

# Psychological Premenstrual Symptoms as a Clinical Diagnosis: An Ethical Review

Isabelle Carren-Le Sauter

“No I don’t remember any women apart from someone that I was maybe in a relationship with, not just someone I was working with, coming up and saying...I mean, at times I’ve suspected that’s why they’ve gone home, or not feeling very well or whatever, but I don’t remember anyone ever saying that. It’s not something that people openly come out and say, is it?”

-Laws, 1990, quote from man

## **Introduction**

Throughout most of history, there has been a certain amount of taboo involved in the discussion of the female menstrual cycle. There is certainly something unnerving about the idea that, every month, women lose about 70-80ml of blood. There are also hormonal fluctuations during the cycle, which have other effects such as mood changes and physical discomfort. It seems that much of the current stigma is related more to these side effects than the actual menstruation itself, and they have come to be known as premenstrual syndrome, or PMS. Though many are aware of this syndrome in a colloquial sense, it is in fact a real disorder called Premenstrual Dysphoric Disorder, or PMDD. It is currently listed in the DSM-IV under the Depressive Disorders NOS (not otherwise specified), meaning it is a legitimate diagnostic disorder. This is helpful in that psychologists are recognizing the problems women have with their menstrual cycle and allowing them to get help, but there are many downsides that come along with having the diagnosis of PMDD in the DSM. Should PMDD be included in the DSM? What are the consequences?

## **Menstruation**

A woman experiences menstruation for about 5 days every month. The uterus develops a lining in preparation for pregnancy, and if the woman does not become pregnant, the uterus sheds its lining (exiting the body through the vagina) to develop a new lining for the following

month. The menstrual cycle begins somewhere around age 12, and continues until about age 50 when menopause begins.

### **A History of Menstruation**

For centuries, menstruation was taboo, not only as a topic of conversation (which is still the case today), but in general (Delaney, 1976). Women in many societies were thought to emit “mana,” or “threatening supernatural power,” while they were menstruating, and were therefore separated from society. There are many myths as to the properties of menses; “the Mae Enga believe that contact with menstrual blood or a menstruating woman will ‘sicken a man and cause persistent vomiting, ‘kill’ his blood so that it turns black, corrupt his vital juices so that his skin darkens and hangs in folds as his flesh wastes, permanently dull his wits, and eventually lead to a slow decline and death” (Delaney). There have been positive beliefs about the effects of menses; it has been thought to cure leprosy, warts, birthmarks, gout, goiter, hemorrhoids, epilepsy, worms and headache. However, these beliefs were the exception, and one of the more prominent descriptions came from Pliny’s Natural History:

Contact with the monthly flux of women turns new wine sour, makes crops wither, kills grafts, dries seeds in gardens, causes the fruit of trees to fall off, dims the bright surface of mirrors, dulls the edge of steel and the gleam of ivory, kills bees, rusts iron and bronze, and causes a horrible smell to fill the air. Dogs who taste the blood become mad, and their bite becomes poisonous as in rabies. The Dead Sea, thick with salt, cannot be drawn asunder except by a thread soaked in the poisonous fluid of the menstruous blood. A thread from an infected dress is sufficient. Linen, touched by the woman while boiling and washing it in water, turns black. So magical is the power of women during their monthly periods that they say that hailstorms and whirlwinds are driven away if menstrual fluid is exposed to the flashes of lightning (Pliny, 7:549) (Wijngaards)

Even today, women are treated differently during their menses. Many religions have laws about menstruating women. The Orthodox Jewish faith requires a “niddah” or a separation of husband and wife during her “unclean” period (Whelan, 1975). This period lasts from a few

days before her menses to seven days following, when she must undergo a purifying ritual bath to lie again with her husband. During the niddah, they may not make any kind of physical contact, and if a woman finds any kind of staining, from either vaginal or uterine bleeding, she is to consult a religious advisor and abstain from sexual activity for seven days following the end of the bleeding. What is interesting to note here is the several days of no contact leading up to the woman's period; why would that be if the woman has not even started her period yet?

Another religion that has very specific rules regarding the menstrual cycle is the Muslim religion. They take their beliefs from a section of the Qur'an:

“They question thee (O Muhammad) concerning menstruation. Say: It is an illness, so let women alone at such times and go not in unto them till they are cleansed. And when they have purified themselves, then go in unto them as Allah hath enjoined upon you. Truly Allah loveth those who turn unto Him, and loveth those who have a care for cleanness. (QS. 2:222)

Finley mentions that the word translated to ‘illness’ in this translation should actually be defined as ‘something that causes vulnerability’ (Finley, 1998). Because women are considered unclean when they are menstruating, and therefore a ‘threat to holiness,’ they are not allowed to fast or pray during Ramadan, and they are also not allowed to perform sexual intercourse for seven days after bleeding, followed by a ritual washing (Whelan, 1975).

Hindu and Buddhist traditions have similar restrictions. If a Hindu woman on her period, considered a pariah, even thinks about the gods, it is a sin. The presence of a woman at a Buddhist shrine at any time taints it. (Golub, 1992) There are other horrifying practices of malnourishment, complete social ostracism and degradation in other religions and cultures, which are still practiced today.

### **Current Public Views of Menstruation**

Though these are very culturally specific views on menstruation, it seems as though many people have conservative views on menstruation. There was a TAMPAX survey done in 1981 asking Americans for some information regarding their beliefs about menstruation and there were some very interesting statistics (Golub, 1992). 20% of men and 24% of women believe menstrual pain is psychological rather than physical. Over 50% of both men and women believe they should not have intercourse while menstruating. About one third of men believe that women are affected by their period in the workplace. And finally, 39% of men and 31% of women said that menstruation affects a woman's ability to think. There seems to be a common belief that menstruation significantly affects and changes women, but more interestingly, it seems as though males believe this more strongly than females. In a study done by Brooks-Gunn and Ruble on college students, "while females perceived symptoms to be more severe, males perceived menstruation to be more debilitating and to have more of an effect on moodiness" (1986).

### **The Physiology of Menstruation**

The cycle begins with the follicular phase, which starts at day one of bleeding. The endometrium (the lining of the uterus) is quite thick at this point, full of nutrients and fluids meant to nourish an embryo. If there is no embryo (fertilized egg) to put in the uterus, estrogen and progesterone levels will be low causing the lining to be shed, which is when menstruation occurs. The hypothalamus releases follicle stimulating hormone (FSH), which will stimulate the growth of several follicles, each of which contains an egg. Levels of FSH begin to decrease around day 7 and only one of the follicles continues to grow, while estrogen levels increase, and the remaining follicles begin to break down. Around day 13 or 14, LH levels increase dramatically, causing the follicle to rupture and release the egg, the ovulatory phase. The egg is

then pushed down the fallopian tube, where it can be fertilized. The luteal phase begins right after ovulation, and lasts until the end of the cycle. During this phase, the ruptured follicle becomes what is known as the corpus luteum, which produces very large amounts of progesterone, causes the endometrium to thicken. The corpus luteum is formed in preparation of fertilization of the egg, but if the egg is not fertilized, it degenerates after 14 days and the cycle begins again. There are a lot of hormonal changes during the cycle, particularly in the luteal phase: the rise in progesterone, along with a rise in estrogen levels in this period cause many bodily changes such as slight increase in temperature and widening of the milk ducts in breasts (often causing breast tenderness). (Golub, 1992, Taylor, 1976, Rosenblatt, 2007)

### **What is PMS?**

Premenstrual syndrome (PMS) is a blanket term, used to refer to the symptoms a woman experiences leading up to her menstruation. These symptoms are varied and there is a large spectrum as to how severely they are experienced from woman to woman. Common symptoms can be broken down into 3 categories: physical, behavioral, and mood. Common physical symptoms include swelling, breast tenderness, aches, headaches and bloating or weight changes. Behavioral symptoms include sleep disturbances, appetite changes, poor concentration, decreased interest in previously enjoyable activities and social withdrawal. Some common mood symptoms are irritability, mood swings, anxiety, tension, depression and feelings of lack of control (Freeman, 2003). Many women identify with having symptoms from each of these categories at one point or another; incidence rates of PMS range from 20% to 90%. (Golub, 1992) Delaney et. al. say that they believe most women have experienced symptoms of PMS, including that PMS symptoms are “real rather than imaginary” (Delaney, 1976). There are people who believe that believe PMS does not exist, or at least, should not affect women in such

a significant way, but to any woman who has experienced these symptoms, this statement would seem obvious, and many people recognized some change in women throughout their cycle. In her studies on male views of menstruation, Laws asks men about their experience hearing about periods in the work place. She found that it seemed to be a relatively open topic amongst males in public settings, and particularly in the workplace, because men seem to attribute bad moods or harsh attitudes in women to being on their period (note that they believe the moodiness occurs during a woman's period and not after) (1990). Another interesting finding in her interviews was that men had only heard of menstrual pain on the rare occasion that a woman would call in sick because of it. Laws also brought up a study by Merves (1983) where women were asked if they had ever been asked about having their period. 52 percent said they had been asked by someone they did not know, and they were generally asked things such as "are you on the rag" because they were being "bitchy." (1990) The way symptoms are perceived in the public eye is baffling. One man even mentioned he didn't realize PMS involved physical symptoms of pain; he had only been exposed to the mild depression and irritability. Unfortunately, the lack of knowledge about menstruation and PMS extends to the female sex as well.

### **Premenstrual Symptoms Diagnosed**

The concept of symptoms associated with the menstrual cycle as a clinical diagnosis was realized by Dr. Robert Frank in 1931. (Rodin, 1992) He called it Premenstrual Tension (PMT), and it encompassed the physiological and emotional symptoms that occurred in the week leading up to the beginning of the period. The physical symptoms included headache, backache, abdominal pain, breast fullness and discomfort, weight gain, abdominal distension, fatiguability and nausea, while the emotional symptoms included depression, difficulty concentrating, nervousness, irritability, restlessness and general emotional tension. In 1953, Dr. Katherine

Dalton defined the same symptoms by the term premenstrual syndrome. She has since defined 3 patterns in which these symptoms present themselves throughout the menstrual cycle. The first is four days prior to menstruation (premenstruum), which seems to be the most common time for women to experience symptoms. The second pattern involves symptoms at the time of ovulation which remit within a day or two and then return about 7-10 days prior to menses and continue through the third day. The third pattern also begins at ovulation, but the symptoms continue to increase in severity until the beginning of menses. However, Dr. Dalton's findings are not concrete. Even she has come to realize the term 'premenstrual syndrome' is a misnomer because PMS can occur "whenever there is a pathological variance in levels of estrogen and progesterone during the cycle." (Rodin, 1992) There has been a lot of research done on the topic of defining PMS. Some believe that PMS can only occur prior to the onset of menses, and any symptoms that occur after that must be due to a different disorder. It seems as though there really is no set time period in which symptoms must occur for it to clinically be labeled. Despite a lack of coherence in the definition, however, clinical terms have been set for a diagnosis.

In 1982, the Food and Drug Administration defined PMS as "A recurrent symptoms complex that begins during the week prior to menstruation and usually disappears soon after the onset of the menstrual flow." (Golub, 1992) Then in 1983, the National Institute of Mental Health contributed this: "a diagnosis of premenstrual syndrome should be made when symptom intensity changes at least 30 percent in the premenstrual period (six days before menses) compared with the intermenstrual period (days 5-10 of the cycle) for two consecutive months." (Leibman, 1990) Then in 1985, the DSM-III came out with a category including the affective symptoms of PMS which they called Late Luteal Phase Dysphoric Disorder, or LLPDD. Appendix A has the DSM-III criteria for the disorder (Spitzer, 1989). Finally, in 1994, later



republished in 2000, the DSM-IV included Premenstrual Dysphoric Disorder or PMDD, as an example of a depressive disorder not otherwise specified. Appendix B has the DSM-IV-TR criteria for the disorder. (Htay, 2009)

Beginning with Dr. Frank's PMT diagnosis, the previously mentioned diagnoses for premenstrual symptoms have been based in the emotional side of PMS. However, there is a separate diagnosis specifically for the physical symptoms as opposed to the psychological ones. The diagnostic criteria for PMS established by the *International Classification of Diseases, 9th Revision* state that PMS symptoms begin during the luteal phase, peak right before the beginning of menstruation, and stop during the onset of menses or shortly after that. (Dell, 2004) It is listed under gynecologic disorders, and symptoms (of which there are well over 100) include breast tenderness, bloating or weight gain, food cravings, mood swings, headaches, irritability, depression and decreased interest in activities.

When looking at the original diagnosable set of symptoms described by Dr. Frank as PMT, it seems as though many women would be able to identify with these symptoms. However, as the diagnosis became more defined, less and less women fit into the criteria. In the case of LLPDD, only about 5% of PMS sufferers would receive the actual diagnosis. (Rodin, 1992) Then in the case of PMDD, there is a small range of 2-9% prevalence (Offman, 2004, Freeman, 2003, Endicott, 1999). Contrarily, it has been shown that up to 90% of women experience premenstrual symptoms. Does this diagnosis even have a purpose? What are the positive and negative effects of having a diagnosis for the psychological symptoms of 'PMS'?

### **Arguments in Support**

#### **Female Suffering**

There are many women who suffer from these symptoms. As mentioned above, the percentages of women who experience premenstrual symptoms range from 20-90%. Even 20% is a very large part of the population, and though some women only experience some minor cramping and maybe a little irritability, the statistics for the different diagnosable forms of PMS described above show that about 5% of these women experience extreme emotional symptoms. In 1997, a survey of 1045 menstruating women in three countries showed the extent to which premenstrual symptoms interfered with home life, social life and work. Among the American subjects, 30% reported distress in their relationships with their partner and children, 17% reported interference with their social lives and 14% reported interference with work. (Freeman)

In 2000 a study of 242 was conducted in which women who met criteria for PMDD were tested for psychosocial functioning using the Social Adjustment Scale (SAS), and the scores were compared with samples of women showing community norms on their SAS tests, and women showing major depression. These women all showed normal SAS scores during the follicular phase of the menstrual cycle. However, when they were tested during the luteal phase, their scores were far closer to those scores taken from women with major depression. (Freeman, 2003)

It is quite apparent from this data that this is a real and serious disorder that affects the daily life and functioning of many women, but in order for these women to receive any recognition for this disorder, diagnostic criteria must be available. Without a real diagnosis, women with these problems may not be taken seriously, and may not be able to receive treatment. This violates the principle of beneficence, because these women who are suffering should be able to receive treatment so they can function properly in their daily lives.

### **Biological Aspects**

In order to be sure women's suffering is real, we must look at the biological basis for this disorder. Unfortunately, little is understood about the exact effects of the changes hormones make on the female body throughout the cycle. Dr. Frank was the first to suggest that estradiol played a role in causing premenstrual symptoms. (Backstrom, 1983) Progesterone deficiency has also been suggested, though progesterone therapy has not been shown to be an effective treatment for the disorder. What we do know is that symptoms of negative mood have been shown to correspond with the luteal phase of the menstrual cycle, beginning when ovulation ends, increasing in severity, and peaking during the last 5 days before menstruation begins, (Backstrom) despite the fact that the levels of hormones associated with these times have been variable across many studies.

Though an effective treatment has not yet been found for premenstrual symptoms through the regulation of hormones, efficacy has been shown in treating PMDD patients with Selective Serotonin Reuptake Inhibitors (SSRIs), an antidepressant used in the treatment of Major Depressive Disorder (MDD). (Endicott, 1999) Endicott et al, in their article on PMDD as a clinical entity, brought up the differentiation between the pathophysiology and treatment of PMDD and the treatment of MDD with SSRIs. The role of serotonin in PMDD is not fully understood, so it could be the change in serotonin levels, or it could just be related to serotonin transport. If the latter is the case, Endicott suggests low doses of serotonin transport blocker might be the most effective treatment. The way SSRI's work in PMDD is very different from the way they work in treating depression. Differences include increased efficacy of intermittent dosing, more rapid onset of response, maximal response at low doses, decreased efficacy of non-SSRIs, and more rapid recurrence of symptoms following discontinuation of treatment. (1999) So we know there is something going on that is distinct to the luteal phase, and it is not

attributable to another disorder if the treatment effects are different. And one very important addendum to that concept is women with diagnosable PMDD but without any other disorders can be identified. This means we cannot use the argument that it is simply a comorbid disorder from which the emotional symptoms arise.

### **Arguments Against**

#### **Is PMS Real?**

Though there definitely appear to be physiological symptoms associated with the hormonal fluctuations throughout the menstrual cycle, it still seems unclear whether there are also emotional symptoms. A study by Sigmon, et. al. on gender differences in self-reports of depression, shows definite differences in the reported cases of depression (2005). Obviously, depression and premenstrual symptoms do not manifest in the same ways, and they have very different chemical causes. However, the purpose of the article was to show that it is response bias, which causes men to underreport depressive symptoms. It is possible that depression rates are actually equal in men and women, but that the symptoms associated with depression are perceived as less masculine, thereby causing men to keep their emotions to themselves so as not to seem weak or dependant. Studies show the stereotypical belief is that “women express and experience more depression and anxiety than men do...[and] men are typically viewed as more agentic or instrumental than women are.” (Sigmon, 2005) Sigmon’s main finding was that when men were told there would be no follow up to the study, they reported higher rates of depression than when they knew they would later be contacted, which may indicate that men viewed the follow-up contact as having more consequences for reporting depression, so they conformed to stereotypical behavior, revealing less emotion. Another finding of this study was that women rated the importance of paying attention to feelings higher than men did. This, through the

stereotypical lens that men have less emotion than women, when applied to premenstrual symptoms may imply that men have similar symptoms women do, and simply do not report them. In fact, a World Health Organization study found that women's perception of their pain may be caused by cultural influences, that because PMS is labeled a disorder, feeling sick around the time of menstruation is normal. This perception may increase likelihood for a woman to feel symptoms. (ablongman.com) There is also evidence that twice as many women as men report their general state of health to be 'poor', so it's also possible that women just tend to vocalize their feelings more, whether physical or emotional. (Anson, 1993) By assuming that women feel more strongly than men, we are violating the principle of justice for men because they should be given fair and equal treatment for psychiatric disorders. By allowing women to have a specific diagnostic disorder that allows them to get treatment if the symptoms are not any different from what men are feeling, we are not only creating an imbalance, we are perpetuating a preexisting one caused by stereotypes.

### **Stigmatization of Women**

Let's say we assume there is psychological symptomology associated with PMS; it is important to look at the effects a diagnosis will have on the female population. If we look back to the history of the menstruating woman, we see how degraded and undermined they are in many cultures simply for a natural bodily function which is necessary to perpetuate the species. However, it seems as though the physical and emotional state menstruation causes in women creates negative associations to it. Looking back to the current public views on menstruation, we see that men's views on menstruation apply generally to the psychological symptoms. One man excused a woman in the workplace for yelling at her employee because she was "on the rag." Does this mean that women's actions are regarded by some men based solely on their menstrual

cycle? In 1970, Dr. Edgar Berman announced that women should not be allowed to have certain jobs such as president or surgeon because of their raging hormonal imbalances. (Figert, 1995)

“For centuries women have been told that PMS is all in their heads, that it isn't real. Yet, to actually call PMS a psychiatric disorder takes the diagnosis out of the hands of most women and into the control of a predominantly male profession.” (1995) By including premenstrual symptoms as a diagnosable disorder in the DSM, we are taking away the power of women in an already male dominated world. Denise Russell describes the diagnosis of PMS as a way of “disciplining women and invalidating our anger...and providing a rationale for restriction of employment opportunities.” (1995) In fact, Spitzer says that a diagnosis of LLPDD would cause employers to be reluctant to hire a woman, (1989) and looking at male reactions to women of power in the workplace, it certainly seems unlikely that a woman would want people to know she was suffering from such a disorder. Does it seem worth it to have a diagnosable syndrome for premenstrual symptoms if it is only creating more problems for women? By including this diagnosis, we are violating the principles of autonomy, consequentialism and Kantianism. It would violate the principle of autonomy because by creating a diagnosis that implies women are less responsible for their actions, we are not respecting their decision-making capacities. This does not only apply when symptoms are present, but women are said by some to be “on the rag,” it seems, whenever they express anger or harsh emotions of any kind. The principle of consequentialism also applies for similar reasons: we are taking power away from women through this diagnosis. Does the recognition of pain of the small percentage of women who would actually receive the diagnosis outweigh the disempowerment of women everywhere? This also relates to Kantianism because by allowing people to assume a woman's emotions are

due to her clinical diagnosis, we are taking away her inherent dignity, and not respecting her psychological state.

### **Financial Gains**

There is a drug targeted toward the treatment of PMDD called Sarafem. This drug is being promoted not only by the pharmaceutical industry, but by the creator of the drug, a man named Eli Lilly. The invention of a drug that would effectively treat PMDD would be a great step forward in the field and would help the many women suffering from this disorder. But is there anything else the pharmaceutical industry and the creator of this drug could seek to gain from the promotion of this drug?

The conflicts-of-interest in the clinical sciences related to the ties between the DSM-IV panel members and the pharmaceutical industry have become increasingly apparent. The funding for conventions, journals and research for DSM related disorders is largely funded by the pharmaceutical industry because their drug sales rely largely on the diagnosable disorders in the DSM. (Cosgrove, 2006) A study looking at the financial relationship between advisory boards to the DSM-IV and DSM-IV-TR and the pharmaceutical industry showed that 83% of DSM advisory board members on the PMDD panel had financial ties with the pharmaceutical industry (2006). The funding from the pharmaceutical companies primarily goes to research, but the study was unable to determine how much money was being given. Even if it is reasonable that there would be financial ties between the two industries, the public and mental health officials have the right to know about these financial ties.

The other person who would benefit from the diagnosis of PMDD in the DSM would be Eli Lilly, the creator of the drug Sarafem. (Brown, 2002) Sarafem is marketed as a treatment option that is separate from the normal SSRI treatment option which is geared towards the

treatment of depression. Women were interested in finding a medication that would provide relief specifically for the disorder of PMDD. However, the active ingredient in Sarafem is fluoxetine hydrochloride, which is the same active ingredient found in Prozac, a leading anti-depressant also created by Lilly, and they both contain 20mg per dose. So why would Lilly be marketing what is essentially the same drug he created that is a leading drug on the market? Though we cannot say for sure, Brown makes an observation that Lilly is about to lose a large portion of his patent protection for Prozac, and by discovering a new use for the active ingredient, he would be able to receive a new patent, and private funding for his discovery. It is entirely possible that Lilly simply believes this new medication will have very positive results in the treatment of PMDD, but if that is not his only goal there are certainly some ethical issues here, as well as with the connection between the pharmaceutical companies and DSM disorder-related research. If creating this diagnosis in order to get more funding, as simply a meal ticket for those involved on the pharmaceutical end, it is incredibly unjust. Having a diagnosis of a disorder is not necessarily a good thing unless it aids in helping the person to improve their condition, so if women do not need a diagnosis of PMDD, creating one violates the principles of nonmaleficence, beneficence and justice as well as utilitarianism. It violates the principles listed for a similar reason: the harm caused by giving an unnecessary diagnosis to people does not outweigh the benefit reaped by the pharmaceutical industry and possibly the board leaders of the DSM.

### **Impairment of Functioning**

The reason having a diagnosis can be bad is because people can use the argument that the disorder creates an impairment of functioning, which can be used against the person. An example of this is when the label of PMDD is used as a tool to win custody battles. This is one



of the major concerns about having an official disorder for PMDD along with the stigmatization of women in the workplace. If a woman were in a custody battle, the other person trying to gain custody of the child may say she is unfit because her functioning is impaired. A label of any disorder could create this problem, but because disorders of premenstrual symptoms are not even fully recognized, is it worth the risk of the diagnosis if it could create such a horrible predicament?

Probably the most controversial, and therefore most publicly discussed argument against the inclusion of a PMS disorder in the DSM is the criminality of women. Up to this point, the arguments against having a disorder of premenstrual symptoms have been in support of female rights and keeping the identity and equality. However, this argument takes a different approach. It seems as though, more and more, defense lawyers have been medicalizing female crime. (Russell, 1995) There is evidence, as shown earlier, that crime rates in females increase during the period of menstruation. However, the issue of whether these women are responsible for their crimes is quite another subject. There are three main issues with this problem: the first the theoretical problem of what it is about PMS that would take away responsibility? The second is, once again, the issues about female perception if we do suggest lessened responsibility. And the third is a general lack of research and understanding about ability to control behavior during the premenstrual and menstrual periods.

There have been several cases in which the diminished responsibility associated with PMS was allowed as a defense. In 1981, Dalton testified in two court cases, giving 'expert evidence' about the diminished responsibility of the women on trial, and the women were freed without punishment. (Russell) This defense has been recognized in Canada in sentencing for

shoplifting charges, in America for plea-bargaining, and is currently recognized in France as an insanity defense.

So what is it about menstruation or premenstrual symptoms that would diminish responsibility? It seems as though most studies on menstruation-related crime look at hormone levels, whether by actually measuring them or by looking at the point in the cycle during which the crime was committed. However, there are extremely inconsistent findings and there is little empirical evidence as to the connection between premenstrual or menstrual symptoms, behavior and endocrine fluctuations. (Harry, 1987) When discussing the use of this defense in court, Harry and Balcer said: "Sometimes used is the Frye test with its standard of "general acceptance" by the "relevant scientific community" ...We believe that the literature is so limited, the findings so speculative, the methodology so flawed, and the criticisms so pervasive as to show that the present knowledge about any relationship between menstruation and crime does not satisfy Frye." (Harry)

This defense is not only unreliable, and therefore unjust for those who were prosecuting a woman who walked because of it, it also creates more gender bias and makes women seem even more hormonal and crazy. In order for this to become a reliable defense, more research must be done. Until then, it will continue to violate the ethical principles of justice, beneficence, utilitarianism and consequentialism. It violates the principles of justice and beneficence because if we are not sure of the real effects of PMS, how can we say the defendant is not responsible for her actions? If she is in fact fully responsible for her actions, she not be receiving the fair cost associated with her actions, and may repeat them due to the lack of consequences. It also violates the principle of utilitarianism because PMDD is only diagnosed in about 5% of the female population who experience premenstrual symptoms. Because of our lack of knowledge

of this disorder, it is possible that many more women have diminished control over their actions during certain parts of their menstrual cycles. So how does that create an equal balance if we do not even know where the line is drawn between the amount of responsibility a woman has during menstruation and the lack thereof? And of course, by not holding a person responsible for their actions if they are responsible, the ethical principle of consequentialism is violated. What we really need to know is, are consequences being justly distributed to these women in every aspect of life, or are we simply making unreasonable excuses to behave the way we want?

### **Conclusions**

As a woman who has experienced quite severe premenstrual symptoms, I understand the plight of women who are suffering, and not being helped. Women with this very real problem endure pain, both physically and psychologically. However, I cannot support the addition of a clinical diagnosis for premenstrual symptoms in the DSM; there is too much to lose in adding it as a full disorder. Because of the stigma associated with “female problems” that has been around for centuries, women are already viewed as fragile or inferior in many ways. The stigma says that we cannot control ourselves, and our weakness makes us less able to function on a day-to-day basis. If we include a full diagnosis of PMDD in the DSM, this stigma will only strengthen, and create even more suffering amongst women. The other reason I believe including PMDD in the DSM does more harm than good in terms of women’s suffering is the paucity of diagnoses. Up to 90% of women who suffer from PMS, yet with the stringent criteria to receive a diagnosis of PMDD, only about 5% of these women receive diagnoses. What about everyone else? With the problems this disorder causes simply existing, the fact that it only helps 5% of these suffering women makes me believe all the more strongly that it should not be in the DSM.

There is also the question of whether the disorder actually exists which I find tricky. I personally believe that the hormonal changes during the menstrual cycle cause emotional fluctuations, but not only is it completely variable between women, there is no real understanding of where the emotional fluctuations arise from. Before we include this diagnosis in the DSM, I believe we should have some understanding of which hormones affect emotions during the cycle and why this is so variable. Without this knowledge, how can we know for sure if it is a real disorder?

A somewhat related issue is the lack of understanding about treatment. The current method of treatment for PMDD is SSRIs, but psychologists do not really understand why this treatment works. There is also a lot of research about alternative treatment methods for premenstrual symptoms, and it has been shown that cognitive-behavioral therapy, dietary changes, exercise, calcium supplements and other natural supplements are effective in the treatment of premenstrual symptoms. (Hunter, 2001, Endicott, 1999, Halbreich, 2003) If these methods work, is there really a need for medication for this disorder? There is certainly not enough research to know which treatments are most effective and why, and this needs to be understood before we know if psychotropic drugs are necessary.

Despite my understanding of how unpleasant emotional premenstrual symptoms can be, we currently do not have a good enough understanding of them to call them a disorder, particularly due to the dilemmas this label can cause.

## References

- Anson, O. et al (1993). Gender differences in health perceptions and their predictors. *Social Science & Medicine*, 36, 4. doi:10.1016/0277-9536(93)90404-R
- Brooks-Gunn, J., Ruble D. N. (1986). Men's and Women's Attitudes and Beliefs About the Menstrual Cycle. *Sex Roles* 14, 5/6. Retrieved from <http://www.springerlink.com/content/f36q1m771201x228/>
- Brown, J. R. (2002). Funding, objectivity and the socialization of medical research. *Science and Engineering Ethics*, 8. doi: 10.1007/s11948-002-0048-8
- Cohen, H. (2003). Endocrinology of the Menstrual Cycle. Retrieved from <http://sprojects.mmi.mcgill.ca/menstrualcycle/physiology.html>
- Cosgrove, L. et al (2006). Financial ties between DSM-IV panel members and the pharmaceutical industry. *Psychotherapy and Psychosomatic*, 75. doi: 10.1159/000091772
- Delaney, J., Lupton, M. J., Toth, E. (1976). *The Curse: A Cultural History of Menstruation*. Chicago: University of Illinois Press.
- Dell, D. L. (2004) Diagnostic Challenges in Women with Premenstrual Symptoms. *Primary Psychiatry* 11, 12. Retrieved from <http://www.primarypsychiatry.com/asp/articleDetail.aspx?articleid=721>
- Endicott, J. et al (1999). Is Premenstrual Dysphoric Disorder a Distinct Clinical Entity? *Journal of Women's Health & Gender-Based Medicine* 8, 5. doi:10.1089/jwh.1.1999.8.663
- Figert, A. E. (1995). The three faces of PMS: The professional, gendered, and scientific structuring of a psychiatric disorder. *Social Problems*, 42, 1. doi:10.1525/sp.1995.42.1.03x0455m
- Finley, H. (1998) *Religion and Menstruation*. Retrieved from <http://www.mum.org/religmen.htm>

- Freeman, E. W. (2003). Premenstrual syndrome and premenstrual dysphoric disorder: definitions and diagnosis. *Psychoneuroendocrinology* 28: 25-37. doi: 10.1016/S0306-4530(03)00099-4
- Golub, S. (1992). *Periods*. Newbury Park: Sage Publications.
- Halbreich, U. et al (2003). The prevalence, impairment, impact, and burden of premenstrual dysphoric disorder (PMS/PMDD). *Psychoneuroendocrinology*, 28. doi:10.1016/S0306-4530(03)00098-2
- Halbreich, Uriel et al (2003). The prevalence, impairment, impact, and burden of premenstrual dysphoric disorder (PMS/PMDD). *Psychoneuroendocrinology* 28, 3. doi: 10.1016/S0306-4530(03)00098-2
- Harry, B., Balcer, C. M. (1987). Menstruation and crime: a critical review of the literature from the clinical criminology perspective. *Behavioral Sciences and the Law*, 5, 3. doi: 10.1002/bsl.2370050306
- Htay, T. T. (2009). Premenstrual Dysphoric Disorder. *eMedicine*. Retrieved from <http://emedicine.medscape.com/article/293257-overview>
- Hunter, M. S. et al (2002). Medical (fluoxetine) and psychological (cognitive-behavioral therapy) treatment for premenstrual dysphoric disorder: A study of treatment process. *Journal of Psychosomatic Research*, 53. Retrieved from [http://www.jpsychores.com/article/S0022-3999\(02\)00338-0/abstract](http://www.jpsychores.com/article/S0022-3999(02)00338-0/abstract)
- Laws, S. K. (1990). *Issues of Blood: The Politics of Menstruation*. London: Macmillan Press.
- Liebman, B. (1990). PMS: proof or promises? – treating premenstrual syndrome with diet & vitamins. *Nutrition Action Healthletter*. Retrieved from <http://www.primarypsychiatry.com/asp/articleDetail.aspx?articleid=721>

- Offman, A., Kleinplatz, P. J. (2004). Does PMDD belong in the DSM? Challenging the medicalization of women's bodies? *The Canadian Journal of Human Sexuality* 13, 1. doi:10.1016/j.psychrons.2005.02.012
- Rodin, M. (1992). The social construction of premenstrual syndrome. *Social Science and Medicine* 35, 1. Doi 10.1016/0277-9536(92)90118-A.
- Rosenblatt, P. L. (Ed.). (2007). *Menstrual Cycle*. Retrieved from <http://www.merckmanuals.com/home/sec22/ch241/ch241d.html>
- Russell, D. (1995). *Women, Madness & Medicine*. Massachusetts: Polity Press.
- Sigmon, S. T. et al (2005). Gender Differences in Self-Reports of Depression: The Response Bias Hypothesis Revisited. *Sex Roles* 53, 5-6. doi: 10.1007/s11199-005-6762-3
- Spitzer, R. L. et al (1989). Late luteal phase dysphoric disorder and DSM-III-R. *American Journal of Psychiatry*, 146, 7. Retrieved from <http://ajp.psychiatryonline.org/cgi/content/abstract/146/7/892>
- Taylor, H. C. (1976). *Human Reproduction: Physiology, Population, and Family Planning* (Vol 1). Cambridge: MIT Press.
- Whelan, E. M. (1975). Attitudes Toward Menstruation. *Studies in Family Planning* 6, 4. <http://www.jstor.org/stable/1964817>
- Wijngaards. *Women Were Considered Ritually Unclean*.

## Appendix A

A. In most menstrual cycles during the past year, symptoms in B occurred during the last week of the luteal phase and remitted within a few days after onset of the follicular phase. In menstruating females, these phases correspond to the week before, and a few days after, the onset of menses. (In nonmenstruating females who have had a hysterectomy, the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.)

B. At least five of the following symptoms have been present for most of the time during each symptomatic late luteal phase, at least one of the symptoms being either (1), (2), (3), or (4):

(1) marked affective lability, e.g., feeling suddenly sad, tearful, irritable, or angry

(2) persistent and marked anger or irritability

(3) marked anxiety, tension, feelings of being "keyed up," or "on edge"

(4) markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts

(5) decreased interest in usual activities, e.g., work, friends, hobbies

(6) easy fatigability or marked lack of energy

(7) subjective sense of difficulty in concentrating

(8) marked change in appetite, overeating, or specific food cravings

(9) hypersomnia or insomnia

(10) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain

C. The disturbance seriously interferes with work or with usual social activities or relationships with others.

D. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depression, Panic Disorder, Dysthymia, or a Personality Disorder (although it may be superimposed on any of these disorders).

E. Criteria A, B, C, and D are confirmed by prospective daily self-ratings during at least two symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)



## Appendix B

A. In most menstrual cycles during the past year, at least 5 of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least 1 of the symptoms being either (1), (2), (3), or (4):

1. Markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
2. Marked anxiety, tension, feelings of being "keyed up" or "on edge"
3. Marked affective lability (eg, feeling suddenly sad or tearful or increased sensitivity to rejection)
4. Persistent and marked anger or irritability or increased interpersonal conflicts
5. Decreased interest in usual activities (eg, work, school, friends, hobbies)
6. Subjective sense of difficulty in concentrating
7. Lethargy, easy fatigability, or marked lack of energy
8. Marked change in appetite, overeating, or specific food cravings
9. Hypersomnia or insomnia
10. A subjective sense of being overwhelmed or out of control
11. Other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (eg, avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, dysthymic disorder, or a personality disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least 2 consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)