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Letter

Premenstrual dysphoric disorder: a subjective perspective through a clinical lens

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'How do we distinguish typical experience from something clinically diagnosable?' This is a fundamental question considered in any psychiatric setting, where we seek to understand an individual's difficulties and their holistic context to best inform their treatment. However, more recently, this question was asked of me in relation to premenstrual dysphoric disorder (PMDD) by a male colleague. Quite understandably, he has no subjective experience of the menstrual cycle or the possible associated symptoms. The subsequent conversation was enlightening for both of us. For him, I was able to provide an account of PMDD symptoms first-hand from a personal perspective, within a clinical framework. For me, I began to appreciate in a new way the difficulty our assigned-female-at-birth patients may have in conveying what has become their 'normal'.

PMDD is characterised by changes in mood with additional somatic or cognitive symptoms, occurring in the majority of a woman's menstrual cycles over the past 12 months.[1] These symptoms include mood lability, depression, irritability, anxiety, anger, feelings of helplessness, decreased interest in usual activities, difficulties with concentration, lethargy and fatigue, and a sense of being overwhelmed or out of control. This is in addition to physical symptoms of pain, cramps, bloating, and so on. Symptoms usually commence in the final week before menses and start to improve within a few days after the period starts.

A recent meta-analysis suggested a 1.6% prevalence rate of PMDD within the general population.[2] However, in clinical populations, the prevalence is much higher. For example, it is thought to range from 10 to 76% among individuals with a comorbid diagnosis of bipolar disorder;[3] moreover, a study found that 83% of women with PMDD had experienced early life trauma,[4] and women with PMDD are at greater risk of attempting and completing suicide than those without the diagnosis.[5] However, there has been little research or training to support clinicians to incorporate this into standard mental health assessment, and emerging evidence suggests that the burden is on the patient to advocate for a suspected diagnosis, rather than this being routinely considered in healthcare settings.[6]

My hope is that sharing my subjective experience – one that is understood through my clinical profession and expertise – will not only promote greater awareness of these symptoms and the effects they may have, but also give clinicians (of all genders) more confidence in asking their assigned-female-at-birth patients about their symptoms.

PMDD: a subjective account

Approximately 7–10 days before my period begins, my mood will start to deteriorate. I transition from being generally well to pronounced tearfulness, irritability and feeling 'on edge'. Critical thoughts become more frequent and intensify as the days pass. In the days closest to onset of menses, I begin to experience ego-dystonic suicidal ideation – often in response to the smallest of inconveniences. My internal narrative becomes hostile, with critical thoughts morphing into a non-stop diatribe of my failings, perceived weaknesses and imagined flaws, shaming and berating me for aspects of myself I have no power to change and would not want to change when I feel well.

My value in important relationships is questioned, with (again, ego-dystonic) thoughts emerging that my husband or family only tolerate me, that my friends do not really care for me and that my colleagues secretly deride me at any given opportunity. I begin to perceive myself as a burden to others, an inconvenience or annoyance. I evaluate my work more critically and am disparaging about my ability to contribute meaningfully or to help the patients with whom I work. When measured through psychometrics such as the ten-item Clinical Outcomes in Routine Evaluation or nine-item Patient Health Questionnaire, my scores when symptoms are most intense fall within the severe range of psychological distress, in contrast to being within the healthy range over the rest of my cycle.

My profession as a clinical psychologist means that I am particularly well equipped to understand what is happening to me while my PMDD symptoms are severe, and to manage them using adaptive strategies. Although I can understand that the thoughts I experience are a result of hormonal changes rather than a suddenly emerging mental illness – and can draw upon a litany of techniques to diffuse and challenge them – this requires constant attention. It is exhausting. Even with this understanding, the intensity and frequency of intrusive suicidal ideation can be distressing. Before I was diagnosed, I felt like I was 'going mad', something that has been expressed by many of my patients with PMDD.

During our discussion, my colleague expressed astonishment that I experience this every month – that he would never have known. And this, perhaps, is what I felt was so key to our discussion. Many women experience these symptoms in relative silence. The imagined alternative – that women may take time off or freely express their pain or distress for what could be a quarter of the month, every single month – seems impossible. We continue to attend work, to contribute to our families, to do our share of chores or household tasks. We will contribute to professional discussions and hold clinics, deliver therapy and write reports, all while masking the physical and mental pain we are experiencing (It should be noted that this is also true for all individuals experiencing chronic, unseen illness, be it mental or physical). Life goes on, and so must we.

What can we do?

Let us, then, as mental health professionals, do better at supporting our patients with these difficulties. Let us not assume that 'not seen'

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equates with 'not experienced'. Let us do better in advocating for our patients, colleagues, mothers, sisters and daughters, and for ourselves. Small changes are a positive start in reducing stigma and increasing awareness. The following are roles we can all take in improving our care of women with PMDD.

(a) Include questions about variation in mood or physical symptoms across the menstrual cycle in routine assessment.
(b) Highlight common ego-dystonic thoughts that can occur to validate an experience that might feel shameful or stigmatising to share.
(c) Reassure them that they are not alone and that management of symptoms is possible.
(d) Signpost to relevant organisations such as The PMDD Project (https://thepmddproject.org/) and the International Association for Premenstrual Disorders (https://www.iapmd.org/).
(e) Support and promote much-needed research into effective interventions for PMDD.

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In addition to NHS employment, K. Mitchell works in the private sector as a co-director of LINKAT Psychology, LLP.

References

1 World Health Organization (WHO). *International Statistical Classification of Diseases and Related Health Problems*, 11th edn. WHO, 2019 (https://icd.who.int/).
2 Reilly TJ, Patel S, Unachukwu IC, Knox CL, Wilson CA, Craig MC, et al. The prevalence of premenstrual dysphoric disorder: systematic review and meta-analysis. *J Affect Disord* 2024; **349**: 534–40.
3 Sharma V, Mazmanian D, Eccles H. Relationship of premenstrual dysphoric disorder with bipolar disorder: a systematic review. *J Clin Psychiatry* 2022; **83**: 43549.
4 Kulkarni J, Leyden O, Gavrilidis E, Thew C, Thomas EH. The prevalence of early life trauma in premenstrual dysphoric disorder (PMDD). *Psychiatry Res* 2022; **308**: 114381.
5 Prasad D, Wollenhaupt-Aguiar B, Kidd KN, de Azevedo Cardoso T, Frey BN. Suicidal risk in women with premenstrual syndrome and premenstrual dysphoric disorder: a systematic review and meta-analysis. *J Womens Health* 2021; **30**: 1693–707.
6 Chan K, Rubtsova AA, Clark CJ. Exploring diagnosis and treatment of premenstrual dysphoric disorder in the US healthcare system: a qualitative investigation. *BMC Womens Health* 2023; **23**: 272.

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