The Controversy of PMDD as a Disorder

Premenstrual Dysphoric Disorder (PMDD) shocked many when it made its debut as an officially diagnosable psychiatric disorder in 2013. After years of waiting within the “Conditions for Further Study” section of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), PMDD was “upgraded” to an official disorder in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) (American Psychiatric Association, 1994; American Psychiatric Association, 2013). In a time when science is held as the foremost discipline of truth, PMDD’s inclusion in the manual that psychiatrists and psychologists use to diagnose their patients has significant ramifications. And because only women can be diagnosed with PMDD, the ramifications of its classification as a psychiatric disorder have much to do with how we view “normal” versus “abnormal” female functioning and the role of menstruation and hormones in women’s mental health.

PMDD has faced strong resistance from feminist scholars who see possibly devastating sociocultural and medical dangers for women who are given diagnoses of the disorder. Though its supposed existence is not exactly common knowledge—unlike that of premenstrual syndrome (PMS)—the debate surrounding its validity as a disorder creates one of the most passionate rifts between psychiatry and feminist scholarship today. The controversy of PMDD’s classification as a psychiatric disorder
revisits an important question in the critical examination of mental illness: Is mental illness purely biological or can culture influence which symptoms we come to consider pathological?

What is Premenstrual Dysphoric Disorder?

Premenstrual Dysphoric Disorder (PMDD) is currently classified as a depressive disorder in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5). Produced by the American Psychiatric Association (APA), the DSM-5 places PMDD in the same category as the more commonly recognized and accepted Major Depressive Disorder. PMDD’s essential features are “the expression of mood lability, irritability, dysphoria, and anxiety symptoms that occur repeatedly during the premenstrual phase of the cycle and remit around the onset of menses or shortly thereafter.” A woman must exhibit a minimum of five of the DSM-5’s listed symptoms in order to qualify for a diagnosis of PMDD (American Psychiatric Association, 2013).

A-1 provides the full diagnostic criteria for PMDD as it appears in the DSM-5. This is the criteria currently in use by mental health professionals to diagnose women with PMDD.

Though many of the symptoms and even the diagnostic process of PMDD are similar to those of Major Depressive Disorder, one notable difference is that symptoms of PMDD usually only persist for the week before menstruation. This is in contrast with a major depressive episode, in which symptoms must last consistently for two weeks or longer to qualify for a diagnosis (American Psychiatric Association, 2013). The average
duration of an “episode” in a woman suffering from PMDD is only six days per month (Yen, et al., 2014). The APA does stress, though, that PMDD should not be assigned as a diagnosis to women who may simply be experiencing premenstrual exacerbation of other disorders (American Psychiatric Association, 2013).

**Treatment for PMDD**

Selective serotonin reuptake inhibitor (SSRI) antidepressants are considered the first line of medical defense when treating PMDD (“Adjunctive quetiapine,” 2015). Some women choose to take SSRI antidepressants all through the month, while others choose only to take them during the time that they normally experience symptoms. Other possible treatments include oral contraceptives (with a shortened, or without any, pill-free interval), herbal remedies, and diet and lifestyle changes (Thielen, 2015).

Women who experience severe inhibition and diminished functioning due to PMDD may choose the surgical treatment of a complete hysterectomy with bilateral oophorectomy and hormone replacement. Though the treatment is radical, women who undergo the procedure do normally experience full relief of PMDD symptoms and see a dramatic improvement in quality of life (“Treatment Options,” n.d.). While women who undergo hysterectomies to treat PMDD find relief through the treatment, the fact that women experience enough distress from their symptoms to willingly undergo surgery for treatment indicates how important it is that psychiatrists be certain of its legitimacy as a disorder rather than a cultural phenomenon.
Premenstrual Dysphoric Disorder vs. Premenstrual Syndrome

PMDD is often described as a more severe form of Premenstrual Syndrome (PMS); however, they are two separate phenomena. Although the symptoms of PMS and PMDD are similar, a woman need not display the minimum five symptoms in order to receive a diagnosis of PMS. A diagnosis of PMS also does not immediately suggest the presence of affective symptoms (American Psychiatric Association, 2013). Women experiencing symptoms such as breast tenderness, abdominal pain, joint and muscle pain, bloating, changes in appetite, sleep disturbances, and acne, among others, may be eligible for a PMS diagnosis with or without the presence of affective symptoms (Johnson, 1987).

The greatest variance between PMS and PMDD is in prevalence. PMS is significantly more prevalent than PMDD. In a recent meta-analysis of 17 different studies, the pooled prevalence of PMS was nearly half (47.8%) of menstruating women. This study took data from several international studies into account, in order to calculate the global percentage of women exhibiting PMS (Direkvand-Moghadam et al., 2014). PMDD is far less common. In a study of a randomly selected group of rural and urban American women, which the APA cites as “the most rigorous estimate of premenstrual dysphoric disorder,” the prevalence was only 1.3% (American Psychiatric Association, 2013; Gehlert et al., 2009).
A History of Pathologizing Women

Historically, women have been viewed as abnormal or even ill when they display emotions or behaviors outside what is considered appropriate for their gender. Even medical professionals and psychologists are not immune to the influence of culturally rooted gender stereotypes. This is the concern for many feminist scholars who identify PMDD as an extension of the overarching diagnosis of hysteria (Ussher, 2013).

Today, “hysteria” is defined as “a psychoneurosis marked by emotional excitability and disturbances of the psychic, sensory, vasomotor, and visceral functions,” or “behavior exhibiting overwhelming or unmanageable fear or emotional excess” (Hysteria n.d.). But in the 18th and 19th century, hysteria was the most commonly diagnosed illness among women (Ussher, 2013). Derived from the Greek word for “uterus,” hysteria’s recognition as an illness can be traced back to Hippocrates’ time (North, 2015; Tasca et al., 2012). Even before Hippocrates gave hysteria its official name, the Ancient Egyptians treated symptoms that they believed to be caused by spontaneous migration of the uterus within the body as early as 1900 BC (Tasca et al., 2012). Women’s odd physical, emotional, and behavioral symptoms were believed to be the result of the uterus becoming “physically displaced from its normal position in the pelvis” creating symptoms in whichever parts of the body to which it “wandered” (North, 2015).

Treatments for hysteria ranged from the quizzical to the undoubtedly cruel and unusual, often serving more as punishment than medical care. Hippocrates described
hysteria as an illness resulting from the lack of a normal sex life. He recommended that women promote uterine health with regular sexual satisfaction—within the confines of marriage, of course—evidencing long-lived biases that women must marry in order to be regarded as “normal.” Centuries later, the Greek physician Soranus would recommend that women recover from hysterical diseases by living out their lives in abstinence. Other cures and punishments included purges, leeches, herbal remedies, sedation, exorcism, trial for witchcraft, and in some cases death sentences (Tasca et al., 2012).

For centuries, hysteria was used to categorically discriminate against people, mostly women, who exhibited nearly any symptoms which deviated from socially acceptable behavior. By the late 19th century, almost any malady a woman suffered from could be attributed to hysteria. Depressed mood, disordered eating, anger, anxiety, tearfulness, fatigue, chronic pain, limps, and even “fits” resembling seizures could all warrant a diagnosis of hysteria. Further, women considered idle and self-indulgent and who defiantly demanded privacy and independence were at risk for diagnoses of hysteria (Ussher, 2013). To many physicians, psychologists, philosophers, and other men in positions of great power, hysteria was viewed as the natural state of women (Tasca et al., 2012; Ussher, 2013). Feminist concerns about the reemergence of an exclusively female psychiatric disorder, especially as it is associated with the relatively uncontrollable menstrual cycle, stem from fears justified by what seems like a continuation of pathologizing women in order to control or punish them for deviating from the assigned female gender role.
Support in Favor of the Argument for PMDD as a Disorder

The first question opponents to any mental disorder’s classification in the DSM usually ask is “Who decides what should be considered a disorder?” The answer is fairly simple: the DSM task force. In the case of the DSM-5, a long list of advanced professionals in medicine, public health, psychiatry, psychology, and a few other disciplines decide what doctors and mental health professionals should recognize as a diagnosable disorder. As one may suspect, the majority of the professionals on the list are men (American Psychiatric Association, 2013).

Regardless of the gender of those on the DSM-5 task force, the group only officially includes disorders for which there is supporting evidence from multiple peer reviewed studies. This section summarizes some of the supporting evidence for PMDD’s legitimacy as a psychiatric disorder. It is important to note that scientific claims are often mistaken for “truth” in Western culture, but even scientists themselves admit their inability to ever prove that something is true. Within this essay, the studies I outline serve only as support for the legitimacy of PMDD as a disorder, not incontrovertible evidence of it.

Neurological Differences in Women with PMDD Compared to Women Without PMDD

Studies using neuroimaging techniques have confirmed a difference in brain function in women with PMDD compared to healthy women. In particular, a 2013 multi-modal study used functional magnetic resonance imaging (fMRI) and positron
emission tomography (PET) to compare the brains of women with PMDD to those of asymptomatic women. The subjects were studied under three different manipulated hormonal conditions: “ovarian suppression induced by the gonadotropin-releasing hormone agonist leuprolide acetate, leuprolide plus estradiol, and leuprolide plus progesterone.”

Both the fMRI and PET imaging confirmed abnormal functioning in women with PMDD under all three hormonal conditions. Specifically, women with PMDD showed abnormalities in working memory activation in the dorsolateral prefrontal cortex. Moreover, the abnormality that a subject with PMDD exhibited was related to the symptoms she experienced, the severity of symptoms, her age at onset, and disease burden (Baller et al., 2013).

**PMDD in Different Cultures**

The DSM-5 rejects the possibility of PMDD being a culture-bound syndrome, stating that researchers have observed diagnosable PMDD in studies of women in the United States, Europe, India, and Asia. Studies also have not established clear differences in rates of PMDD between women of different racial backgrounds. The DSM task force feels it is more likely that culture may influence “frequency, intensity, and expressivity of symptoms and help-seeking patterns.” (American Psychiatric Association, 2013). For example, noticing that specialty clinics for premenstrual syndromes were almost exclusively attended by white women, Stout et al. (1986) observed the premenstrual symptoms in women of a more representative community-
based sample. The data did not suggest any discernable difference in the prevalence of severity of symptoms, showing only slight differences in the types of symptoms, exhibited by black women versus white women (Stout et al., 1986).

**Abnormality in Serotonin 1A Receptor in Women with PMDD**

Cases of depression and suicide have been associated with observed alterations in the 5-HT1A receptor, a receptor linked to the processing of serotonin. This abnormality suggests a genetic predisposition to some mood disorders. In another study which utilized PET scans to observe the brain function of women with PMDD, researchers found that the binding potential of 5-HT1A in the raphe nuclei showed “a smaller change from the follicular to the luteal phase in women with PMDD.” This abnormality indicates a likelihood that women with PMDD have genotypic abnormalities affecting their 5-HT1A receptors like persons with depression (Yen, 2014).

**Support for the Argument Against PMDD as a Disorder**

Feminists against the classification of PMDD as a disorder have concerns about a disorder of which only women are capable of receiving a diagnosis. Linking a mental disorder to menstruation, a natural bodily function experienced by most premenopausal women, perpetuates the social perception of women becoming irrational, emotional, and sometimes dangerous due to their natural body chemistry. And while the DSM-5 claims that PMDD has been observed in other cultures outside the United States and Europe, it’s possible that Western culture still contributes to the
types of symptoms women complain of before menses. Meanwhile, classifying distressing premenstrual symptoms as a disorder invites negligent caregivers and friends and families to dismiss a diagnosed woman’s complaints as symptomatic rather than reasonable responses to poor conditions in her life.

**Differences in Presentation of PMDD Across Cultures**

One of the studies that the DSM-5 lists as support for the assertion that PMDD is not a culture-bound syndrome is a study of self-reported premenstrual symptoms in a population of women in Japan. Though the study did find that women in Japan were eligible for diagnoses of both PMS and PMDD, the DSM fails to mention that the study also found a lower prevalence of both syndromes in Japanese women compared to Western women. What’s more, the researchers themselves note that this difference in prevalence may be due in part to differences in culture. They also note that higher fat diets in Western women may be the cause of their greater likelihood to experience premenstrual distress (Takeda et al., 2006). In fact, diet changes is considered a natural treatment option to relieve some of the symptoms of PMDD (Thielen, 2015).

In other populations of Asian women, the premenstrual symptoms they complain of are more commonly physical symptoms such as “water retention, pain, fatigue, and increased sensitivity to cold.” Western women are more likely to complain of the mood dysregulation characteristic of PMDD (Browne, 2015; Ussher, 2013). Additional research also suggests that the more time that women of ethnic minorities spend in the United States, the more at risk they are of developing PMDD (Browne,
The correlation between time spent in the United States and a woman’s risk of developing PMDD indicates that Western culture may be a key contributor to negative premenstrual experience.

The positive correlation between Western culture and the likelihood of developing PMDD presents the possibility that the symptoms are not actually defective functioning, but adaptations to a woman’s cultural environment. The fact that that same culture deems these adaptations inappropriate does not necessarily mean that they are maladaptive or pathological.

**A PMDD Diagnosis May Ignore the Causes of Women’s Complaints**

A particularly worrisome finding is that women with diagnoses of PMDD are statistically more likely than individuals in the general population to have experienced abuse, problems in their relationships, and mistreatment at work. The prevalence of lifetime sexual and physical abuse in women with PMDD is greater than 60 percent (Browne, 2015). This is more than double the prevalence of lifetime physical, sexual, or psychological intimate partner abuse in all women, which is 29 percent (Tracy, 2016). Women’s distress in the week before menses may not be due to maladaptive responses to natural bodily changes after all; the distress may actually be a reasonable emotional response to poor conditions in their lives.

Browne (2015) expresses concern that diagnosing a woman who is responding to real issues in her life with PMDD in turn blames the woman (the victim) for her negative emotions rather than the abuser(s) that caused them. A woman diagnosed
with PMDD then faces the burden of correcting her own disorder rather than the abuser facing the burden of correcting his or her own behavior.

**Positive Response to Treatment Does Not Prove the Presence of a Disorder**

Though women diagnosed with PMDD show differences in serotonin receptors compared to supposedly healthy women, the influence of serotonin reuptake inhibitor (SSRI) antidepressants on the processing of serotonin is less established (Yen, 2014; Browne, 2015). Browne (2015) points out that confirming PMDD’s existence through observation of desirable results in diagnosed women who take SSRIs is faulty logic. Studies which reveal negative effects of SSRIs on healthy individuals indicate the failure in supporting the hypothesis that the drugs target serotonin effectively (Browne, 2015).

The failure to support the appropriateness of SSRIs for treating irregularities in serotonin levels certainly raises questions on the logic of using SSRIs as tools for confirming illnesses. Even more, it communicates a frightening incaution on the part of psychiatrists who continue to prescribe SSRI antidepressants as first-line treatment for a shoddily confirmed illness (“Adjunctive quetiapine,” 2015).

**Further Questions**

The interrogation of PMDD’s legitimacy as a psychiatric disorder stems from questions that scholars have been asking regarding gender, class, power, and culture for decades. This skepticism could easily be extended beyond the realm of PMDD itself.
The controversy associated with its inclusion in the DSM-5 raises many more questions like the following.

**Could Men Experience Similar Mood Dysregulation Related to Their Hormonal Cycles?**

Women’s hormonal cycles are more discussed and recognized in part because menstruation serves as observable evidence that their bodies are undergoing cyclical changes and also because of historical prejudices against women and their presumed emotionality in response to their hormones. However, men do experience hormonal cycles as well. A daily cycle in men’s testosterone levels has been established—their testosterone spikes in the morning and decreases throughout the day. And these cycles are thought to be related to men’s natural circadian rhythms.

Some scientists have worked to find evidence of monthly hormonal cycles in men, similar to those of women. A few studies have found support, but none have been widely replicable (Engber, 2015). But if a monthly cycle does eventually become identifiable in men, could that open the door for them to become eligible for diagnoses of PMDD or a similar male-exclusive disorder? It’s possible that we simply know too little about male hormonal cycles to study or even have the motivation to study how their hormones affect their moods.
Is the Question of PMDD’s Legitimacy Part of the Larger Question of Whether Mental Illness as a Whole Could be a Social Construct?

Some scholars have argued against the legitimacy of the very concept of mental illness as a whole, pointing out that people in positions of power are the ones who supposedly determine what sorts of behaviors and emotions ought to be considered “normal.” If PMDD is not worthy of the title of “psychiatric disorder,” could none of the disorders laid out in the DSM be worthy of their assumed legitimacy?

Social constructivist theorists believe that psychiatry frames mental illness diagnosis as objective, but that professionals subjectively select relevant information to confirm a psychiatric formulation that ignores patient’s own perspectives. Patients’ own participation in their diagnosis is limited for the sake of psychiatric reporting (Isreeli, 2014). It’s possible that the easier targets PMDD provides for criticism (the gender disparity, the unflattering similarities to hysteria diagnoses, the inadequate amount of research on it) make it possible to ignore the bigger picture, which is that mental illness in general may be a social construction to control those that deviate from cultural norms.

Women Deserve More Research and More Trust

The debates over PMDD’s placement in the DSM-5 between mental health professionals and feminists—both on behalf of struggling women—have remained quiet, not extending into mainstream pop psychology discourse. And truthfully, there isn’t often much news regarding the disorder. Perhaps this lack of hype is
understandable as the prevalence of PMDD is lower than those of the widely discussed Major Depressive Disorder (7 percent), Social Anxiety Disorder (7 percent), and Posttraumatic Stress Disorder (3.5 percent). But the nearly sensationalized disorder Schizophrenia has a lifetime prevalence of only 0.3 percent to .07 percent and Anorexia Nervosa (another disorder associated mostly with women) has a twelve-month prevalence of only 0.4 percent (American Psychiatric Association, 2013). Why then is the research on Premenstrual Dysphoric Disorder so sparse?

Combing through the limited amount of research on a disorder that affects more people in the United States than Schizophrenia and Anorexia Nervosa combined is a bleak indication of the consideration being afforded to these suffering women. As the state of research on PMDD stands, an unbecoming portrait of neglect is beginning to emerge. Despite biological evidence for PMDD’s existence, adequate research on social and environmental influences is necessary to ensure that women receive help for the true causes of their distress. Both mental health professionals and feminists alike should communicate their concerns by extending the simple courtesy of listening to women, trusting their experiences, and giving them a say in their mental health care.
Appendix

A-1 Diagnostic Criteria of Premenstrual Dysphoric Disorder
As it appears in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5) (American Psychiatric Association 2013)

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.

B. One (or more) of the following symptoms must be present:
   1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
   2. Marked irritability or anger or increased interpersonal conflicts.
   3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
   4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

C. One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms from Criterion B above.
   1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
   2. Subjective difficulty in concentration.
   3. Lethargy, easy fatigability, or marked lack of energy.
   4. Marked change in appetite; overeating; or specific food cravings.
   5. Hypersomnia or insomnia.
   6. A sense of being overwhelmed or out of control.
   7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating,” or weight gain.

Note: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).
F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (Note: The diagnosis may be made provisionally prior to this confirmation.)

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).
Sources


