notion seems likely to be strengthened rather than discouraged.

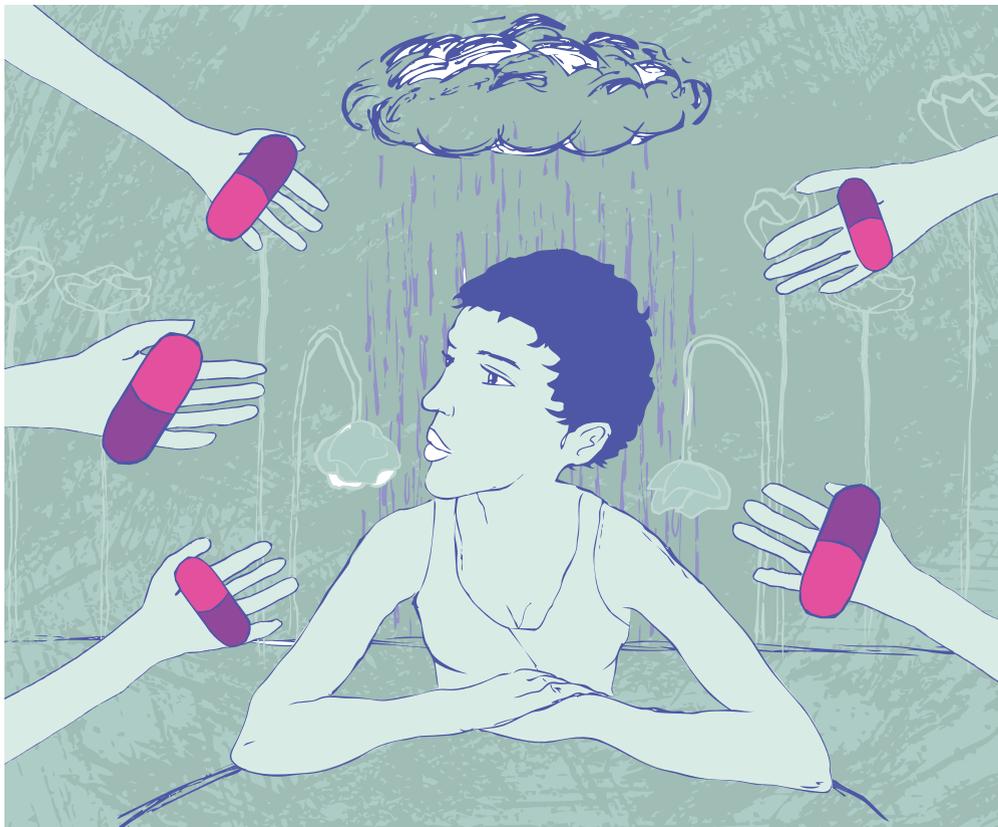
Contrary to popular opinion, the creation and use of psychiatric categories is rarely based on solid science, as I learned when I served on two DSM committees. The absence of science leaves a void into which every conceivable kind of bias has been found to flow—including sexism. The DSM's own PMDD committee reviewed more than 500 studies for the 1994 edition and concluded that no high-quality research supported the existence of PMDD, yet PMDD was placed in the manual anyway.

Do some women report feeling worse before their periods than at other times of the month? Certainly, although in some countries and cultures more than others. Premenstrual discomforts are also more often reported by women who were sexually abused as children, are struggling with abuse or harassment, or are just plain overburdened. But that is worlds away from a *mental illness*.

What helps these sufferers? Research has shown that they can find relief through changing eating patterns, intake of vitamins and minerals, exercise, self-help groups and, when possible, leaving hurtful situa-

tions or dealing with past abuse. Even women who say they are moodier premenstrually rarely display anything close to the levels of irritability, anger or violence displayed by many men, yet the DSM includes no parallel with PMDD such as "testosterone-based aggressive disorder."

In the mid-1980s, two powerful DSM authors proposed adding PMDD to the next edition of the manual. It would represent an extreme form of PMS—the popularly accepted "syndrome" of physical and emotional symptoms between ovulation and menstruation. To qualify, it would have to include five familiar



PMS-type symptoms (sore breasts, headache, “tightness of fit of clothing, shoes or rings”), at least one of them a “mood disorder,” such as feeling hopeless, “on edge,” self-deprecating, irritable, angry or tearful. No one keeps comprehensive records of how often a PMDD diagnosis is given, but based on PMDD committee estimates, approximately half a million American women could be given the PMDD label.

Quick to spot the misogyny in PMDD, individuals and organizations representing millions of people—spearheaded by feminist psychiatrist Teresa Bernardez—sent petitions and letters. The publicity led then-DSM head Robert Spitzer to create an appendix for “proposed diagnostic categories needing further study” and place PMDD—then called late luteal phase dysphoric disorder (LLPDD)—there. In the next edition of the DSM, published in 1994, the category remained in the appendix but was renamed PMDD and was now classified as a depressive disorder—though one can meet the PMDD criteria without being depressed. Never did the DSM include a warning to practitioners to avoid using the label.

Hundreds of researchers have tried unsuccessfully to prove that women are more likely to have mood problems premenstrually than at other times. University of British Columbia researcher Christine Hitchcock says, “Something like half of women say they have premenstrual problems, but when you ask them to keep daily ratings of their moods, the data don’t reflect that.” Another study showed that *men* identified PMDD symptoms in themselves as commonly as women did.

Despite this, when Eli Lilly and Company’s patent on antidepressant Prozac was about to expire, the phar-

maceutical giant successfully asked the Food and Drug Administration to approve it to treat PMDD, providing a patent extension worth millions. (In stark contrast, the European Union’s equivalent of the FDA concluded that the research showed PMDD was *not* a well-established disease entity and criticized pertinent drug-company-sponsored research.) Eli Lilly repackaged Prozac in pink and purple and rechristened it the feminine-sounding Sarafem. Ads for the drug featured women looking crazed when unable to extricate one grocery cart from a row, or unaccountably enraged at an apparently gentle husband.

As the Prozac patent extension expired, other drug companies rushed to market similar products. In explanatory materials, they specifically listed *physical* problems associated with menstruation for some women, such as breast tenderness or bloating, and added a list of mood problems from the PMDD list that virtually every human being experiences. Even the National Institute of Mental Health website muddies the distinction between PMS and PMDD. This is called “category creep,” a way of deeming increasing numbers of people mentally ill.

The PMDD mood symptoms are also listed for menopause, although they are caused at menopause by *deficiency* in the hormones whose increase supposedly causes PMDD. I half-jokingly predicted that we would soon hear about premenarcheal dysphoric disorder between a baby girl’s birth and her first period, thus pathologizing women’s moods from birth to death.

Frantic to be loving, nurturant and serene, women learn to pathologize *themselves*, often ignoring the real causes of their upset. It seems less daunting to say, “It must be hormon-

al!” than to begin the frightening process of looking at underlying causes and realizing, for instance, “I need to leave this job—or relationship.” Many have claimed the PMDD label for themselves and asked for medication, hoping for a quick solution.

Although preparations for the 2012 edition of the DSM (DSM-V) began in 1999, there is no longer a PMDD committee. Instead, the Mood Disorders Work Group will have input, along with, possibly, the Gender and Cross Cultural Study Group and the General Medical Interface Study Group. Work-group members may not directly receive more than \$10,000 of industry funds per year, but they will have PMDD advisors who only need *disclose* industry income and connections, and may provide data from their own research, even if it is drug-company-financed. Drug-money ties are a concern because, as one university researcher put it, “PMDD is a diagnosis looking for a drug.”

Women should be wary of believing claims that high-tech research has now proven that PMDD is real. We should also advocate a national conversation—even congressional hearings—about the often hidden, devastating consequences of simply being given diagnostic labels such as PMDD. Finally, we should stop pathologizing ourselves and other women and help each other look at what’s really behind our feelings. ■

PAULA J. CAPLAN, PH.D., is a clinical and research psychologist, and formerly head of the Centre for Women’s Studies in Education at Ontario Institute for Studies in Education. She is author of *They Say You’re Crazy: How the World’s Most Powerful Psychiatrists Decide Who’s Normal* (Da Capo Press, 1996) and is currently a nonresident fellow at the DuBois Institute, Harvard University.