Statistical Manual of Mental Disorders, where it is called Late Luteal Phase Dysphoric Disorder, or LLPDD. LLPDD is supposed to apply to premenstrual symptoms that are severe enough to "seriously interfere with work or with usual social activities or relationships with others." Even for women who have severe symptoms that are unrelated to existing emotional disorders, it is bizarre, and many researchers think detestable, to have such a diagnosis in a manual of *mental disorders.* If LLPDD is a medical condition, why is a psychiatric diagnosis necessary? Thyroid abnormalities cause mood and behavior changes, but we don't consider these physiologically based changes a psychiatric disorder. And if LLPDD reflects a psychological problem, such as depression, why is a medical diagnosis of "late luteal phase disphoric disorder" necessary? We might draw an analogy to a man who suffers from chronic anxiety. Several times a month, he plays racquetball, an exercise that raises his heartbeat and sets off an anxiety attack. The man's problem is anxiety, not racquetball; he does not have Post-Exercising Syndrome.

Because of the evidence of sloppy research and confusion over the prevalence, diversity, and nature of premenstrual changes, LLPDD was relegated to an appendix in the manual, in a section of diagnoses needing "further study." Nevertheless, there it sits, a convenient label for physicians and psychiatrists to use in diagnosing patients and in turn receiving insurance compensation.

In the early 1970s, Parlee published a major review of the research that had been done to date on the effects of the menstrual cycle. She put "PMS" in quotation marks, in order to denote it as an odd or unusual concept that "was purportedly scientific but was not supported by data." In a recent speech she described what happened:

> A copy editor took out all the quotation marks, and with them the meaning I wanted to establish. I lost—was silenced—then in my effort to shape in a small way the scientific discourse about PMS. The processes through which "PMS" has come to mean what it does today are too powerful, too internally and mutually self-sustaining, for that meaning to be affected by the results of good science. . . . People—women, researchers, the media, drug company representatives—now use the term PMS as if it had a clearly understood and shared mean-ing; the only question is how to help women who "have" it. Thus PMS has become real. The quotation marks have been removed.

Many institutions and individuals now benefit from the concept of PMS. Biomedical researchers, medical schools, and drug companies profit financially.

Gynecologists, many of whom have closed their obstetrical services because of malpractice insurance costs, have lost a traditional source of income and are turning to new patient groups and new diagnoses for replenishment. Many psychiatrists have shifted from conducting long-term psychotherapy to prescribing short-term (repeatable) drug treatments. Indeed, obstetricians and psychiatrists are already engaged in turf wars over who is best suited to diagnose and treat all those women with premenstrual symptoms.

But the success of PMS is not entirely a conspiracy of big institutions, although, as Parlee says, if PMS didn't exist as a "psychologically disturbing, socially disruptive, biologically caused disease" they would have needed to invent it. (They did.) We must also ask why so many women have responded so favorably to the term and use it so freely. Parlee suggests that "the language of 'PMS' is a means by which many women can have their experiences of psychological distress, or actions they do not understand, validated as 'real' and taken seriously." In that sense the language of PMS is empowering for women, she believes, because it gives a medical and social reality to experiences that were previously ignored, trivialized, or misunderstood.

Like all psychological diagnoses, then, PMS cuts two ways: It validates women, but it also stigmatizes them. Psychiatrist Leslie Hartley Gise directs a PMS program at Mt. Sinai Hospital in New York, yet she too is worried about the stigmatizing effects of making PMS a psychiatric diagnosis. "If even the rumor that Michael Dukakis had undergone treatment for depression could be held against him," Gise told an interviewer, "think of what a PMS diagnosis would mean for a woman seeking public office." We've come full circle. The ghost of Edgar Berman must be smiling.

OF MENSTRUATION AND MEN: THE STORY BEHIND THE HEADLINES

The research on the physiology and psychology of the menstrual cycle paints a very different picture from the popular impression that PMS is a proven, biomedical syndrome. It is clear that some physical changes normally occur: breast tenderness, water retention, and increased metabolism being the most common. The key word here is *normally*. It is normal for premenstrual women to have some aches and pains, to gain a few pounds (because of temporary water retention), or to crave food (because of increased metabolism). Leslie Gise puts it this way: "Although PMS is used for convenience, *premenstrual changes* is a more accurate term."