TREATING PREMENSTRUAL DYSMORPHIC DISORDER


By

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Dedication

This thesis is dedicated to my grandparents John and Lois Pepper, who are the only reason I entered this program and without whom I may not have gotten this far. Also Caffeine, I dedicate this thesis, and the rest of my life, to Caffeine.
Abstract

The prevalence of Premenstrual Stress (PMS) is 30% and Premenstrual Dysmorphic Disorder (PMDD) is 8% of the current female population. There is very little research available on PMS and PMDD, however, the manual created for this thesis covers various topics and techniques to help reduce aversive the symptoms. The manual also provides easy to access information that is understandable to all women from various backgrounds. The manual focuses on best practices according to the literature. It includes techniques known as common treatments for PMS and PMDD such as stress reduction, cognitive behavioural therapy, maintaining a healthy life style, antidepressants, and hormone therapy. The manual was informally reviewed by women who provided feedback on strengths and limitations of the content.
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Chapter I: Introduction

According to the Mood Disorder Association of Ontario (2013) Premenstrual Stress Disorder (PMS) affects approximately 30% of women between puberty and menopause and of these women 8% meet the diagnostic criteria for Premenstrual Dysmorphic Disorder (PMDD). According to WebMD (2014), PMS and PMDD share the same symptoms except that PMDD is greater in severity. The DSM-5 diagnostic criteria for PMDD includes the presence of at least five of the following symptoms (at least one being of the first four) depression, anxiety, increased emotional sensitivity, irritability, difficulty concentrating, lethargy, change in appetite, change in sleep patterns, and feeling overwhelmed (American Psychiatric Association, 2013). Other symptoms include breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain. These symptoms must be severe enough to interfere significantly with daily functioning. They must also occur during the last week of the individual’s luteal phase, begin to fade within a few days of the onset of her menstrual flow, and not be present during menstruation or the week following (American Psychiatric Association, 2013).

PMDD significantly interferes with an individual’s daily life, and while there are no known methods to prevent the occurrence of PMDD (Stöppler, 2013) there is some research into effective treatments. Common treatments include stress reduction, cognitive behavioural therapy, maintaining a healthy life style, antidepressants, and hormone therapy (Mood Disorder Association of Ontario, 2013).

This manual is written as a fourth year thesis project that enables those with PMS and PMDD, as well as those living and working with these women, to have a basic understanding of common treatment options. Each treatment includes a brief overview of relevant literature as well as a description of its application. The purpose of this manual is to provide treatment information that can be applied consistently to reduce symptoms for women with PMDD in any setting.

Manual Description

This manual is designed to provide easy to access information on treatment options for women with PMS/PMDD that can be used both by the women themselves and, in some circumstances their caregivers. Caregivers may be necessary with minors, and women with severe symptoms, medical conditions or developmental delays. The manual includes eight chapters detailing different types of information. The first chapter provides an overview of PMS/PMDD including the prevalence, diagnostic criteria, intended audience and an overview of informed consent in case of implementation in an agency setting. Chapters 2-7 provide specific information on treatments including definitions relevant to each treatment, which symptom(s) it targets, a brief literature review, as well as specific method(s). These treatments include mostly behavioural approaches; medical treatments are included as well given that they are one of the
most common treatment methods. Medical interventions are included to provide readers with a comprehensive understanding of what treatments are available. It is important that readers consult their physicians about any medical decisions and bring immediate concerns to their physical health care providers. The final summary chapter provides a brief overview of important information and direction to additional resources as well as the appendix which is a topic guide that provides suggested topics to talk about to a physician.
Chapter II: Literature Review

There are many treatments for PMS/PMDD; however there is a notable lack of empirical literature endorsing any one form of intervention. The general consensus in the current literature is that treatment must be individualized as there is no universally effective treatment for PMS/PMDD. Some treatments only target individual symptoms but the majority of treatments target multiple symptoms. Stress reduction, Cognitive Behavioural Therapy (CBT), maintaining a healthy lifestyle, as well as medical treatments such as antidepressants, and hormone therapy are amongst the more common treatments as indicated by the Mood Disorder Association of Ontario (2013). Various symptoms according to the American Psychiatric Association include depression, anxiety, emotional instability, irritability and difficulty concentrating, and pain. Exploring effective treatments for each of these symptoms is both important and relevant because those interventions can be incorporated to reduce the physical and emotional distress experienced by the woman.

Kharbanda, Kulkarni, Bhandari et al. (2012) conducted a cross sectional study of PMS among 348 medical students in South India. Of these 219 (67%) were found to have PMS. They found that irritability was the most common affective symptom affecting 252 (77%) of the women followed by anger outbursts affecting 208 (63%) of the women; these symptoms were reported primarily by those who are overweight. Other symptoms that are more common in overweight women were depression, anxiety and irritability. Of the women studied 188 women (57.5%) reported interference in daily activities (decrease in going out habits) and loss of concentration was reported by 196 (59.9%); these symptoms being reported evenly among women of all weight categories. Kharbanda and associates concluded that PMS was common among the participants indicating the need for increased availability of effective interventions.

Depression and Anxiety

Depression and anxiety are among the five key symptoms in diagnosing PMS/PMDD according to the American Psychiatric Association; Mohamadirizi and Kordi (2013) found that 44.3% of women studied reported anxiety and 45.5% reported depression during their premenstrual cycle. Lin, Tsai, Peper, and Yen (2013) sought to explain the prevalence and found a relationship between premenstrual distress, depressive symptoms, and frontal alpha asymmetry. Yonkers (1997) noticed a similarity in the treatments used for both anxiety and PMDD and postulated that there is a link between them. An effective nonmedical treatment for these symptoms according to Roshanaei-Moghaddam, Pauly, and Atkins (2011) is CBT. These results are supported by findings from other researchers, including Hunter, Ussher, Cariss, et al. (2002) and Oei and McAlinden, (2014).

In order to determine the association between menstruation signs and anxiety, depression, and stress Mohamadirizi and Kordi (2013) conducted a cross sectional study on 407 high school girls in Mashhad, Iran who were selected using two-step random sample. These students were
required to complete a questionnaire concerning demographic characteristics, menstrual flow, the Depression, Anxiety, and Stress Scale of 21 questions (DASS-21), as well as menstruation signs in three phases of their menstruation. This data was then analysed using the Pearson correlation coefficient, Student's t-test, one-way analysis of variance (ANOVA), and regression through SPSS version 14. They found that 74% of the subjects reported signs during pre-menstruation, 94% reported signs during bleeding, and 40.8% reported signs after their menstruation period. In addition 44.3% of the subjects had anxiety, 45.5% had depression, and 47.2% had stress (Mohamadirizi & Kordi, 2013). These results suggest a correlation between pre-menstruation, menstruation and increased perception of anxiety, depression, and stress among the participants. The main strength of this study was that it included a large sample size of 407 high school girls. However, a potential limitation is that the sample only included high school students in Mashhad, which means the results, may not generalize to other populations. Specifically, there may be confounding variables in the study, such as age and social pressures related to the physical demographic due to their culture and religious beliefs.

Another study by Lin et al. (2013) examined the relationship between premenstrual distress, depressive symptoms, and frontal alpha asymmetry. They studied the differences in frontal alpha asymmetry in 12 college women with PMDD and 12 without PMDD during a depressive induction condition while in the luteal and follicular phases of their menstrual cycles. The participants received frontal electroencephalograms during these phases of the menstrual cycle first during resting baseline, then depressive induction, followed by depressive recall, recovery, and a period of relaxation. They also completed a premenstrual distress questionnaires and the Beck Depression Inventory II (BDI-II). It was revealed that frontal alpha asymmetry was higher among patients with PMDD during the depressive induction and relaxation conditions during the luteal phase. As well, there was a positive correlation between negative affect (measured by premenstrual distress questionnaires) and frontal alpha asymmetry during the depressive induction stage. Another finding was a positive correlation between somatic depression (BDI-II) and frontal alpha asymmetry in the depressive induction stage. These findings indicated significant differences in frontal alpha asymmetry between women with and without PMDD. While no causation can be implied further research is warranted for future diagnostic and intervention approaches.

According to Yonkers (1997), the symptom profile of PMDD has been empirically derived from a number of investigations. Depression and mood swings are the most commonly reported symptoms, and a substantial number of women report tension and anxiety. Yonkers suggests there is an association between PMDD and an anxiety disorder because the same treatments are effective for both.

Roshanaei-Moghaddam, Pauly, and Atkins (2011) compared the effectiveness of CBT on anxiety and depression through a meta-analysis of 21 studies on depression and 21 studies on anxiety. They found that panic disorder benefitted from CBT significantly more than from medication and obsessive compulsive disorder benefitted from CBT marginally more than from medication. Medication was slightly more effective for social anxiety disorder and depression
showed equally beneficial results. These results are similar to Oei and McAlinden, (2014) who also found that CBT is effective in treating both symptoms.

Oei and McAlinden, (2014) assessed the connection between quality of life and symptom change following group CBT for anxiety or depression. They studied 177 outpatients undergoing eight sessions of group CBT, 124 for anxiety and 53 for mood disorders. Using a pretest-posttest design, the researchers collected data using the Beck Anxiety Inventory (BAI), Zung Self-Rating Depression Scale (Zung-SRDS), Quality of Life Inventory (QOLI), and Satisfaction with Life Scale (SWLS). They determined that overall group CBT appeared to be successful in increasing quality of life and satisfaction with life in addition to reducing anxiety and depression symptoms among those participating in the study. Hunter and colleagues (2002) found similar results when comparing CBT and medication with a group of women with PMDD.

Hunter and colleagues (2002) compared the effects of fluoxetine, and CBT on depression and anxiety experienced by women with PMS. Forty-five women were divided into CBT (n=24) and fluoxetine (n=21) groups. Their reported levels of anxiety and depression were then measured at baseline, 3 months into treatment, and 6 months into treatment and again at one year follow up. They found that the fluoxetine group showed fewer symptoms of anxiety and depression at 3 months; both groups demonstrated an equal decrease in symptoms after 6 months. Additionally the CBT group reported having better coping mechanisms at the one year follow-up.

These studies all demonstrate the effectiveness of using CBT to treat anxiety and depression, however, Roshanaei-Moghadam and associates (2011) states that medical treatments may be slightly more effective in the treatment of anxiety. Roshanaei-Moghadam and associates (2011) compared multiple studies but did not specify whether the studies included a post treatment and if they did when the post treatment was conducted. Hunter and colleagues (2002) noted that medication is slightly more effective at 3 months post treatment but is equally as effective at 6 months. The time dependent difference in effectiveness at post treatment may contribute to the difference in findings by Roshanaei-Moghadam and associates (2011) and Hunter and colleagues (2002).

Another factor to consider when comparing CBT and medical treatments is quality of life. According to Oei and McAlinden, (2014) CBT increases the quality of life even after the termination of treatment. This is probably due to the acquisition of coping skills. CBT teaches lifelong skills that the client can use even after treatment whereas once the client stops taking medication her ability to cope deteriorates. CBT and medication may show similar effectiveness during therapy but CBT may be more resilient because it incorporates skill building that clients can continue to use.

**Emotion Instability**

Emotional instability is another major symptom of PMDD outlined by the American Psychiatric Association (2013). According to Cubeddu, Bucci, Giannini, et al. (2011) the cause
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of emotional instability is different than what causes depression and anxiety according to Lin, Tsai and associates (2013). Cubeddu and associates (2011) believe that emotional instability is caused by an alteration in the cyclical hormonal modifications and ovarian steroids. The treatment of emotional instability is, however, similar to that of depression and anxiety. Hill and Updegraff (2012) found that mindfulness based CBT was effective in increasing emotional stability among non PMS/PMDD specific subjects and Van-Leeson, Totterdell, and Parkinson (2006) had similar results with women with PMDD.

Cubeddu and colleagues (2011) state that PMS may be caused by an alteration in the cyclical hormonal modifications and ovarian steroids that are directly involved in the regulation of mood, emotions and cognitive functions. These hormones also influence neurotrophins expression, particularly the brain-derived neurotrophic factor (BDNF). In order to evaluate whether plasma BDNF levels in women with PMS differ from those of normally menstruating women plasma samples were collected at day 7 (follicular phase) and day 21 (luteal phase) of the menstrual cycle from 35 women with PMS and 27 normally menstruating women. They found that BDNF levels increased significantly in the control group from the follicular phase to the luteal phase while they decreased in the PMS group. Cubeddu and associates (2011) determined that the lower luteal BDNF levels of the PMS women might be a consequence of an altered hormonal response which may be the cause of PMS symptoms, particularly mood regulation.

Hill and Updegraff (2012) studied the effects of mindfulness based CBT on the emotional regulation of 96 undergraduate students from a large Midwestern university (70 female, 26 male). They had participants record their emotional experiences on a PalmPilot device 6 times a day for a week and concluded that mindfulness based practices contributed to higher emotional self-regulation. In a similar study by Van-Leeson, Totterdell, and Parkinson (2006), 22 women between the ages of 17 and 48 recorded their mood every two hours during the time they were awake using the Mood Awareness Scale (MAS) (Van-Leeson, Totterdell, & Parkinson, 2006: Swinkel & Giuliano 1995). Participants also recorded the onset of their menstrual flow. It was determined that monitoring mood and using cognitive distraction techniques helped participants to regulate their moods during PMS.

Irritability and Difficulty Concentrating

According to Yen et al. (2012) there is a relationship between working memory, concentration and irritability among women with PMDD. They studied 60 women with PMDD and 60 without, measuring severity of irritability, difficulty concentrating, total symptoms, and functional impairment using Premenstrual Symptoms Screening Tool. They found that women with PMDD had significantly poorer performance on memory tasks than the control group during luteal phase, but had similar performance during the follicular phase. The PMDD group also had more deterioration in performance during luteal. Performance during the luteal phase was associated with irritability, symptom severity, and functional impairment by PMDD.
Another common symptom of PMDD is pain. Straneva, Maixner, Light, et al. (2002) suggest that lower cortisol and beta-endorphin levels may be the cause of pain during menstruation for both women with and without PMDD. This means that pain may be caused by a different mechanism than emotional instability and depression and anxiety. Two common treatments for pain management are relaxation and heat therapy.

Straneva and associates (2002) examined pain sensitivity and pain modularity mechanisms (e.g., beta-endorphin levels, blood pressure) in 27 women with premenstrual dysphoric disorder and 27 women without during the follicular and luteal phases of the menstrual cycle. Both groups displayed lower resting cortisol and beta-endorphin levels, exhibited shorter pain threshold and tolerance times and greater pain unpleasantness ratings (Straneva, Maixner, Light, et al., 2002). In addition, Straneva et al. found that women with PMDD reported greater pain unpleasantness and intensity, had lower beta-endorphin levels in their luteal phase and tended to display higher blood pressure levels at rest and during pain testing.

One nonmedical treatment for pain is relaxation; Slavin-Spenny, Lumley, and Thakur (2013) used relaxation training to reduce the pain of headaches. Since suppressing emotions, particularly anger, tends to intensify the experience of pain they tested the effects of mindfulness and acceptance training. One hundred and forty-seven young adults were divided into three groups, relaxation training, mindfulness and acceptance training, or the control group. They found that both treatments increased pain management but only the mindfulness and acceptance training group reduced alexithymia and increased emotional processing and assertiveness.

Delara, Ghofranipour, and Fallah (2013) conducted another study on the effects of relaxation on pain management. They conducted a trial on 1578 high school students with PMS who were separated into three groups: the first group had 98 participants who received an intervention containing detailed information about relaxation, the second group had 150 participants and received an intervention containing general information about relaxation and the third group of 163 participants was the control and received nothing. They found that the participants who received more education on stress reduction had a higher decrease in symptoms.

Another possible nonmedical treatment for pain management is the application of a heat pad. Mee-Young, Ju-Hyun, Jeong-Uk, et al. (2011) found that using heat pads for 30 minutes decreased pain for three hours as assessed using the Visual Analogue Scale (VAS), the Faces Pain Rating Scale (FPRS), and the Iowa Pain Thermometer (IPT). This study was done on 74 patients (45 female; 29 male) with chronic pain in the low back, knee, or shoulder regions; there is evidence to suggest that heat pads are effective for PMS specific pain as well. Han-Fu, and Yu-Hua (2011) investigated the efficacy of various strategies to self-manage menstrual cramps. They conducted a survey of 616 young Taiwanese women, 570 reported experiencing menstrual cramps at least once in the past year, 180 of whom reported experiencing them during every period. These women were divided into two groups, group one being the women experiencing menstrual cramps every period and group two being the other 390 women. They found that
group one used self-management strategies more frequently and benefited less. While herbal medicines, such as Paracetamol and Dang-Qui-Shao-Ya-San were reported to be most effective, other strategies such as heat and brown sugar were effective as well. Gregson (2000) also mentions the use of heat treatment along with various medical treatments and massage for treating symptoms of PMS. While there may be more effective methods available, heat application appears to be effective in decreasing pain associated with PMS.

**Combined Treatments**

Some treatments target multiple symptoms. CBT and life style choices have been found effective in decreasing all symptoms of PMS/PMDD. Lustyk, Gerrish, Shaver, and Keys (2009) recommend mindfulness and acceptance-based CBT interventions to reduce symptoms of PMS/PMDD, while Bussell (1998) states that specific life style choices may contribute to the symptoms of PMDD and therefore changing life style choices may be effective in reducing symptoms.

CBT is listed by the Mood Disorder Association of Ontario (2013) as a common treatment for PMDD; after systematically reviewing empirical studies on the use of CBT for PMS or PMDD Lustyk et al., (2009) support this notion. They conclude that applying mindfulness and acceptance-based CBT interventions may be effective in reducing symptoms of PMS/PMDD. However they caution that further research in this area is still required as there is a notable lack of empirical evidence.

According to the Mood Disorder Association of Ontario (2013) life style change is another common treatment. Bussell (1998) recommends that all women reporting PMS related symptoms be assessed for dietary issues. If diet is determined inadequate dietary changes should be the first choice for treatment as proper diet may increase a woman’s tolerance to pre-menstrual changes thereby reducing the impact of all PMS symptoms on her daily life.

Bussell (1998) describes a four phase dietary approach. In the first phase fats, simple sugars, salt, alcohol and caffeine are reduced while fiber and starch are increased. If this does not produce sufficient improvements in 3 months phase two should be initiated. In phase two refined sugars are phased out and avoided as much as possible and starchy food is consumed every 3-4 hours. If after a month there are still little to no improvements the third phase begins and an array of vitamins and minerals are prescribed including B6, GLA and magnesium; other supplements such as calcium, vitamin D and zinc may be recommended as well. This phase continues for 3-4 months; if still not effective, the fourth phase begins. Bussell describes this phase as the time to rule out and treat other underlying medical conditions such as allergies, and intolerances, diabetes, anaemia and irritable bowel syndrome.
Medical Treatments

If all other methods of treating PMDD are ineffective drug therapy may be considered. It is important that all medical decisions be made in consultation with a physician and any complications be discussed with him or her directly. Common medical treatments for PMDD include antidepressants and hormonal medications. A meta-analysis conducted by Freeman (2005) found that antidepressants may be beneficial. As another option, Studd stresses the importance of balancing transdermal estrogens, testosterone and, progestogen. Pincus, Alam, and Rubinow, et al. (2011) on the other hand found that Lupron (a hormonal medication) can decrease mood fluctuation in women with PMDD. Freeman (2005) conducted a meta-analysis on the use of antidepressants, finding that specifically selective serotonin reuptake inhibitors (SSRIs) are an effective treatment for both mood and behavioural effects of PMDD. The findings suggest that both continuous and luteal-phase SSRI dosing regimens are similarly effective and well tolerated.

Another effective form of medical treatment is hormonal therapy. Studd (2011) states that premenstrual depression, as well as postnatal and climacteric depression are related to changes in ovarian hormone levels and can therefore be treated by hormone therapy. This is because it is necessary to have a balance of transdermal estrogens, testosterone and, progestogen. Transdermal estrogens suppress ovulation and the cyclical hormonal changes that are produced during the premenstrual period. According to Studd, transdermal testosterone may be recommended to improve mood, energy and libido. On the other hand, Studd warns that progestogen should not be recommended to all women, as progestogen-intolerance is common. Special consideration should also be taken if the woman has had her uterus removed; in this case, to prevent unpleasant side effect such as endometrial hyperplasia or return of PMS-type symptoms, progestogen should be used in the lowest dose and for the shortest duration necessary. In addition Studd states that while hormone-responsive depression cannot be diagnosed by measuring hormone levels, it can be diagnosed by a carefully recording and analysing depression history related to the menstrual cycle.

Pincus and colleagues (2011) found that in a study of 45 women with PMDD, they responded better on self-ratings of sadness, anxiety, and irritability over the three month period following leuprolide injections. These findings were replicated by Baller, Wei, Kohn, et al., (2013) in their study on 29 patients over a six month trial period. The U.S National Library of Medicine (2014) state that leuprolide injections work by suppressing estrogen and inducing a menopausal state thereby preventing PMS and PMS related symptoms.

These studies recommend medications that target different chemicals in the women’s bodies suggesting that there are multiple potential biological factors contributing to the experience of PMS/PMDD. Freeman (2005) suggests the use of antidepressants, specifically SSRI’s. Studd recommends ensuring the balancing sex hormones such as transdermal estrogens, testosterone and, progestogen. Similarly Pincus and associates (2011) found that Lupron, which suppresses the development of estrogen, may be effective. This strongly suggests a hormonal
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influence in the experience of PMS/PMDD however a diagnosis of PMDD does not imply a specific hormone imbalance.

Conclusion

PMDD is rare affecting only 8% of women in childbearing years; however PMS is more common with 30% women being affected (Mood Disorder Association of Ontario. 2013). There are many potential treatment options for women with PMS and PMDD and therefore treatment should be carefully considered to target an individual’s specific symptoms. Not all treatments will be effective for all women; therefore different approaches may be required to find the most effective intervention for each individual.

Different symptoms of PMDD have been linked to different physiological factors such as depression and frontal alpha asymmetry (Lin et al., 2013). Cubeddu and colleagues (2011) attributed emotional regulation to an alteration in the cyclical hormonal modifications. Pain during PMS may be caused by ovarian steroids and beta-endorphin level according to Straneva and associates (2002). Furthermore it has been proposed that there is a link between PMDD and an anxiety disorder (Yonkers, 1997)

Despite different factors contributing to different symptoms CBT may be effective in treating all of them as demonstrated by Lustyk, Gerrish, Shaver, and Keys (2009) using mindfulness based CBT. Anxiety and depression in particular may benefit from CBT treatment (Hunter, Ussher, Cariss, et al. 2002). Van-Leeson, Totterdell, and Parkinson’s (2006) study also supports the effectiveness of mindfulness practice through mood recording and cognitive distraction on PMDD. Delara et al., (2013) found that increasing education on stress reduction decreases pain. Another possible pain management strategy may be heat treatment as suggested by Han-Fu, and Yu-Hua (2011) and Gregson (2000).

According to Mood Disorder Association of Ontario (2013) life style change can be highly effective in reducing the effects of PMDD. This is supported by Bussell (1998), who claims that maintaining adequate nutrition is effective in reducing symptoms. Bussell suggests that all women experiencing symptoms of PMDD first be screened for nutritional factors before seeking other treatments.

If other treatments remain ineffective, it may be necessary to consult a physician about medical treatment options. There are two common possible medical options; these include antidepressants and hormonal medications. Selective serotonin reuptake inhibitors (SSRIs) may be prescribed either continuously or during the luteal-phase and both prescription methods were found to be similarly effective and well tolerated (Freeman, 2005).

Finding a balance off transdermal estrogens, testosterone and, progestogen using hormonal therapy appears to be effective in decreasing symptoms of PMDD (Studd, 2011). Studd states that this treatment is particularly effective for depression. In addition to transdermal estrogens, testosterone and, progestogen supplements Pincus et al. (2011) and Baller et al.,
(2013) found that leuprolide injections successfully treated sadness, anxiety, and irritability associated with PMDD.

These studies provide preliminary evidence of potential treatments for multiple symptoms of PMS/PMDD. Despite the lack of research what little evidence there is, is in support of cognitive behavioural therapy, stress reduction/relaxation techniques, maintaining a healthy life style, antidepressants, and hormone therapy.
Chapter III: Methodology

Participants

As the focus of this thesis was the design of a theoretical manual of best practices, there were no human participants. The manual provides an overview of the literature on best practices and strategies in the treatment of symptoms of PMS and PMDD. It was designed for the use of women experiencing symptoms of either PMS or PMDD. These women should be assessed to ensure that symptoms only occur during the last week of the luteal phase and are related to PMS/PMDD and not caused by other factors. For most women the interventions described in this manual can be chosen and implemented independently. Some treatments, including medication and CBT, may require the assistance of a medical professional. Some women such minors and women with severe symptoms, medical conditions or developmental delays may require assistance from a primary care provider. In the case of a minor, assistance may only be needed in the form of consultation with a healthcare provider or consent for treatment while actual application of some interventions (such as applying a heat pack, relaxation, mindfulness and life style changes) may be implemented with minimal to no outside assistance. Some women may require additional assistance with implementing interventions such as providing access to heat pads and prompts to take a break. They may also require assistance engaging in mindfulness and implementing life style changes.

Design

A manual of best practice was designed to inform women with PMS/PMDD and their primary caregivers of available treatment options according to empirical literature (Appendix A). The manual is divided into seven chapters, which direct readers to the desired section as well as subheadings to help locate specific information. The first chapter provides an introduction as well as definitions of PMS and PMDD. The following five chapters explain the best practice according to treatments: Mindfulness, Relaxation, Heat Pads, CBT, Diet Modifications, and Medications. These chapters include all pertinent definitions for each chapter, a brief review of supporting literature, as well as specific intervention methods. The final chapter includes a final summary of all information presented in the manual and direction to the appendices. The manual was written to maximize the user’s understanding of the material presented. Since it is necessary to consult a professional before implementing treatment a topic guild was included in Appendix A of the manual which highlights key topics/questions to discuss with a professional regarding determining if symptoms are PMS/PMDD related and determining an effective treatment method.
Evaluative Measure

The original manual included an evaluation form to provide users the opportunity to provide feedback after reading the manual (Appendix B). Feedback was collected from women who report experiencing PMS to test its compatibility for personal use. This feedback was used to ensure the manual provides all information necessary to conduct each intervention in an understandable manner for users without a behavioural background as well as the feasibility of implementing interventions. The user was requested to identify areas that need to be modified, added or deleted from the manual to ensure thorough understanding of each of the topics; the author will use this feedback to improve the manual in the future.
Chapter IV: Results

A manual was created (Appendix A) and informal feedback was solicited from various women who reported experiencing PMS related symptoms. The manual was then updated in accordance to the comments and suggestions provided in the feedback. The feedback collected was qualitative, not quantitative; therefore no analysis could be conducted.

Feedback from the original manual indicated it was too formal and boring which made it difficult to read. Another common criticism was that there should be more specific examples and resources mentioned. These critiques were incorporated in the manual to the extent possible, however, due to time constraints and inability to obtain permissions specific worksheets could not be included directly and instead readers were directed to outside resources.

Some positive comments was also provided; reviewers found the suggested methods easy to use and effective in diminishing minor symptoms of PMS. None of these women however experience severe symptoms that would lead to a diagnosis such as PMDD so could not comment on the effectiveness of treatments on severe symptoms.
Chapter V: Discussion

The Mood Disorder Association of Ontario (2013) states that 30% of females between puberty and menopause experience PMS and 8% experience PMDD. Kharbanda et al. (2012) found that of 348 participants, 219 experienced PMS. They found that some symptoms such as depression, anxiety, irritability, and angry outbursts were more common among the overweight women in the study. Irritability was the most commonly reported symptom within the study with 77% of women reporting symptoms. Angry outbursts were the next commonly reported symptom within the study with 63% of women reporting symptoms. According to the Mood Disorder Association of Ontario (2013) stress reduction which is further supported by Delara, Ghofranipour, and Fallah, 2013, cognitive behavioural therapy (CBT) as demonstrated by Hunter et al. (2002), maintaining a healthy lifestyle as stressed by Bussell (1998), as well as medical treatments such as antidepressants (Freeman, 2005), and hormone therapy (Studd, 2011) are amongst the more common treatments. This manual goes over these treatments in a well-organized manner to help those with PMS and PMDD in reducing these aversive symptoms and provides evidence to their effectiveness.

Strengths and Limitations

The biggest limitation to the completion of this manual is the lack of research. The current research is sparse and conflicting, each recommending a different treatment while acknowledging that it will be ineffective for a lot of women. PMDD is not very well known and there is little research or experts in the field, therefore this manual could not be reviewed by an expert. The manual was informally reviewed by women who experience PMS symptoms, but no formal review was conducted. Despite the limitations this manual can provide insight into PMS as well as potential treatments. The manual reviews multiple treatment options and offers links to additional resources that can help women find a treatment that can work for them.

Implications and Contributions

One important contribution of this manual is that those with PMS/PMDD or those who work with individuals suffering from PMS/PMDD may use the manual to their benefit. The manual could be beneficial if made available to women experiencing discomfort during their premenstrual period as a resource to help them understand more about symptom reduction strategies.

Recommendations

There is currently a lack of empirical literature on the treatment of PMS/PMDD, and more research is required. There is no current research on the effects of PMS and PMD in
regards to transgendered individuals, this is an important gap in the research that should be addressed. It is recommended that more research be conducted by professionals who work in the field, as a more informed and potentially more accurate and beneficial manual may be constructed. In the meantime this manual may be revised according to feedback collected through Appendix B of the manual regularly. Updates should also be done to reflect any changes and updates in the literature.

**Multilevel Challenges**

The main challenge on a societal level is the stigma of PMS and PMDD. People view menstruation as dirty and embarrassing and women of varying ages may feel uncomfortable speaking about what they go through during this time in their life. Due to being ashamed or embarrassed, women are more likely to be stressed and unable to find effective treatments. This manual can potentially increase women’s knowledge of this topic and strategies that may be effective to them and their individual needs. The organizational level challenge of the manual was the inability to spread the information of PMS and PMDD through different agencies. The manual is unofficial and has not been tested therefore it is difficult to find agencies willing to endorse it. For this reason it is not likely to be read. The program level challenge of this manual was the difficulty of finding activities that would be fun for clients to learn to help reduce symptoms. PMS is an uncomfortable and boring topic to most people this makes it difficult to write a manual that people are willing to read. The client level challenge is that the manual may be difficult for all clients to read because the topic is uncomfortable and provides little intrinsic reinforcement. The treatments are not effective for all women; this further contributes to the lack of reinforcement because even if treatments are attempted the reader may not experience a decrease in symptoms.
References


Appendix A: Best Practice for the Treatment of Premenstrual Stress/Premenstrual Dysmorphic Disorder

Best Practice for the Treatment of Premenstrual Stress/Premenstrual Dysmorphic Disorder

Faith Benoit
(2014)
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Chapter I: Overview

PMS/PMDD

According to the Mood Disorder Association of Ontario (2013) Premenstrual Stress Disorder (PMS) affects approximately 30% of women between puberty and menopause and of these women 8% meet the diagnostic criteria of Premenstrual Dysmorphic Disorder (PMDD). According to WebMD (2014) the symptoms for PMS and PMDD are the same, only PMS is less severe. The DSM-5 diagnostic criteria for PMDD includes the presence of at least five of the following symptoms (at least one of the first four): depression, anxiety, increased emotional sensitivity, irritability, difficulty concentrating, lethargy, change in appetite, change in sleep patterns, and feeling overwhelmed (American Psychiatric Association, 2013). Other symptoms include breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain. These symptoms must be severe enough to interfere significantly with daily functioning. They must also only occur during the premenstrual phase, which is about a week before bleeding starts (American Psychiatric Association, 2013). There are no known methods to prevent the occurrence of PMDD (Stöppler, 2013).

According to Kharbanda, Kulkarni, Bhandari et al. (2012) some symptoms of PMS are more common among women who are overweight; these symptoms include irritability, anger, depression and anxiety. Other symptoms such as loss of concentration are experienced evenly among women of all weight categories.

Audience

This manual was created for women who experience symptoms of PMS or PMDD. For most women the interventions described in this manual can be chosen and carried out independently or with the discretion of a medical professional; however for some, such as minors, and women with severe symptoms, medical conditions or developmental delay assistance from a primary care provider may be necessary. In the case of a minor, assistance may only be needed in the form of consultation with a healthcare provider or consent for treatment while actual application of some interventions (such as applying a heat pack, relaxation, mindfulness and life style changes) may be carried out with minimal to no outside assistance. However, some women may require additional assistance with implementing interventions such as providing access to heat pads and prompts to take a break. They may also require assistance engaging in mindfulness and implementing life style changes.
Informed Consent

This manual may be used in an agency setting; however if treatments are used as part of a behavioural intervention, or if treatments are being implemented by someone other than the woman they are being used on, informed consent must be obtained. Legal informed consent can only be obtained if the participant is above the age of 16 and capable of understanding the procedures of intervention, their rights as a participant, as well as the benefits and consequences of participating. If the participant cannot give legal consent, consent must be obtained from their legal guardian.

Rights as a participant include knowing that participation is voluntary and they can withdraw at any time without any repercussions. If consent is withdrawn intervention must be immediately terminated if safe to do so. The participant has the right to view any notes, files, or documents with information about them. Another right of the participant is confidentiality; no information can be shared without the client’s consent unless there is risk of harm to herself or others, or if there are reports of potential child abuse.
Definitions
Mindfulness is defined as a process of bringing nonjudgmental conscious awareness to thoughts and emotions.

Symptoms Targeted
Emotional Stability and Pain Management

Literature Reviewed
Hill and Updegraff (2012) studied the effects of mindfulness based CBT on the emotional regulation by asking participants to record their emotional experiences on a PalmPilot device six times a day for a week. They found that mindfulness based practices contributed to higher emotional self-regulation. A similar study was done by Van-Leeson, Totterdell, and Parkinson (2006) on women with PMDD. These women were given a pocket computer that was programmed with the rating schedule. Participants recorded their mood every two wakeful hours and the onset of their menstrual flow for one month. They found that monitoring mood and using cognitive distraction techniques helped mood regulation during PMS.

Method One
Using either an electronic device or a note book record your mood every two hours you are awake.

Method Two
Attend mindfulness training, or CBT. Examples of what this may include can be found in examples 3-6.

Method Three
Learn and practice meditation; in order to meditate find a comfortable position such as sitting up straight with your back pressed against the back of a chair and both feet on the floor. Close your eyes. Focus your attention on reciting, out loud or silently, a positive mantra such as “I feel at peace”. Place one hand on your stomach to sync the mantra with your breaths. Block out any distractions by momentarily acknowledging them then letting them go as though on a leaf in a stream.

There are many good resources online that can help you learn different meditation practices. About Health has a page on different kinds of meditation including mindfulness, walking, mantra and more. If you are interested in meditation you can read up on eight different kinds of meditation at http://stress.about.com/od/meditation/tp/Learn-How-To-Meditate.htm (Scott, 2014).
Method Four

Learn and practice deep breathing. Take a 5-minute break and focus on your breathing. Sit comfortably: up straight, back against a chair, feet on the floor, eyes closed, with a hand on your belly. Slowly inhale through your nose, feeling the breath in your throat, feel it move to your abdomen and work its way through the rest of your body to your head. Reverse the process as you exhale through your mouth. Try counting the seconds you breathe. Breathe in for 3 seconds, hold for 3 seconds, breathe out for 3 seconds, hold for three seconds and repeat. Try increasing the amount of time you can spend on each breathe. See how long you can suspend your breathe. Weil (2015) explains three deep breathing exercises on his site, including links to videos demonstrating the procedure; they can be found at http://www.drweil.com/drw/u/ART00521/three-breathing-exercises.html.

Method Five

Learn and practice to be present; take five minutes to focus only on a specific experience. Notice how the air feels on your face when you’re walking and how your feet feel hitting the ground. Enjoy the texture and taste of each bite of food.

Method Six

Learn and practice progressive muscle relaxation. Find a comfortable position, ideally sitting straight with your back pressed lightly against the back of a chair with your feet touching the floor. Start by focusing on your breath, and then begin to shift your focus on flexing and releasing individual muscles, noticing how each one feels. Start with the muscles in your feet, then move slowly up your body until you reach your face, try to focus on every muscle group before you’re done. A complete script, as well as other relaxation scripts can be found at http://www.innerhealthstudio.com/progressive-muscle-relaxation-exercise.
Definitions
Relaxation is a state of being free from tension and anxiety.

Symptoms Targeted
Pain

Literature Reviewed
One nonmedical treatment for pain is relaxation; Slavin-Spenny, Lumley, and Thakur (2013) used relaxation training to reduce the pain of headaches. They found that relaxation increased pain management. Another study by Delara, Ghofranipour, and Fallah, (2013) assessed the effects of relaxation on pain management for women with PMS. They found that as education on relaxation increased, symptoms reported by participants decreased.

Method One
You may want to plan to take breaks throughout the day during your premenstrual period and decrease the amount of stress and demands you expect to have at this time.

Method Two
You may decide to engage in activities you find enjoyable that can reduce stress. This can include things like reading a book or watching TV.

Method Three
Attend relaxation classes such as yoga or meditation (as described above in mindfulness chapter, example of potential exercises in examples 3-6.)
Concentrating Chapter IV: Heat Pads

Definitions
A heat pad comes in many forms. You can use a hot water bottle, sodium acetate heat pad, microwaveable heat pad, electric heat pad, moist heat pad etc.

Symptoms Targeted
Pain

Literature Reviewed
Mee-Young, Ju-Hyun, Jeong-Uk, et al. (2011) found that using heat pads for 30 minutes decreased pain for people experiencing chronic pain in the low back, knee, or shoulder regions. There is evidence to suggest that heat pads are effective for PMS specific pain as well. Han-Fu, and Yu-Hua (2011) investigated the efficacy of various strategies to self-manage menstrual cramps. They found that women rated herbal medicines to be most effective but that other strategies such as heat and brown sugar were effective as well. Gregson (2000) also mentioned the use of heat treatment along with various medical treatments and massage for treating symptoms of PMS.

Method One
Apply a heat pad to the area you are experiencing pain for a half an hour at a time as needed.

Method Two
Apply a wrap-around heat pad to the area where you are experiencing pain.
Chapter V: Best Practice Cognitive Behaviour Therapy

Definitions
Cognitive Behavioural Therapy (CBT) is a problem focused therapy that aims to modify the maladaptive cognitions and self-statements, as well as the antecedents and consequences that support the maladaptive behaviours in order to increase adaptive ones.

Symptoms Targeted
All but may be most effective for depression and anxiety

Literature Reviewed
CBT is listed by the Mood Disorder Association of Ontario (2013) as a common treatment for PMDD. Research by Lustyk, Gerrish, Shaver, and Keys (2009) has shown that applying mindfulness and acceptance-based CBT interventions may be effective in reducing symptoms of PMS/PMDD.

More symptom specific research has been conducted on CBT’s effects on depression and anxiety. Roshanaei-Moghaddam, Pauly, and Atkins (2011) compared the effectiveness of CBT on anxiety and depression according to 42 previous studies (21 on anxiety and 21 on depression). They found that medication was slightly more effective for social anxiety disorder but that medication and CBT are equally beneficial for depression. Oei and McAlinden, (2014) found that eight sessions of group CBT is effective in treating both symptoms and improving quality of life among women with PMDD as well.

Method
CBT can only be performed by a qualified professional and exact procedures will be designed and altered by them. They may use specific skills such as active listening, reframing, reflecting feeling/meaning, paraphrasing and goal setting, providing feedback and assigning homework. There is both individual and group CBT; though it depends on the client on what works best for them as everyone has individual needs. A professional will be able to give their opinion on what they think would work best for each of their individual clients. An example of assigned homework could be self-talk; self-talk is when you talk to yourself using a mantra (similar to example three in Chapter 2: Mindfulness). Develop your own mantra such as “It’s only five days”, “I can get through this”, or “I’m almost done!” Repeat this to yourself when having a hard time.
Chapter VI: Diet Modifications

Literature Reviewed
Bussell (1998) recommends that all women reporting PMS related symptoms be assessed for potential dietary deficiencies. If diet is determined to be inadequate, dietary changes are recommended as a line of treatment. Proper diet is thought to increase a woman’s tolerance to pre-menstrual changes thereby reducing the impact of all PMS symptoms on her daily life.

Symptoms Targeted
All.

Method One
Bussell (1998) describes a four phase dietary approach. Each phase should last approximately three months, if no significant changes occur participants should try the next phase of treatment.

- Phase one:
  - Reduce fats, simple sugars, salt, alcohol and caffeine
  - Increase fiber and starch

- Phase Two:
  - Reduce or avoid sugars
  - Eat starchy foods every 3-4 hours

- Phase three:
  - Talk to a physician or dietitian about taking vitamins and minerals such as B6, GLA, magnesium, calcium, vitamin D and zinc

- Phase four:
  - Talk to your doctor to rule out and treat other underlying medical conditions such as allergies, and intolerances, diabetes, anaemia and irritable bowel syndrome.

Method Two
Incorporate light exercise routine such as yoga or walking.
Chapter VII: Medical Treatments

Definitions

Antidepressants are medical mood stabilisers often used for the treatment of anxiety or depressive disorders. Selective serotonin reuptake inhibitors (SSRI’s) work by preventing the reuptake of serotonin, allowing more serotonin to be available to be taken by other nerves. Serotonin is a neurotransmitter that is responsible for regulating brain functions such as mood, appetite, sleep, and memory.

Estrogen is produced mainly in the ovaries, but it is also produced by fat cells and the adrenal gland. It helps regulate the menstrual cycle, controlling the growth of the uterine lining during the first part of the cycle. If the woman’s egg is not fertilized, estrogen levels decrease sharply and menstruation begins. If the egg is fertilized, estrogen works with progesterone, another hormone, to stop ovulation during pregnancy.

Testosterone is a male hormone however is made in small amounts by a woman's adrenal glands and ovaries. It is believed that testosterone may help women with menstrual symptoms; it is believed that it may also heighten their sex drives.

Progestogen is the main progestogenic steroid hormone secreted by the female reproductive system and is connected with the female menstrual cycle, pregnancy and embryogenesis. The ovaries, placenta and the adrenal glands produce progesterone to regulate the condition of the endometrium (inner lining) of the uterus.

According to the U.S National Library of Medicine (2014) leuprolide injections work by suppressing estrogen and inducing a menopausal state thereby preventing PMS and PMS related symptoms.

Symptoms Targeted

All.

Literature Reviewed

If all other methods of treating PMDD are ineffective drug therapy may be considered. It is important that all medical decisions be made in consultation with a physician and any complications be discussed with him or her directly. Common medical treatments for PMDD include antidepressants and hormonal medications. A meta-analysis conducted by Freeman (2005) found that antidepressants may be beneficial. As another option, Studd (2011) stresses the importance of balancing transdermal estrogens, testosterone and, progestogen. Pincus, Alam, and Rubinow, et al. (2011) on the other hand found that Lupron (a hormonal medication) can decrease mood fluctuation in women with PMDD.

Freeman (2005) conducted a meta-analysis on the use of antidepressants, finding specifically that selective serotonin reuptake inhibitors (SSRIs) are an effective treatment for both mood and behavioural effects of PMDD. Freeman concluded that both continuous and luteal-phase SSRI dosing regimens are similarly effective and well tolerated.
Another effective form of medical treatment is hormonal. Studd (2011) stated that premenstrual depression, as well as postnatal and climacteric depression are related to changes in ovarian hormone levels and can therefore be treated by hormone therapy. It is necessary to have a balance of transdermal estrogens, testosterone and, progestogen.

Pincus et al. (2011) found that women with PMDD responded better on self-ratings of sadness, anxiety, and irritability over the three month period following leuprolide injections. These findings were repeated by Baller, Wei, Kohn, et al., (2013) over a six month trial period.

Method
Consult your doctor taking medication, he or she will work with you to determine which treatments will work best but may advise you to try a nonmedical treatment alternative before starting and medications.
Chapter VIII: Summary

PMS is relatively common among women, there is no way to prevent it, but there may be some treatments available to effectively decrease its symptoms. This manual was designed to educate women and their care providers about best practices according to current literature. While most women with PMDD can use this manual to learn about treatment options some women may require the assistance of a primary care provider. Informed consent must always be obtained before starting any interventions, in some cases additional professional consultation must also be provided.

There are many different treatment options for PMS/PMDD and it may be difficult to find the right one, therefore, a Topic Guide of possible questions to ask the doctor is included in Appendix A. This guide includes different things you can do to help make this process smoother; such as monitoring your menstrual cycle before talking to the doctor. For additional information for young girls, and for help tracking your period see http://www.beinggirl.com/. This website includes information about periods, stories of first periods, a period calculator, as well as, other fun and interactive things to look at!


Appendix B: Topic Guide

The following is a list of things to consider before and during consultation with medical professionals about PMS/PMDD.

Diagnosing PMS/PMDD
- Do symptoms occur only during the week before menstruation? (keep record of menstruation and symptoms)
- Is there the potential of other medical causes for symptoms?

Intervention Selection
- Which intervention best suits my symptoms
- What are the potential side effects
- Can interventions be implemented given pre-existing schedules?

Implementing Interventions
- How long should I continue an intervention without improvement before considering changing approaches?
Manual Appendix B – Feedback Form

It would be appreciated if this manual could be completed and emailed to the author, Faith Benoit, at faithbenoit641@gmail.com, thank you.

Was this manual easy to understand?

Were the ideas suggested in the manual practical and easy to use?

Were the ideas effective?

Is there anything else that you would like to see in this manual?

Is there anything else you liked or didn’t like about this manual?