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Premenstrual Dysphoric Disorder: Current Barriers to Diagnosis and Treatment

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Policy Brief

March 2026

Premenstrual Dysphoric Disorder: Current barriers to diagnosis and treatment

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Introduction

Premenstrual Dysphoric Disorder (PMDD) is a distinct mood disorder associated with symptoms such as depressed mood, irritability, anxiety, sleep disturbance, difficulty concentrating and suicidal thoughts in the two weeks before a menstrual period (APA 2013; Prasad 2021). PMDD is severe enough to affect a person's functioning, relationships, and quality of life (APA 2013). It affects at least 3-8% of females/AFAB[i] of reproductive age (Reilly 2024). PMDD can have a negative impact on a person's home, work and social life and can have a similar magnitude of detrimental impact as depression (Halbreich 2003).

This policy brief outlines the causes, diagnosis, and treatment of PMDD, underlining how it impacts sufferers, and how it is often mistaken for other common mental health conditions. It concludes with key policy recommendations.

PMDD has already been highlighted in research by the National Office of Mental Health Engagement and Recovery (2023, p. 21) as needing greater recognition and understanding within mental health services:

> *"What women want:*
>
> *— Greater understanding amongst professionals of the connection between women's life stage and mental health. Hormones can have a massive impact on mental health and this is largely ignored or not discussed.*
>
> *— There needs to be links grown between gynaecologists, psychiatrists and psychologists to understand how hormonal cycles and things like Endometriosis can affect women's mental health.*
>
> *— Greater recognition of the influence of hormones and oral contraceptives on mental health.*
>
> *— …There also needs to be more awareness into premenstrual dysphoric disorder, as many women suffer horrifically with their mental health during their cycle."*

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Cause of PMDD

Symptoms of PMDD arise through the effect of the normal fluctuation of female reproductive hormones (oestrogen and progesterone) on the brain. There is no disorder of reproductive function nor any abnormality in hormone levels. It is an abnormal brain reaction to normal hormonal function (O'Brien 2011).

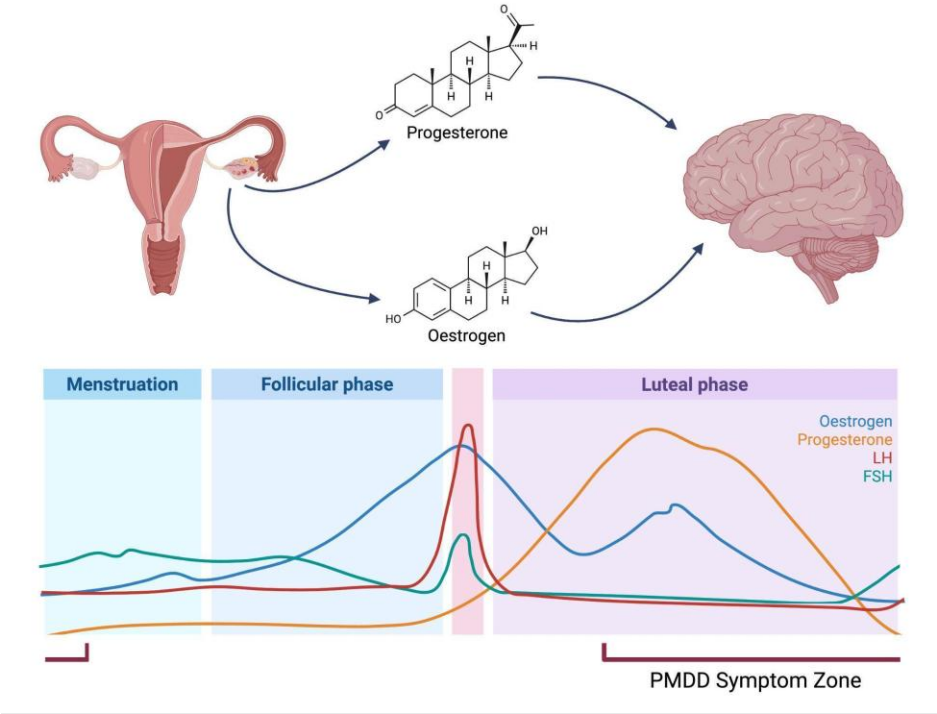

Figure 1: Image depicting the Menstrual Cycle timeline and PMDD Symptom Zone. Created in https://BioRender.com

The Impact of PMDD on Sufferers

There are economic impacts associated with PMDD. Indirect economic costs are incurred due to reduced productivity levels during the luteal phase (second half of the menstrual cycle) (Islas-Preciado et al., 2025). While unquantified, there are also costs to healthcare systems where PMDD is misdiagnosed as another condition and ineffective treatment is provided.

For those who have PMDD, suicidal thoughts and actions are the rule rather than the exception. At some point in their lives, 71% of people with the diagnosis have had suicidal ideation, 33% have attempted suicide, and over 50% have self-harmed (Eisenlohr-Moul 2022).

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Diagnosis

Most cases of PMDD are straightforward to diagnose. Diagnosis and treatment for PMDD can largely remain in primary care settings with education and training in PMDD provided for general practitioners.

If the relationship with the menstrual cycle is not identified, PMDD can mimic or be mistaken for other common mental health conditions such as depression, bipolar disorder, anxiety disorders or personality disorders (Epperson 2012; Osborn 2012, Hantsoo 2012). There is a cohort of women seeking help from primary care services, secondary mental health services, and emergency departments with symptoms of PMDD (including suicidality) that are going unrecognised. Premenstrual exacerbation (PME) of an underlying condition also frequently occurs in a range of mental health problems (Nolan 2022).

Mental health professionals skilled in the diagnosis and treatment of mental disorders, such as psychiatrists and clinical psychologists, are best placed to assess complex cases where there are mental health comorbidities or where the person presents to their service. It is also crucial to involve mental health professionals, such as psychiatrists, who are skilled in the assessment and management of suicidality.

Treatment

First-line treatment for PMDD is either an antidepressant medication (an SSRI) or the combined oral contraceptive pill (ACOG 2023; O'Brien 2011). Both options can be prescribed by a GP based on individual preferences. For more severe cases or cases resistant to treatment, the second and third line treatments involve inducing menopause through medication or surgery (removal of ovaries and uterus). This treatment is the remit of gynaecology.

This means that the route through diagnosis and treatment can be complex and may require a GP (primary care), a psychiatrist (community care), and a gynaecologist (acute hospitals). In order for a person to navigate this complex diagnosis and treatment route, which traverses components of the Irish health service with historically disparate funding streams, it requires high levels of self-advocacy and health literacy on the part of the person affected.

Therefore, there is an urgent need to develop clear guidelines and integrated clinical pathways for the diagnosis and treatment of PMDD as the professionals involved do not have clear lines of communication and there is a lack of integrated working.

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Policy Recommendations

PMDD is a serious and distinct mood disorder that impacts a person's ability to function and, therefore, it warrants immediate action to improve diagnostic and treatment pathways, and the services that are accessible.

We outline four key policy recommendations below.

1. PMDD needs to be recognised and prioritised by the *Women's Health Taskforce.*
2. Create a population-wide education and awareness-raising programme for self-recognition of PMDD symptoms, particularly for young people.
3. Develop healthcare professional education and training at the undergraduate and postgraduate levels on PMDD - this may include a toolkit for healthcare professionals to guide the diagnosis and treatment of PMDD.
4. Implement an integrated care pathway for the assessment and treatment of complex cases of PMDD to bridge the required medical specialities – gynaecology, mental health and primary care are all required to provide comprehensive safe care for this condition.

About the Authors:

Samantha Trevaskis is a PhD researcher in the School of Psychology at UCD. Her work focuses on the psychosocial and health behaviour risk factors associated with PMDD symptom severity. She is also working as a research officer within the HSE.

Dr Yvonne Hartnett is a medical doctor who is a specialist in general adult, liaison and perinatal psychiatry and is currently working as an Aspire Fellow in Women's Mental Health in St Vincent's University Hospital. She is also a PhD candidate exploring the need for integrated mental health and gynaecological care.

Conflicts of interest: YH is a public sector employee and has no conflicts to declare.

ST has lived experience of PMDD and is currently a self-funded PhD researcher studying PMDD. ST has no financial conflicts of interest to declare.

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[i] Assigned female at birth.

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