Voice of the Student

Pre Menstrual Dysphoric Disorder (PMDD): A brief overview

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PMDD stands for Pre Menstrual Dysphoric Disorder. According to Osborn et al. (2020), "Prevalence estimates for PMDD range from between 3 and 8%" (p. 1), whilst the International Association for Premenstrual Disorders (IAPMD) suggests that the figure is between 5-10% (https://iapmd.org/facts-and-figures). PMDD is a condition which can have a truly debilitating effect on sufferers. Despite this impact, the condition is still relatively unknown in the general population and the medical community. It is my belief that raising awareness of the condition among mental health professionals will help them to understand the impact on clients with this condition. This increased awareness and understanding then, will help therapists to more deeply empathise with these clients. Furthermore, this enhanced understanding and empathy can be experienced by clients with PMDD and promote safety sufficient to open up about their experiences free from shame and judgement.

What is Pre Menstrual Dysphoric Disorder (PMDD)?

The World Health Organisation's International Classification of Diseases (ICD-11) gives a specific code to PMDD (GA34.41), which legitimises PMDD as a valid medical condition worldwide. According to this classification, PMDD is a mood disorder which occurs during the luteal phase (second half) of the menstrual cycle, and which "cause[s] significant distress or significant impairment in personal, family, social, educational, occupational or other areas of functioning and do not represent the exacerbation of a mental disorder" (World Health Organisation, 2019, para. 1). PMDD also appears in the DSM-5, which specifies that PMDD is "not an exacerbation… of another disorder" and is not caused by "physiological effects of a substance… or a general medical condition" (American Psychiatric Association (APA), 2013, pg. 172) offering further legitimacy of PMDD as a condition.

Both the ICD-11 and DSM-5 state that PMDD is temporally related to the luteal phase. The menstrual cycle consists of two phases: follicular and luteal. In an average 28-day cycle, the follicular phase takes place during days 1 – 14 and this includes the actual period. The luteal phase takes place during days 15 – 28, and it is during this phase that progesterone levels are at their highest. It is this increase in progesterone which is responsible for PMDD because PMDD is caused by an increased sensitivity to this hormone. When the luteal phase ends and progesterone levels decrease, PMDD symptoms disappear. This is significant because there are a range of other health conditions such as thyroid issues and bipolar disorder (among others) which present similarly to PMDD,

however these other conditions are not solely limited to the luteal phase. Furthermore, many of these other conditions can be ruled out via a blood test – PMDD cannot. It is therefore useful if a person feels they may have PMDD that they monitor their symptoms (for example, by keeping a diary, or using a symptom tracker) and that they get a full blood panel, in order to rule out alternative underlying issues.

Symptoms

PMDD presents with a range of 11 symptoms, which are divided into two categories. At least 5 of the 11 symptoms must be present overall, with at least one from each category, in order to confirm a diagnosis of PMDD. The DSM-5 outlines the symptoms as follows:

> ***Affective Symptoms:*** *lability of effect (e.g. sudden sadness, tearfulness or sensitivity to rejection); irritability, anger or increased interpersonal conflicts; depressed mood, hopelessness or self-deprecating thoughts; anxiety or tension, feeling keyed up or on edge.*
>
> ***Behavioural/Cognitive Symptoms:*** *decreased interest in usual activities; difficulty concentrating; lethargy, low energy, easy fatigability; change in appetite, overeating, food cravings; hypersomnia or insomnia; feeling overwhelmed or out of control; physical symptoms (breast tenderness or swelling, headache, joint or muscle pain, bloating, weight gain)* (APA, 2013, pg. 172-173).

To sum up, then, PMDD is the likely diagnosis if conditions with similar symptoms have been ruled out; if at least 5 of the 11 symptoms are present (with a minimum of 1 Affective and a minimum of 1 Behavioural/Cognitive symptom); if these have occurred in at least two menstrual cycles over the past year; and if symptoms only occur during the luteal phase.

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Diagnosis

However, getting a medical diagnosis is not easy and many people self-diagnose. This is because PMDD is still widely misunderstood despite being a valid condition. Ro (2019) gives the example of a woman with PMDD whose concerns were "dismissed" by five doctors, one of whom stated "Oh, it's just PMS. My wife gets that" (para. 4). Likewise, Osborn et al. (2020) discuss "the poor understanding of PMDD by most health professionals", the effect of which is "many years of unrecognised and untreated symptoms, and mental health misdiagnoses" (p. 2).

Additionally, enormous stigma surrounds menstrual health: Kerrigan (2022) discusses the numerous experiences of her friends who "were constantly disregarded by their doctors"; whilst her own severe menstrual symptoms were "unequivocally dismissed" until she was eventually diagnosed with endometriosis.

Likewise, there is so much shame and embarrassment relating to periods: many people use euphemisms like "That time of the month", instead of explicitly stating that they have their period. And let's not forget the mysterious otherworldly blue liquid that appeared in ads for sanitary products for years: it's only this year, 2022, that Always Ultra have started using the colour red in their ads. Whilst that is progress, as is Lidl's campaign for free sanitary products, and various workplaces and entertainment venues offering free sanitary products in their bathrooms, more needs to be done to erode the shame attached to something which is completely natural. Equally, more awareness is needed to emphasise that PMDD is a real condition with real symptoms, and those with this condition need to be supported instead of their experiences being laughed at, derided or dismissed. As Ro (2019) suggests, "It should be possible to… recognise the severity and rarity of PMDD, and dismantle tired jokes and sexist misunderstandings about PMS".

If proof were needed of the severity of PMDD, Eisenlohr-Moul et al. (2022) reported that 34% of those with PMDD have attempted suicide (p. 8). That figure is deeply troubling, especially because it may underestimate the actual number of people attempting suicide due to PMDD. The stigma, and for many, overwhelming shame, can prevent people from speaking about their experiences and represent a barrier to seeking support.

Lived Experience

Shame, and the reluctance to speak up, is something with which I personally am all too familiar. In 2017, I was working in an extremely toxic workplace environment, and often had to work 14-hour shifts or 12 straight days without a break. I was physically, mentally, and emotionally exhausted, and I began to notice an unusual pattern occurring. For 9 days before my period arrived, I could feel a visceral gnawing anger and feeling of being "keyed up" in my chest, bubbling away like a pot of pasta on the hob, and it was so intense that I was terrified of the pot essentially boiling over. At the same time, I was constantly exhausted but barely slept, due to a combination of insomnia and itching skin that was so severe I'd end up with scars on my legs from scratching (severe itching is another physical symptom of PMDD, which mostly occurs at night when progesterone levels are at

their highest). Whilst I've always been an openly emotional person, I would frequently have crying fits that were so intense it was like experiencing profound grief and loss.

When my period arrived, these symptoms would completely disappear and I felt so confused and ashamed because I thought there was something seriously wrong with me: it was like I was Jekyll and Hyde, becoming a completely different person for at least 9 days of every month and I was too scared to tell anyone for fear of what they would think of me. Furthermore, I was genuinely terrified that this changed personality would become permanent. I was used to being content with my life and being the person who would make my friends (and myself) laugh all the time. So instead of opening up and seeking help, I internalised how I was feeling and the fear and shame just ate me up and exacerbated my PMDD symptoms.

I finally decided to start researching my symptoms to find out what was going on, and the moment I realised that I had PMDD was a huge revelation – because I knew that this wasn't my fault. Many people don't like labels, but those of us with PMDD like this diagnosis because it means that we have something to work with, we can name the enemy. Most importantly, we know we're not broken or damaged – we're just highly sensitive to our own progesterone and that isn't our fault. Unfortunately, however, PMDD is a condition without a cure, and it only fully ceases when menopause starts. Whilst that is a horrible realisation for those who endure it every month, there are some forms of treatment and management which numerous studies have found to be successful.

Research Studies

In research conducted by Fathizadeh et al. (2019), magnesium was found to be significantly beneficial in lowering pre-menstrual symptoms in trial participants, because magnesium normalises the action of progesterone on the central nervous system. From my own personal experience, I notice if I don't take magnesium every day: in these cases, the feelings of anger and of being "keyed up" heighten significantly. Other supplements which have led to decreased symptoms for some of those with PMDD include tryptophan, which increases serotonin and acts as a sleep aid. Additionally, tryptophan can be found in a number of foodstuffs such as milk, tinned tuna, turkey, cheese, and nuts (specifically cashews, pistachios, almonds), whilst Omega-3 fatty acids also reduce the psychiatric symptoms of premenstrual conditions. However, it is important to state that there is no one-size-fits-all form of management for PMDD symptoms and that the supplements mentioned here are suggestions only: they will not be effective for everyone with PMDD.

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Other researchers have examined the use of serotonergic antidepressants (SSRIs) in treating PMDD. Given the fact that PMDD is limited only to the luteal phase, rather than occurring throughout the month, efficacy studies of "luteal phase" dosing (Rapkin and Lewis, 2013, p. 537) have been conducted. However more research is required, as the success of such trials remain limited, and many of those with PMDD with whom I have spoken in peer support groups have expressed a reluctance to take medication for the condition.

Other research suggests that smoking increases the likelihood of developing PMDD, because for smokers the Hypothalamic-Pituitary-Adrenal (HPA) stress response is negatively impacted by nicotine. This causes a sensitivity and susceptibility to stress, meaning that pre-menstrual symptoms worsen for smokers. In fact, when smokers who experience severe pre-menstrual symptoms gave up smoking, those symptoms either became less severe or disappeared completely (Choi and Hamidovic, 2020).

The connection between stress and PMDD, as per the research by Choi and Hamidovic, is important because many studies indicate that a history of trauma can lead to PMDD (Epperson et al., 2012). The association between early life trauma and PMDD is affirmed by Kulkarni et al. (2022) who associate "emotional abuse and/or chronic trauma across childhood" with PMDD. These studies also show that those with PMDD may have a history of other trauma-related conditions such as Chronic Fatigue Syndrome, Fibromyalgia, Irritable Bowel Syndrome.

The Power of Therapy

Since 2017, I have been in regular contact with other people who are severely affected by PMDD. Through our collective experiences, it is our belief that counselling and psychotherapy, particularly a humanistic approach, are an effective means of supporting those with PMDD. Due to the aforementioned stigma surrounding menstrual health, many of those with PMDD will have some level of internalised shame and guilt, not least because we all start off believing that we are to blame for our condition. Validation, as well as reassurance that PMDD is not our fault, is therefore extremely beneficial. Ro (2019) has found that menstrual health is something that many people joke about, which leads to further shame for those with PMDD. The lack of judgement present within therapy can help with overcoming internalised shame, effect catharsis and heal self-limiting shame dynamics during and post-treatment.

The IAPMD have published personal

accounts of many people with PMDD on their Blog:

> *In the bad weeks leading up to my period, I literally crawled into bed and wished I would die… My mood would plummet so low. I'd be so negative about myself and everyone else that any little thing could trigger me off into a whirlwind of anger or bursting into tears* (Holly, 2021).

It is clear that for many people with PMDD, they are filled with self-hatred and have no self-compassion. Therapy can therefore be incredibly helpful due to the presence of therapist compassion and kindness where clients are unable to furnish such feelings to themselves.

Likewise, the IAPMD also recently published the below quote:

> *The majority of people who feel suicidal do not actually want to die; they do not want to live the life they have. The distinction may seem small but is very important. It's why talking through other options at the right time is so vital*. (IAPMD, 2022)

This, for me, affirms the power of therapy: if clients with PMDD can talk through how they are feeling with a therapist who is empathetic and non-judgemental, this can be transformative. Indeed, Kirschenbaum and Jourdan (2005) affirm that "It is the therapist's empathy, acceptance, and genuineness that allow many clients to feel safe enough to enter into a real relationship with the therapist" (p. 46). Providing the core conditions with a client who has PMDD is extremely beneficial, especially if the client has a history of trauma and the self-cruelty and shame which accompany such experiences.

Conclusion

From my own lived experience, I can testify to the positive benefits of good PMDD informed therapy. I was attending a therapist when I first developed PMDD, however the material discussed in those sessions was very much on a surface level only. In the past year, however, I have been unpacking some incredibly difficult material relating to trauma with a different therapist, who has been incredibly supportive and compassionate. I have noticed that over the course of my sessions with him, my symptoms each month have either been less severe, or, on a few occasions, almost non-existent. Indeed, I believe that Rogers (1974) said it best when he wrote "simply to listen understandingly to a client and to attempt to convey that understanding were potent forces for individual therapeutic change" (p. 116). The power of empathy, compassion and support, with clients who have PMDD cannot be underestimated. As awful as the symptoms can be during the luteal phase, they are not permanent. Just like a phoenix, those with PMDD can rise again each month, especially if we have therapists who can be there to support us during those days when we absolutely cannot support ourselves.

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