Jean Endicott, Ph.D. is Professor of Clinical Psychology, Department of Psychiatry, College of Physicians and Surgeons at Columbia University and Director, Division of Clinical Phenomenology and Chief of the Department of Research Assessment and Training at the New York State Psychiatric Institute. Much of Dr. Endicott's work has involved the development of procedures to aid in the diagnosis and assessment of clinical features in both patients and non-patients, with a particular emphasis on the evaluation of outcomes of treatment. She has also conducted studies of the diagnostic process, risk for the development and relapse of various mental disorders, course of illness, pathophysiology, treatment, as well as familial aggregation and genetics of mood disorders, including Premenstrual Dysphoric Disorder. Dr. Endicott has also served on a number of national and international advisory committees focusing upon the diagnosis and treatment of various mental disorders.

At the time of this interview, Laura Guidry-Grimes was an undergraduate student at Florida State University. She is now pursuing her Philosophy Ph.D. at Georgetown University.

This interview was conducted as part of a project entitled “Premenstrual Dysphoric Disorder: Psychological Malady or Social Construction?”. This transcript can now be uploaded from another project, “Mental Illness and Compounded Vulnerability”, which can be found on the website of Georgetown’s Bioethics Research Library, here: http://engage.bioethics.georgetown.edu/mentalillness

[LGG] 1. What APA research studies on LLPDD [Late Luteal Phase Dysphoric Disorder] and PMDD would you recommend?
[JE]: I think a good up-to-date review of the literature would support the inclusion of PMDD in the body of DSM-V. There is considerable evidence that PMDD is a clinically relevant condition characterized by clinical features that can be reliably defined and diagnosed, that a number of different FDA approved treatments are now available, that when untreated the condition is associated with considerable distress and impairment in psychosocial functioning, that the genetic factors involved differ from those of other mood and anxiety disorders, and that the condition is not better accounted for by other medical disorders. Research studies focused upon possible etiological factors or ways of improving differential diagnosis would be informative but I do not think they are needed to warrant inclusion of PMDD in DSM-V.

[LGG]: 2. How do you define 'malady'? 'psychological malady'?

[JE]: I do not have a definition for "malady" or "psychological malady" since I never use those terms. I assume others may use the term "malady" to cover or include the concepts of "disorder" or "Illness" or "disease." However, I'm not sure how others might use the phrase "psychological malady"---perhaps to imply that a "disorder" includes "psychological clinical features" --or that a "disorder" has "psychological causes." Personally, I do not think either concept is particularly useful--since we now recognize that essentially all conditions include biological and psychological factors--including diabetes, immune functioning, etc.

[LGG]: 3. How important is the concept of normality to your argument?

[JE]: "Normality" is also a term I rarely use since it can have multiple definitions and implied constructs associated with its use. I tend to think of the terms disorder, illness, or disease as conditions that are associated--in time if not concurrently--with distress and disability. It is not necessarily associated with statistical deviance since dental caries are quite common or have a known etiology--since we do not know the causes of many such conditions (e.g. "essential hypertension").

[LGG]: 4. Is there a comparable case of a hormonally-based psychological disorder?

[JE]: This question implies that we "know" that PMDD is "hormonally-based." On the contrary, while we know that the timing of the onset and offset of PMDD is related to the hormonal changes, there is nothing about the hormones (levels, ratios, timing of changes, etc.) that differ between women with and without PMDD who are having menstrual cycles. The usual hormonal changes associated with the menstrual cycle evidently "trigger" other changes that are associated with the mood and behavioral changes manifested in vulnerable women. There are other mental disorders which are associated
with hormonal changes, such as major depressive disorder and low thyroid functioning--again only in some, not all, patients or depressive disorders (major or NOS) associated with low testosterone levels in some men.

[LGG]: 5. What do you believe is the strongest argument for the inclusion of PMDD in the main text of the DSM (as more than just a reference)?

[JE]: See my response to question # 1 above and question #6 below--which summarize the many reasons why I think PMDD should be in the main text of DSM V.

[LGG]: The strongest argument against?

[JE]: I do not think there are any strong arguments against inclusion. Some people state that the diagnosis implies that most women have a mental disorder--which is not the case since PMDD is clearly differentiated from PMS. Some people object to inclusion in the mental disorder section of medical disorders--however, the primary complaints of the women who seek treatment and of the definition of the condition are the changes in mood and behavior which are involved. Some people say the cause is "not psychological" (whatever that means)--this implies that all the other mental disorders are "psychological" rather than biologically based, which is not true. Some people say it will be "used against women"--which may be true since other medical conditions are "used against" the patients, for example having had cancer, or heart trouble. The fact that people may "use" knowledge of a condition to discriminate against someone is not a reason to exclude a condition from the part of the nomenclature where it logically fits.

[LGG]: 6. Do you believe that women might suffer damaging labeling effects as a result of including PMDD in the DSM-V?

[JE]: No. See above response to question #5. On the contrary. I think women are more likely to benefit from having the correct diagnosis made when they seek help for their severe premenstrual problems with mood and behavior. Fortunately there are now identified treatments which are much more effective than placebo---the research would not have been performed if the criteria and differential diagnostic studies had not been available. Women were being diagnosed as "Borderline Personality" or "Explosive Personality", etc. and were not being effectively treated. Some were being given medications that, while effective for other mood disorders or anxiety disorders, were not at all effective for PMDD. Many were being told, "It's just something you have to live with." or "It's a natural part of being a woman." or other such statements that were not at all helpful.
[LGG]: 7. How do you think health insurance companies would respond to the official inclusion of PMDD in the DSM-V?

[JE]: Since the FDA has approved a number of different compounds for the treatment of PMDD, I assume the insurance companies will cover such treatment. Currently, given that the diagnosis of Depressive Disorder, Not Otherwise Specified (DSM IV code 311), the treatment of PMDD is usually covered. 

[LGG]: 8. According to Thomas Szasz, many medical professionals believe that a particular neurological defect underlies all thinking and behavior disorders. Do you agree with this generalization, and do you personally agree that there's a particular, underlying defect?

[JE]: I think Szasz's generalization is a great over simplification of what "medical professionals" or other scientists think! I think it is generally recognized that biological factors and brain functioning are involved in mental disorders, but that a "particular neurological defect" is always involved fails to recognize the complex nature of such factors and functioning. Complex disorders, such as heart disease, hypertension, cancer, major depression, panic disorder, etc. are unlikely to involve a "particular" defect of any type, but rather many different patterns of factors.

[LGG]: 9. Do you agree with Szasz's statement, "a disease of the brain, analogous to a disease of the skin or bone, is a neurological defect, and not a problem in living"?

[JE]: I don't tend to think any type of disorder is just a "problem in living." I also do not find dividing disorders into diseases of the brain versus diseases of the body to be helpful. For example, it is evident that the brain is involved in a number of "skin" diseases and that the body is involved in many mental disorders--for example, see research on some of the "physical" symptoms associated with depressive and anxiety disorders.

[LGG]: 10. Do you agree with Michael S. Moore that denying the reality of psychological illness (understood as a problem in living) is dangerous?

[JE]: I do not know what Michael Moore covers by the terms "psychological illness" (i.e. problem in living) and "dangerous". However, in general I think it is unwise to ignore any type of identified problem. I think you should try to rectify problems, including
problems in living. If there are no methods available to help rectify them, they still should not be ignored.

[LGG]: 11. Jerome Wakefield described the pure value concept of psychological disorder as social "judgments of desirability according to social norms and ideals". Do you find this account problematic? Do you think this conception is widespread among medical professionals?

[JE]: I think reducing mental disorders to mere "judgments of desirability according to social norms and ideals" ignores the distress and dysfunction associated with them and the fact that patients often seek help and would prefer to not have them. I certainly do not think his concept is widespread or accepted by most medical professionals.

[LGG]: 12. How do you believe medical professionals should distinguish physiological and psychological disorders and mechanisms?

[JE]: I do not think they should try to do so. I believe physiological and psychological disorders and mechanisms are so highly interrelated that it is best to recognize that both are involved in human conditions—nonpathological as well as pathological.