Addressing Concerns About the Inclusion of Premenstrual Dysphoric Disorder in *DSM-5*

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ABSTRACT

Objective: Inclusion of premenstrual dysphoric disorder (PMDD) into the main text of the *DSM* has been a point of controversy for many years. The purpose of this article is to address the main concerns raised by opponents to its inclusion. Concerns are presented and countered in turn.

Literature Search: To identify the most prevalent arguments against inclusion of PMDD, we searched MEDLINE (1966–2012), PsycINFO (1930–2012), the Internet, and reference lists of identified articles during September 1–17, 2012, using the keywords *PMDD, premenstrual syndrome (PMS), DSM, DSM-5, concerns, controversy, women, political power, workforce, courts,* and *history.* The search was restricted to English-language publications. A total of 55 articles were identified and included. The most pressing arguments against inclusion were grouped by similarity and addressed if they were reported 5 or more times. Our review of the sources yielded 38 concerns regarding PMDD; 6 concerns were reported at least 5 times and are addressed in this article.

Discussion: Evidence culled from historical and legal trends does not support the alleged societal use of PMS to harm women (eg, keeping women out of the workforce or using PMS against women in child custody disputes). Further, current epidemiologic research has answered all of the methodology criticisms of opponents. Studies have confirmed the existence of PMDD worldwide. The involvement of pharmaceutical companies in research has been questioned. However, irrespective of the level of association with industry, current research on PMDD has consistent results: PMDD exists in a minority of women.

Conclusions: Historically, the pain and suffering of women have been dismissed, minimized, and negated. Similarly, women with PMDD have often had their experience invalidated. With the preponderance of evidence in its favor, PMDD has been placed in the main text of the *DSM-5*, opening the door for affected women to receive the attention full diagnostic status provides.

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Premenstrual dysphoric disorder (PMDD) is now in the main text of the *DSM-5*, after the PMDD subcommittee made a strong case for its inclusion.[1] This event occurred despite controversy surrounding the diagnosis that has endured for years. The level of controversy is illustrated by events that included congressional briefings in the early 2000s. The briefings were sponsored by the Society for Menstrual Cycle Research, among other groups, and argued that thousands of women would be deemed to have an "illness" if PMDD were included in the main text of the *DSM*.[2,3] The culmination of these events was that PMDD remained in the appendix of the *DSM* and debate continued until the release of *DSM-5* in May 2013.

LITERATURE SEARCH

We searched 2 electronic databases, MEDLINE (1966–2012) and PsycINFO (1930–2012), and the Internet at intervals from September 1 to September 17, 2012, using the following keywords: *PMDD, premenstrual syndrome (PMS), DSM, DSM-5, concerns* AND *PMDD*, *controversy* AND *PMDD*, *history* AND *PMDD, courts* AND *PMS, women* AND *political power, women* AND *workforce*. We also searched the reference lists of identified articles. We restricted studies to those in the English language, grouped concerns by similarity, and address in this article concerns mentioned 5 or more times.

The 38 most pressing of the arguments against inclusion were found by a comprehensive literature search that resulted in the use of 55 research articles. Six arguments were mentioned 5 or more times; they are as follows: (1) the PMDD label will harm women economically, politically, legally, and domestically; (2) there is no equivalent hormonally based medical label for males; (3) the research on PMDD is faulty; (4) PMDD is a culture-bound condition; (5) PMDD is due to situational, rather than biological, factors; and (6) PMDD was fabricated by pharmaceutical companies for financial gain. These concerns are presented and then addressed in turn.

CONCERNS RAISED BY THOSE OPPOSING INCLUSION OF PMDD IN *DSM-5*

Concern 1: Inclusion of PMDD Is Harmful to Women

Economic and political harm. Of primary concern to those who oppose the inclusion of the PMDD category in the main text of the *DSM* is that a medical label may harm women economically. Opponents argue that the timing of the proposal to include PMDD in the body of the manual is suspect, coinciding with women's current strength in the labor force in the United States.[4] Historically, the argument goes, whenever women gain power, some form of premenstrual ailment is popularized.[5,6] Females are characterized as cyclically "ill," unbalanced, and therefore an inferior work choice for a prospective employer when compared to noncycling, stable males. Greene and Dalton's[7] article on premenstrual syndrome, first introducing the term, was published in the *British Medical Journal* in 1953. Opponents point to the proximity of the publication date to the return of veterans from World War II who needed the work that female counterparts had filled in their absence.[5] Women were also strong in the workforce in the 1970s after the push of the women's movement in the 1960s. The *DSM*

considered including an earlier form of PMDD in its 1987 version, a move that detractors say followed the pattern of undermining female participation in the workforce when men need work.[6]

In answering the above concern, the evidence of a relationship is at best correlative. Even if a correlation exists, there is no proof that the label of PMDD would *cause* economic harm for women. Opponents fear the label will be used as a tool to oppress women. In examining the history of women in the labor force, there is no evidence that PMS has been used to suppress women's participation. If it had been used successfully, women's participation in the workforce would have declined at some time. However, in 1947, 31.5% of women were in the labor force, up from 24% before World War II.[8] By 1978, 41% of women were in the workforce,[9] and this percentage rose to 60% by 1999.[8] The increase in women in the labor market over time has been a positive, steady trend. This effect has been attributed to economic and technological factors as well as the women's movement of the 1960s and 1970s[9] and appears unaffected by a condition relating menstrual symptoms to a medical disorder.

A diagnosis of PMDD may be used against women trying to gain political office, according to those who oppose its inclusion in the *DSM*.[5,10] For example, jokes about a female president incapacitated by PMS or, worse, having her finger on the "red button" while suffering PMS are not uncommon. Despite these unfortunate jokes, women are gaining political power worldwide, as evidenced by their current positions of executive leadership on 5 continents.[11] The number of female prime ministers and presidents quadrupled in the 1980s and 1990s and quadrupled again in the 2000s.[11] Europe accounts for the largest proportion of these leaders. Not only have women made gains in leadership positions, but since 1945 their numbers in national parliaments have increased 4-fold.[12] As the concept of PMDD has gained recognition, it seems progress would have been halted or slowed by its misuse. Such is not the case.

Interestingly, PMS, of which PMDD is a moderate to severe variant, is argued to be a culture-bound phenomenon specific to Western culture[5] (see Concern 4 in this paper). Yet, PMS has not been used successfully against women vying for political office in Europe, as evidenced by the relative proportion of female executive leaders in Europe, the largest in the world.[11]

While the proportion of women in leadership and parliamentary positions still constitutes a minority when compared to their numbers in the population, there is no evidence that PMS has had an effect on women's political progress.

Legal and domestic harm. Another area of grave concern to opponents is the potential abuse of PMDD in the courts should it become a diagnostic label. In the United Kingdom, PMS has been used successfully by attorneys as a legal defense since the 1980s.[13] Use of PMS as a legal defense was first attempted in the United States in 1982, but the defense was unsuccessful.[13] Since that time, PMS has been used as a defense in cases of shoplifting, infanticide, forgery, and arson.[14,15] PMS could also become a tool used in custody battles. Women might stay with abusive spouses who threaten to use PMS against them in court in custody disputes. Also, employers might not hire or might fire a woman because of her premenstrual psychiatric status.[10]

Although PMS has been attempted as a defense or mitigating factor in court cases in the United States, it has not been well accepted.[15] Opponents fear that this status may change now that PMDD is fully established in the *DSM*. Although there are no direct data on use of PMDD as a defense, to fully appreciate and address this fear, a fair point of comparison might be found in postpartum syndrome. The postpartum onset specifiers are listed under the depressive disorders in the main text of the *DSM*. Both PMDD and postpartum disorders are putatively hormonally based and certainly specific to women. Postpartum illness as a defense has been unsuccessfully attempted since the 1960s in the United States. The defense has failed even under the most controversial circumstances (see Proano-Raps and Meyer[16] for a discussion). In cases of child custody, it has been used with mixed results.[16] Premenstrual dysphoric disorder has been far less sensationalized in the media than have postpartum illnesses. Further, use of PMS as a defense has already been attempted unsuccessfully in the courts for years. Advancing PMDD to the main text of the *DSM* should affect this status very little.

Another concern is that a woman may not leave an abusive situation because of the threat by her partner to use PMS against her in a custody battle.[10] It is difficult to address hypothetical cases such as these. Also, the reasons why people do not leave abusive situations are complex and often not attributable to a lone item (ie, the threat of using PMS in a custody battle). To conclude that someone would avoid leaving her husband because of this threat without truly assessing the entire situation may be premature and unfounded. Moreover, such a conclusion could be applied to virtually every psychiatric disorder.

Regarding employment concerns, it is unlawful to inquire about psychiatric status on any job application, and thus inclusion of PMDD in the main text of *DSM-5* may protect women afflicted with the condition.[17] In terms of firing a woman because of having PMDD, she is protected by the Americans With Disabilities Act. An employer must prove that she is not fit to perform work functions on the basis of her medical condition or that she is a danger to others in the workplace.[17]

Concern 2: Putting a Label on Hormonal Changes Only in Women Is Harmful

Opponents of the PMDD diagnosis question why there is a hormonally related disorder specific to women and not men. They say that society would not label the effects of hormonal changes in men as a mental illness. Displays in men of certain emotions such as anger are seen as normal, while the same displays in women are seen as abnormal.[10]

It may be true that women are not allowed the same displays of certain emotions as men. However, this is a social

Table 1. Diagnostic Criteria for Premenstrual Dysphoric Disorder[a]

A. In the majority of menstrual cycles, at least 5 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 (eg, mood swings, feeling suddenly sad or tearful, or increased sensitivity to rejection)
   2. Marked irritability or anger or increased interpersonal conflicts
   3. Markedly 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 5 symptoms when combined with symptoms from criterion B above
   1. Decreased interest in usual activities (eg, 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 (eg, 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 2 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 (eg, a drug of abuse, a medication, other treatment) or another medical condition (eg, hyperthyroidism)

[a]Reprinted with permission from the American Psychiatric Association.[27]

issue that should not encumber help for women with PMDD. In attempting to ensure social equality between females and males, opponents are losing sight of supporting women in need.

With regard to finding a hormonally based diagnosis specific to men, research has been conducted on testosterone and aggression[18–20] over the years. As yet, the evidence does not support a specific hormonally based disorder in men.

Concern 3: Research Validating PMDD Has Been Faulty

One of the most vigorous arguments against the recognition of PMDD has been methodological flaws. The main problems are (1) acceptably defining the disorder, (2) determining how many and which days of the menstrual cycle should be included in the diagnosis, and (3) addressing response bias in research studies.[5,21,22] Cosgrove and Caplan cite other problems as "small sample sizes, lack of control groups, lack of prospective ratings of symptoms, no documentation of the time and duration of symptoms, and failure to collect appropriate hormonal samples."[2(p222)]

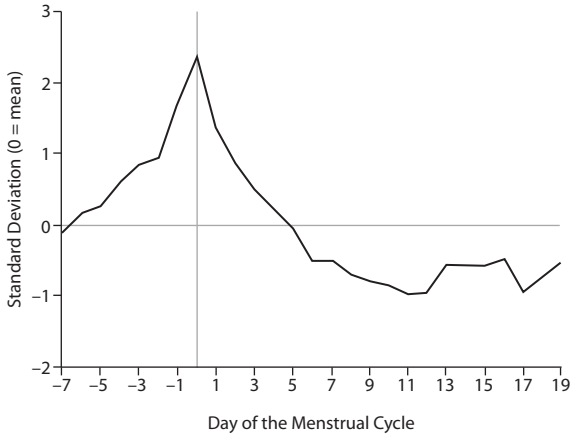
Definitions of PMDD are said to be at fault because they are indistinguishable from those of PMS. PMDD symptoms "virtually overlap" with those of PMS.[5] Most clinicians and investigators do conceptualize PMDD as a type of extreme PMS.[23,24] Many of the disorders in the *DSM* are conceptualized as severe forms of commonly occurring events or emotions. For example, fleeting sadness and major depressive disorder occupy opposing ends of a continuum. However, just as major depressive disorder differs from mere sadness, PMDD is different from PMS in that it is far more severe.

The symptoms most commonly reported by women with PMDD are irritability and mood lability.[1,25,26] These symptoms distinguish the disorder from the sadness or inability to feel pleasure characteristic of major depression. Irritability and mood highs and lows are common to bipolar disorder as well. However, the occurrence of PMDD is dictated by the menstrual cycle, while the occurrence of bipolar disorder is not. Distinguishing PMDD from similar disorders helps delineate it and answers criticisms raised by opponents that it is ill defined.

Diagnostic requirements further define PMDD. Currently, to fulfill a diagnosis of PMDD, a woman must have a premenstrual pattern of symptoms for at least half of her cycles of the previous year. If her symptoms occur in the late luteal phase, improve shortly after menstruation begins, and remit midphase, then she may be given the diagnosis. In addition, several other criteria must be met (Table 1).[27] For example, the symptoms cannot be merely the premenstrual worsening of another disorder (criterion E).

The diagnostic components of the disorder were developed as a result of research. A point seldom underscored by opponents is that to achieve a diagnosis of PMDD in research, requirements have been more stringent than those of other disorders. In many of the studies used to determine the validity of PMDD, women have had to

Figure 1. Standardized Mean Scores Across 50 Physical, Social, and Psychological Symptom Items by Menstrual Day[a]



[a]Reprinted with permission from Meaden et al.[25] Symptom severity peaked on the first day of menses, when severity levels were more than 2 standard deviations above the mean.

chart daily symptom ratings for 2 months in addition to recalling past symptoms.[28–30] The prospective information is a safeguard against the overdiagnosis that retrospective recall may produce. Endicott states: "This is the only diagnosis of a mental disorder that requires any kind of systematic daily documentation of symptoms."[23(p6)] In every other disorder listed in the *DSM*, retrospective recall has sufficed for a diagnosis in studies. The stringent requirements of current research methods have led investigators to feel confident about the definition of PMDD.

The aforementioned concerns with regard to a diagnosis of PMDD overlap with the second focus of criticism: determining the days of the menstrual cycle to be included in the diagnosis. Opponents have criticized that past studies have employed so many different standards of measure that symptoms could be charted for up to 3 weeks of the month.[5] To answer this criticism, it is best to examine the data. In epidemiologic research, the data show a spike of PMDD symptoms in the late luteal phase that remit shortly after menstruation begins.[25,26,31,32] One such study[25] involved 900 urban and rural women and addressed every concern listed at the beginning of this section except lack of control groups. Figure 1 clearly illustrates the spike of symptoms that occurs just before menstruation begins and recedes shortly after menses begins.[25] Similarly, Hartlage et al[26] empirically explored the interval during which women are most likely to experience symptoms. The diagnostic requirements reflect the data: symptoms must appear in the late luteal phase and remit midphase. (There is a qualifier of "minimal symptoms" midphase to allow for stressors, medical conditions, and life events.[22])

The third criticism, response bias, is discussed repeatedly in literature by opponents. A methodology argument becomes sociocultural: you can't "blind" women to a study about PMDD, the argument goes, because our culture is rife with myths about PMS. However, as one example in many, Hartlage et al[26] simply informed their participants that the study was about women's health. Symptoms of PMDD were embedded in lengthy health and quality-of-life questionnaires. When debriefed, very few of the women had guessed the study was premenstrual in origin.

Competing research. Two areas of research are cited so frequently in opponents' literature that they deserve brief mention. The first is a study in which men displayed no more cyclic emotional variation than did women.[33] Opponents cite this one study as though it disaffirms all other studies showing the existence of PMDD (eg, Gehlert et al,[28] Takeda et al,[34] Wittchen et al[35]). In most research validating disorders, conflicting results are found. Evidence is weighed. If the preponderance of data show that PMDD exists in community and clinical samples, then it cannot be denied.

The second is an early study from the National Institute of Mental Health in which women took medication to stop ovulation, but still had premenstrual symptoms.[22] However, it is crucial to underscore that, in the same sample, symptoms were triggered only in the women with PMDD by adding back either estrogen or progesterone. Further, medications that stop the menstrual cycle are an effective treatment for PMDD.[22]

Concern 4: PMDD Is a Culture-Bound Condition

Opponents argue that PMDD is a political tool found mainly in Western cultures and legitimized primarily in the United States.[5,22] An example of the former is the disorder's supposed absence in Asian cultures. Citing 2 studies collected from women in Hong Kong and mainland China, Chrisler and Caplan state that "Chinese women rarely report negative affect"[5(p285)] and conclude that PMS is a culture-bound syndrome. Providing evidence to the contrary, in a review of the research literature on Taiwan, China, Japan, and Korea, Schatz et al[36] found PMDD across these countries, although at lower rates. One study[34] found rates of PMDD in Japan similar to those of US women. Further, Dennerstein et al[37] found that 9% of women in Hong Kong, Pakistan, and Thailand were severely affected by premenstrual symptoms.

Women in Iceland, Mexico, and Saudi Arabia have similar rates of PMS compared to those in the United States.[38] Also, increased health care utilization has been found in women with PMDD across several other countries, as well as impaired work productivity and relationship dysfunction,[23] further eroding the argument that PMDD is culture-bound.

Even within Western culture, opponents argue, the disorder is suspect. As evidence, they cite criticisms of 2 specific studies[39,40] that were outlined by the European Agency for the Evaluation of Medicinal Products (EAEMP)[41] and that led the agency to reject PMDD as an indication for fluoxetine. Those opposing inclusion of the disorder in the *DSM* frequently cite the conclusion of the EAEMP that "PMDD is not a well-established disease entity in Europe,"[42(p1)] as well as the fact that shortly after this statement, Eli Lilly stopped marketing Sarafem (fluoxetine), a treatment for PMDD, in Europe.[42]

Attending to mounting evidence, the European Medicines Agency (EMA; the new name for the EAEMP as of 2004) altered its position in 2010, stating: "There are substantial research data available to support premenstrual dysphoric disorder as a diagnostic entity of a severe form of premenstrual disorder, which causes clinically relevant functional impairment and requires treatment. It is considered a disorder with substantial clinical and public health impact in a [small] subpopulation of menstruating women."[43(p2)] The EMA goes on to support selective serotonin reuptake inhibitors as a viable treatment option for PMDD, fully reversing its former opinion.

Concern 5: Women's Symptoms Are Due to External Factors (fundamental attribution error)

A predominant theme of those who oppose inclusion of PMDD in the *DSM* is that the diagnostic labeling focuses on what is occurring physically rather than attending to what is going on socially. In this way, proponents of the diagnostic label are committing the fundamental attribution error of making personal attributions when they should be making situational attributions.

As an example of a situational versus personal attribution, opponents point to the high prevalence of sexual assault in women with PMS.[44] Cosgrove and Caplan argue that "women who label their experience as PMS or PMDD are significantly more likely than other women to be in upsetting life situations, such as being battered, being mistreated at work, or being in troubled marriages. . . . To classify these women as mentally disordered—to send the message that their problems are individual, psychological ones—hides the real external sources of their troubles."[2(pp226,227)]

In the above quote, the authors imply that a stressor trumps all other possible biological or combination of factors in explaining the onset of PMDD. Further, while stress does appear to play a role in PMDD,[45,46] it plays a role in most mental illnesses. Indeed, there are some disorders, such as posttraumatic stress disorder, in which traumatic stress is a necessary and fundamental component of the illness. Also unclear in this argument is why ongoing stress should explain why symptoms occur only premenstrually. Cosgrove and Caplan's argument becomes a social one: The PMDD label may result in people ignoring the abuse of women.

Why women sometimes embrace the label. Opponents argue that blaming PMS for events that would be otherwise attributed to women's "weakness" makes the label attractive. Traditionally, women are supposed to be cheerleaders, even-tempered at all times. If they are not, something must be wrong. PMS gives women something to blame.[10] It allows women to take on a "not me" persona. If you yell at your children, for example, it's the PMS, *not you*.[5]

Along similar lines, women are supposed to "do it all." They are expected to have a successful career, be perfect mothers, and keep a beautiful home, all while maintaining a perpetually sunny attitude. PMS may be a form of resistance to these cultural demands; that is, women can't be expected to be perfect when they have PMS.[5]

In reality, it may be that opponents are negating a woman's very real experience of suffering symptoms that stem from the biological processes of her body. In this case, she hasn't *chosen* the label in order to resist or escape; rather, she's been blindsided by the situation of having PMDD. Opponents should perhaps guard against committing the fundamental attribution error here.

Concern 6: PMDD Was Forced on the Public by Pharmaceutical Companies to Sell Drugs

Some say that PMDD was elevated from myth to diagnosis by pharmaceutical companies. At the turn of the century, when the patent on Prozac (fluoxetine) was about to expire, Eli Lilly repackaged fluoxetine as Sarafem and marketed it as a treatment for PMDD. They were able to extend the patent on fluoxetine, thereby making more money on the product. Opponents intimate that the timing was suspect.[5] In fact, early clinical trials for PMS or PMDD were not funded by pharmaceutical companies (eg, Stone et al,[47] Vellacott et al[48]). Further, regardless of the timing, fluoxetine is an effective treatment for PMDD,[40] even when taken only premenstrually.[39,49] The same is true of other serotonin reuptake inhibitors (SRIs),[50–52] as well as treatments with oral contraceptives containing drospirenone and ovarian suppression with gonadotropin-releasing hormone agonists.[53] Cumulatively, women may choose from 4 US Food and Drug Administration–approved medications.[23] There are also nondrug treatments,[23] several of which are championed by opponents,[3] all providing much competition for Eli Lilly.

Red flags have been raised about past *DSM* subcommittee members[54] and some present subcommittee members[1] who have received research money from pharmaceutical companies. Opponents wonder how the members of the subcommittee whose research is funded by pharmaceutical companies can remain impartial to inclusion of PMDD in the main text of the *DSM* when they are being influenced by the same companies who stand to gain from its inclusion.[2] In response, a small number of the current members of the *DSM* subcommittee are not conducting research with pharmaceutical companies. These members cannot be accused of a conflict of interest due to their funding by a pharmaceutical company. Their conflict-free status should lend credibility if there is consensus among the group about PMDD's inclusion.

SUMMARY

Opponents to inclusion of PMDD in *DSM-5* fear that the medical label will be used to oppress women. They fear that it will be used to make women appear physically and emotionally weak in order to keep them at an economic and political disadvantage compared to men. Similarly, they are concerned that PMDD will be wielded in courts and domestically to keep women in a secondary position to that of men. In reality, even as PMDD has become more recognized, women have been gaining economic and political power worldwide. PMS has not been used successfully in US

courts in the past, and there is little evidence that PMDD can be used effectively in the future.

Opponents wonder why there is a hormonally based label specific to women. Proponents counter that this is a social issue that should not impede help for women who are suffering with PMDD. Deemphasizing physical factors altogether, opponents say that external factors cause symptoms, not PMS. Proponents acknowledge that stress is a contributing factor to PMDD, as to many disorders, but it is unclear why symptoms of stress would occur only premenstrually.

Current research has answered all of the earlier criticisms of methodology leveled by opponents. The majority of clinical and community data from current research support the existence of PMDD. Further, PMS and PMDD have been found throughout the world, which refutes the argument that they are culture-bound. The EMA reversed its earlier position on PMDD, now calling it "a diagnostic entity of a severe form of premenstrual disorder." Some of the research has been conducted by pharmaceutical companies and researchers that have a financial interest in the outcome, but some has not. The majority of conclusions have been the same. They have supported the existence of PMDD and the efficacy of SRIs in the treatment of PMDD.

CONCLUSION

Historically, illnesses suffered by women have been attributed to female hysteria.[55] It has long been argued that if these same disorders had been predominant in men, they would have been legitimized far sooner. Perhaps if PMDD had been a disorder exclusive to males, it, too, would have been legitimized far sooner. This is not such a far-fetched idea. In looking at the history of PMS, we see that women were told it was "all in their heads" by physicians for years.

Carrying on the tradition, women with PMDD have until now been invalidated with noninclusion in the main text of the *DSM*. This small percentage of women have been denied the full benefits of research, treatment, and recognition that diagnostic status provides. Ironically, their situation has been exacerbated by the very people who champion the cause of women.

Women with PMDD dread their lives for a few days each month. Are we to tell them that in reality they are "stressed?" Perhaps even worse, we could tell them it's the equivalent of "all in their heads"—the result of the medicalization of the menstrual cycle. In this way, we would be negating their experience as surely as a woman in the 1970s with an autoimmune disorder would have had her experience denied.

Understandably, opponents don't want the label misused. However, the label is assigned to a vast minority of women—far fewer than the number diagnosed with major depressive disorder—and should be no more or less abused than any of the other *DSM* labels. With regard to the branding of women with a *DSM* label, females have their first onset of major depressive disorder after puberty at twice the rate of males. People have yet to stigmatize females about depression.

The arguments of benefits outweighing costs aside, evidence validates the existence of PMDD. PMDD simply is. Women need help to relieve the negative effects of the disorder. With the recognition that PMDD is indeed a disorder, and the research and treatment inherent in that recognition, women will receive the help they require.

Drug names: drospirenone (Yaz and others), fluoxetine (Prozac, Sarafem, and others).

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