Stonebriar Psychiatric Services News & Views

PMDD

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"Oh, It's Just That Time of the…"

I admit that men can do a lot of stupid things, but one statement that often makes me cringe is when a man attributes what he feels is certain inappropriate or irrational behaviors on the part of his wife or girlfriend to it being "that time of the month." It has always struck me how women can attribute that to each other or even to themselves, but as soon as a man makes that comment he is in deep, hot water. It doesn't even matter if there is a grain of truth involved, I would recommend to all men reading this to just keep your mouth shut if that is what you are thinking. However…

There are certain things that women must deal with that men do not, and that includes the hormonal fluctuations that normally occur and are related to a woman's menstrual cycle. Some women describe noticing little or no emotional or physical changes around the time of their menses, while others must deal with significant changes. In this newsletter, I would like to address those that may struggle with these issues. Premenstrual dysphoric disorder (PMDD) is a cyclical condition characterized by physical, behavioral, and emotional symptoms that occur in the luteal (premenstrual) phase of the menstrual cycle and tend to ease with the onset of menses. It is distinguished from premenstrual syndrome (PMS) primarily by the number of symptoms and generally the severity of those symptoms in making the diagnosis. Frequently, women with PMDD also may struggle with depression and anxiety disorders, although this is not always the case.

What Is It?

PMDD occurs in approximately 3-8% of women who have regular ovulatory cycles, while PMS may occur in up to 20% of women and by definition have at least one physical or emotional symptom during the five days before her menses. To have the diagnoses of PMDD, at least five of the following eleven symptoms must occur during most menstrual cycles over the previous year with at least one of these being one of the first four symptoms mentioned. These symptoms include depressed mood; anxiety and/or tension; affective lability; anger or irritability out of the ordinary; decreased interest in one's usual activities; problems with concentration; decreased energy or feelings of fatigue; a change in appetite, which is often associated with specific food cravings; an increase or decrease in sleep; a subjective sense of feeling out of control or overwhelmed by events; and physical symptoms such as breast tenderness, bloating or weight gain, headaches, or joint/muscle pain. An additional criterion is that the symptoms must interfere with work or general daily functioning or relationships, are not merely a worsening of symptoms of another disorder, and generally must be confirmed by daily ratings during at least two consecutive symptomatic menstrual cycles.

Generally, the most common mood symptom associated with PMDD is one of irritability and tension. The symptoms generally cause a level of impairment similar to that of major depressive disorder and may significantly affect one's quality of life. Therefore, this should be considered a significant health condition and not just something that one should "snap out of." Even though the diagnosis of PMDD requires the exclusion of other comorbid psychiatric illnesses as a cause of the symptoms, studies do indicate a higher rate of co morbid mood and anxiety disorders in women with PMDD relative to the general population. It is also important to distinguish actual PMDD from the premenstrual worsening of symptoms of the underlying psychiatric disorder. For example, one study by Kornstein and associates indicated that 63% of pre-menopausal women with major depression noted an increase in symptoms premenstrually. The main distinction is that the symptoms are similar throughout the month, even if increased premenstrually. PMDD is diagnosed as a separate, or comorbid, condition when the symptoms occur during the premenstrual phase, cease once the menses begins, and does not duplicate the primary symptoms of the other psychiatric illness.

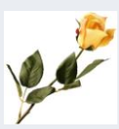
Many studies suggest that major depression is more common in women with PMDD. This also seems to be consistent across cultures. Studies have shown that in women diagnosed with PMDD, the incidence of previously diagnosed major depressive disorder was often 55-60%. Significant feelings of depression, frustration, or hopelessness during the premenstrual phase suggests the presence of a comorbid depression. The significance is that while suicidality is generally evaluated in patients being treated for depression, it is often not assessed in those evaluated for PMDD. One study of 426 women in outpatient obstetrics clinics, who had a current psychiatric disorder and also reported premenstrual complaints, found that 24% with possible PMDD reported suicidal thoughts and 20% for at least several days. This would lend strong support to the idea that all women with mood disorders should also be assessed for PMS/PMDD and vice versa. There is also some evidence that PMDD may represent a risk factor for postpartum depression.

It is felt that PMS and PMDD may have some things in common with seasonal affective disorder (SAD), as their symptoms can also be seasonally made worse. The tendency toward increased appetite and sleep also makes them similar. One study found that 46% of women with SAD had evidence of PMDD even during summer remissions compared with 2% of women in control groups. There is also some evidence of possible genetic linkage between these conditions and affective disorders in first-degree relatives.

Although the specific relationship between PMDD and depression is unclear, both have been linked to possible serotonin regulation with decreased levels of serotonin. Although certain animal experiments have shown an inhibitory effect on aggression and irritability with the administration of serotonin, the primary evidence linking PMDD and major depressive disorders to serotonin dysregulation is the efficacy of the SSRI antidepressants, which increase serotonin levels, with both disorders.

Studies have also indicated a link suggesting that anxiety disorders are more common in women diagnosed with PMDD than in controls. Panic disorder has been found in 25% of women with PMDD, social phobia in approximately 20%, obsessive-compulsive disorder in 12%, and generalized anxiety disorder from 4-38%, all of which are higher than in the general population. There may also be a relationship between having experienced trauma and PMDD. Although this needs further study, it does seem clear that women with a history of trauma should also be asked about symptoms relating to PMS/PMDD.

Do you have topical requests for future newsletters? Let us know at: NewsletterQuestions@stonebriarps.com



Treatment

The SSRI antidepressants are generally the first-line treatment for PMS and PMDD but may be utilized in different ways. If one is still having increased premenstrual symptoms while treating a primary depression or anxiety disorder with an SSRI, frequently it is helpful to increase the general dosage that one is on, or at times to increase it only for the 7-10 days prior to menses. When PMDD is present alone, there have also been studies that show benefit from intermittent dosing with the SSRIs taken during the 7-10 days premenstrually and then discontinued once the menses begins. Anxiety medicines, such as the benzodiazepines (Xanax, Ativan, Klonopin) are frequently helpful when taken premenstrually with the habituation potential being quite limited when taken for that short period of time. Hormonal treatment also at times is frequently helpful. Estradiol affects serotonin synthesis and reuptake and suppression of ovulation has been shown to decrease symptoms of PMS. The use of oral contraception can frequently go either way, at times seeming to reduce PMS/PMDD symptoms, but with other women seeming to increase the mood and anxiety symptoms.

Calcium carbonate has also been shown to frequently reduce premenstrual depression, fatigue, edema and physical discomfort relative to placebo in women with PMS. There is not any clear data regarding using calcium carbonate in women with diagnosed anxiety or mood disorders and PMDD, although it is generally felt that this is a reasonable choice with mild PMS or as an adjunct treatment. Before using it yourself, be aware that constipation or kidney stones can be complications.

In conclusion, I strongly recommend that men avoid diagnosing wives, girlfriends, or coworkers in attributing their irritability or anger to "just that time of the month." Consider that maybe you really can be irritating at times. But for women who feel that this represents a struggle for them, I would encourage you to talk to your family physician, gynecologist, or psychiatrist with regard to whether this might be playing a role in those monthly difficulties you encounter.

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