Premenstrual Dysphoric Disorder and Its Social Factors

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Abstract. Premenstrual dysphoric disorder (PMDD) affects countless women and girls globally; the symptoms are severe enough to generate impairment and distress. The hypothalamic-pituitary-adrenal axis is dysregulated in PMDD, according to previous research. However, few studies examine stress-related processes in real-time and in the real world among affected women. This research aims to analyze the individual and social factors of PMDD. The individual factor is discrimination. Especially for ethnic minority women, perceived discrimination can be toxic. Social factors include poverty, sexism, and abuse. Depression caused by a period of poverty is closely correlated with PMDD. Sexism might reduce the treatment efficacy of PMDD. Among early life traumas, emotional abuse is the most severe. The four factors: discrimination, poverty, sexism, and abuse, are closely related to PMDD. The article calls on the public to be aware of PMDD, and that society needs to treat women with PMDD fairly or even show more respect.

Keywords: Premenstrual dysphoric disorder, Perceived discrimination, Period poverty, Treatment efficacy, Emotional abuse

1 Introduction

Premenstrual dysphoric disorder (PMDD) is an official diagnosis in DSM-5. 80–95 percent of menstruating women experience physiological changes during the premenstrual period, but only 8-13 percent of these women have PMDD. Continually recording symptoms over multiple cycles is the only way to diagnose the condition. The prevalence of this disorder cannot be determined by determining whether it is an exacerbation of an underlying psychiatric disorder. PMDD causes cyclical mental, behavioral, and physical symptoms in the weeks preceding menstruation. There are several factors involved in the etiology of PMDD. Although several theories have been proposed to explain PMDD, it is still unclear as to its exact cause. PMDD resulted in similar impairments and lowered quality of life as a dysthymic disorder but is not nearly as severe as a major depressive disorder [1]. Despite extensive published epidemiological studies

A. Holl et al. (Eds.): ICHESS 2022, ASSEHR 720, pp. 1196–1202, 2022.
https://doi.org/10.2991/978-2-494069-89-3_138

and assessments of disease burden, PMDD remains under-recognized. PMDD is shown in this study to have a similar burden as other major recognized disorders, including disability-adjusted life years (DALY), lost [2]. There are several treatment options for PMDD, but selective serotonin reuptake inhibitors (SSRIs) have emerged as the first-line treatment [3]. It is essential to recognize the disorder and its impact to treat more women with PMS/PMDD. A better understanding of PMS/PMDD and its implications will allow more women to be treated. A literature review is conducted on current studies to study the factors contributing to PMDD.

2 Literature review

2.1 Definition

It affects the behavior, cognitive abilities, mental health, and academic performance of female students who suffer from the premenstrual dysphoric disorder (PMDD) [4]. According to DSM-5, to be diagnosed with PMDD, the women must experience symptoms that appear during the luteal phase and disappear after menstruation begins. Marked lability of effect, irritability or hostility, increased interpersonal conflict, hopelessness, or considerable anxiety must be present in at least one of the five needed symptoms. Symptoms like bloating, weight gain, breast tenderness, muscle pain, energy deficit, marked appetite change, insomnia, and uncontrollable feeling may be present [4].

2.2 Causation

2.2.1. Individual Factor

Previous studies have found that gender and cognitive discrimination are two individual factors of premenstrual dysphoric disorder.

First, The Detroit Area Study's Everyday Discrimination Scale (EDS), which gathered long-time and continuous discrimination during one's lifetime, was used to construct the perceived discrimination scale. Perceived discrimination can be divided into two categories: subtle and blatant. Subtle discrimination is distinguished by perceptions of rudeness and unfairness, which makes people feel cold. Blatant discrimination is one kind of direct discrimination. People use words or physical attacks to hurt others. Perceived discrimination was linked to more severe anxiety disorders, psychosis, drug abuse disorders, symptoms of depression, anxiety, and post-traumatic stress disorder, according to a meta-analysis.

Moreover, discrimination based on gender and race is detrimental to emotional stability [5]. Based on this analysis, a study discovered a link between PMDD and racial and gender prejudice. This implies that ethnic women may encounter two or more types of prejudice, which may affect their experience of PMDD [6]. Subtle discrimination can lower one's self-respect and is badly related to menopausal symptoms and severe depression. Consequently, it might potentially be connected to PMDD [7].

Second, PMDD is one kind of affective disorder. In one study, women with PMDD were given emotional recognition in facial expression tasks to see if processing mistakes resembling those in depression existed and if they were exclusive to the luteal

phase. They found a tendency for women with PMDD to view emotions expressed on faces more negatively during the luteal phase. The movement may extend to the menses. What is worse, a negative bias in the processing of emotion in facial expression can lead to their negative affective state being reinforced. They call this negative bias facial emotional discrimination. A luteal phase-dependent deficit in dealing with dynamic information that can't describe with words is seen in women with PMDD. It may exacerbate depressive symptoms during the luteal phase, before the menses [8].

2.2.2. Social Factors

2.2.2.1. Poverty.

Poverty is also one of the social factors of PMDD. A higher risk of psychological issues is associated with it. It is claimed that the cornerstone for health and well-being is the provision of one's fundamental requirements—food, water, and shelter. Research shows that people's mental health may be adversely impacted when specific demands are unmet. Menstrual hygiene is also a vital requirement for women [9]. Period poverty, a pertinent circumstance characterized by a lack of access to menstruation products, education, hygienic facilities, and waste management, may occur. According to the World Bank, 500 million women and girls worldwide do not have access to menstruation products or sufficient menstrual hygiene management facilities. People who have this syndrome are unable to participate in regular activities like going to work or school. Physical, mental, and emotional difficulties resulting from it. Women who reported past-year poverty every month were likelier to have moderate or severe depression [10]. Although no scientific journal supports that deprivation can directly cause PMDD, research shows that depression and PMDD are closely correlated: Previous histories of depressive and other mood disorders have been recorded in 30 - 70% of women with PMDD and PMS. Among studies that retrospectively diagnosed PMDD, depressive disorders occurred in 18 - 69% of women suffering from PMDD.

2.2.2.2. Sexism

The second social factor of PMDD is sexism. Sexism is to treat and evaluate men and women unequally, such as many daily annoy and passive life occurrences, such as sexual harassment and unequal salary between men and women [11]. Specifically, Szymanski et al. [11] found three types of sexism -- prejudice and stereotypes of traditional gender roles, demeaning and derogatory remarks, and harmful sexually objectifying comments and behaviors. One of the manifestations of sexism is demeaning and derogatory remarks. For instance, 'emotional' is always used to describe women in our daily life. 'High-maintenance' is always used to describe women in a relationship. These two words are more likely to describe women than men, so girls might feel stressed when they are stigmatized with these words. An example of harmful sexually objectifying comments and behaviors is that around 20% of the employees of both genders in Norway report having experienced sexual harassment within the last six months. Girls experience more harassment than men. People who experience sexual harassment might have posttraumatic stress disorder [12]. These sexist events as stressors might influence

people throughout their life, which can be recognized as traits of psychological pressure and distress [11].

Aside from that, hostile and benevolent sexism are two types of sexism that are associated with PMDD. Hostile sexism is an apparent negative view toward women, often containing the thoughts that women pursue to control men by feminism [11]. More specifically, some negative stereotypes of women, such as the belief that women are born to be a housewife [11]. Benevolent sexism is not apparent but includes a chivalrous ideology that stimulates safeguarding women who follow traditional roles [11]. In Feight et al.'s study, many females endorse benevolent sexist thoughts, such as "women should be protected and treatured by males," as " women should be treated " [11]. Therefore, women generally prefer benevolent sexism and reject hostile sexism [11]. Benevolent sexism was linked to the thinking that menstruation leads to physical rest [11].

Furthermore, hostile sexism was positively associated with the rejection of menstruation in women [11]. Sexism might reduce the treatment efficacy of PMDD. Moreover, experiences of sexism and harassment might adversely influence the mental well-being of United States women [11].

In all, the devoid of sexism has been shown that women may gain more understanding of premenstrual changes [13]. Therefore, discussing severe symptoms of the premenstrual dysphoric disorder can be facilitated [13]. This can prevent more and more women from silently enduring a treatable disease [13].

2.2.2.3. Abuse

The other factor is abuse. In other words, one of the causes of PMDD includes unfortunate early incidents. Physical abuse, sexual abuse, emotional abuse, and neglect are four types of precocious life incidents classified by the World Health Organization (WHO). [14] Physical abuse is the intentional use of force against a child that harms the child's health, survival, development, or dignity. Sexual abuse is the involvement of the child in sexual activity that they do not fully comprehend. Emotional abuse damages a child's physical and mental health, including restriction of movement, blaming, threatening, etc. Lastly, neglect includes isolated incidents [14].

However, research indicates that among all types of early life incidents, childhood emotional abuse causes the harshest harm since an adult is expected to love and respect the perpetrated child. Also, the intervention of this prospect is particularly defamatory. Furthermore, the child was supplied with passive cognition from the perpetrator, then gradually develops into a passive self-perception when childhood abuse is oral. The negative awareness includes "how worthless you are." [14]. In addition, standing or iterative reveal of the incident can institute sick mutations of mental and physical disorders. Therefore, chronic precocious life incidents are specifically destructive in their impression of HPA axis functionality [14]. Kulkarni illustrates part of the stack-up phenomenon of matters will be formed by discretionary variations, which lead to PMDD in children of early life vulnus. Besides, larger amygdala volumes after childhood adversities, which are associated with abnormal cortisol response to psychosocial stress, are also noted among women with PMDD [15].

2.3 Treatment

The treatment of PMDD is mainly in the following aspects: medication, psychotherapy, nutritional adaptation, and lifestyle changes.

As mentioned above, PMDD is an emotional disorder similar to depression, so antidepressant medications may be considered when treating P MDD. Symptoms triggered by anxiety can also be relieved by anti-anxiety drugs. According to the researchers, PMS may be related to hormone levels. Serotonin is a brain chemical (neurotransmitter) thought to play a vital role in emotional states, and its fluctuations can trigger PMS symptoms. Insufficient serotonin levels can lead to premenstrual depression, fatigue, food cravings, and sleep problems. Therefore, hormones are also used in the treatment of PMDD.

The focus of psychotherapy is not only to unblock the patient's psychological disorders, help them reshape their self-worth, and restore everyday interpersonal communication but also to deepen the patient's understanding of the disease through the education of the patient's family, which can achieve the effect of reducing conflict and alleviating symptoms. Common psychotherapies are cognitive behavioral therapy.

Because further research is needed on whether drugs have side effects, PMDD patients are also advised to adjust their dietary nutrition allocations and make lifestyle changes. Dietary adjustments, such as high-carb meals and reductions in salt, caffeine, and alcohol, consider eating fewer and more meals. Proper intake of vitamins and trace elements can also alleviate the adverse symptoms of PMDD. Lifestyle changes are reflected in increasing the amount of exercise, reducing staying up late, etc., mainly for the patient's lousy living habits to adjust.

The above treatment regimen can be selected according to the patient's etiology and symptoms, and either unilateral or combination therapy is feasible. As the patient's symptoms and age change, the treatment regimen should also be adjusted appropriately.

3 Implication and future directions

Although the existing literature has already contributed plentiful information about the premenstrual dysphoric disorder, some aspects for improvements in the future still need to be taken into consideration.

First, more research and studies should be continued to provide and support the effects of social factors, such as discrimination, poverty, and abuse, on PMDD. In other words, the public should notify gender and race discrimination and try to avoid such bias against women. More research about the association between poverty and PMDD needs to do to promote PMDD research and find more approaches to help women. Besides, more regulations related to emotional abuse should be acted to protect women from suffering PMDD. Also, it should be ensured to advance understanding of the association between varying individuals and social factors with PMDD in future research.

Moreover, recognizing sexism and correcting people’s attitudes toward different genders are also important to women with PMDD. In the field of treatments of PMDD, if sexism is recognized, people will be more likely to be able to take action to attempt to eliminate or decrease sexism for better publicity among women and the public.

Therefore, the research and discussion of PMDD can be enhanced to some extent through more understanding among women who are the targeted people.

Last, PMDD is a particular disorder that only women have; it is imperative to eliminate or decrease sexism to encourage more professionals to participate in studies related to PMDD. Therefore, the criteria of symptoms and related treatments of PMDD can be standardized in a shorter period, especially mediation treatments, since medication treatment is a more popular treatment worldwide for most disorders. Still, PMDD does not have a specific medication, only general ones.

4 Conclusion

In conclusion, the four social factors: discrimination, sexism, poverty, and abuse are all closely associated with the occurrence of PMDD. Women from ethnic minorities may particularly suffer from perceived prejudice. Moreover, women with facial emotional discrimination can generate more negative emotions. It is better to avoid sexism to facilitate further research of PMDD. Therefore, women can understand more about PMDD. Speaking of poverty, poverty is highly risky for PMDD.

Moreover, depression caused by a period of poverty is closely correlated with PMDD. More severe than other forms of early life trauma is abuse, especially emotional abuse. Also, it can affect PMDD through negative self-perception, impaired interpersonal relationships, the HPA axis, and amygdala volumes.

For our topic, sexism might reduce the treatment efficacy of PMDD, but it is still possible that PMDD patients can heal. It can be treated by changing lifestyle and supplying nutrition. Medical interventions are also critical, such as nonpharmacologic treatments, herbal therapies, pharmacologic Interventions, antidepressant and anxiolytic medications, hormonal therapies, and miscellaneous pharmacologic interventions.

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