MINDSETT

PATIENT EDUCATION

Clear information. Confident choices. Better care.

Understanding PMDD

What hormones are doing and why the brain may react so strongly

Premenstrual dysphoric disorder, or PMDD, is a serious cycle-related mood disorder. Symptoms appear after ovulation, during the luteal phase, and improve within a few days after bleeding begins. PMDD can affect mood, thinking, sleep, the body, relationships, school, work, parenting, and safety.

PMDD is not simply bad PMS

- PMS is uncomfortable but usually does not stop normal functioning.
- PMDD causes severe symptoms that clearly interfere with daily life.
- PMDD may include intense irritability, rage, depression, anxiety, rejection sensitivity, hopelessness, brain fog, fatigue, sleep or appetite changes, and physical symptoms.
- PMDD can include suicidal thoughts. This is a medical concern, not a personality flaw or lack of willpower.

It is usually not a hormone imbalance

Most people with PMDD have estrogen and progesterone levels within the expected range. The leading explanation is that the brain and nervous system are unusually sensitive to the normal rise and fall of these hormones. A standard hormone test cannot confirm PMDD.

PMDD and PME are different

With PMDD, symptoms are mostly absent outside the premenstrual window. With premenstrual exacerbation, or PME, depression, anxiety, ADHD, OCD, trauma symptoms, pain, or another condition is present during the month and becomes worse before the period. Some people may have both patterns.

How PMDD is confirmed

Track symptoms every day for at least two menstrual cycles. The Daily Record of Severity of Problems, or DRSP, is a validated tool. Tracking helps show whether symptoms follow ovulation and improve after the period starts.

Hormones brain signals and the menstrual cycle

The hormone levels may be normal while the brain response is not

Phase	What hormones do	What a person with PMDD may notice
Follicular phase	Estrogen rises as an egg develops.	Many people feel closer to their usual baseline.
Ovulation	An egg is released. Estrogen shifts and progesterone begins to rise.	This hormone change starts the window in which PMDD symptoms can develop.
Luteal phase	Progesterone rises and is converted into allopregnanolone. Estrogen and progesterone later fall if pregnancy does not occur.	Mood, anxiety, irritability, thinking, sleep, appetite, sensory, and body symptoms may appear or worsen.
Menstruation	Estrogen and progesterone are low and the uterine lining sheds.	PMDD symptoms usually ease within a few days. If symptoms stay severe all month, look for PME or another condition.

The allopregnanolone and GABA theory

Progesterone is changed into allopregnanolone, sometimes called ALLO. ALLO acts on GABA-A receptors. GABA is one of the brain's main calming systems. In most people, ALLO helps the brain settle. In PMDD, the brain may have trouble adapting to the changing amount of ALLO. The same signal that feels calming to one person may feel activating, anxious, irritable, or overwhelming to another.

Estrogen and serotonin

Estrogen interacts with serotonin and other brain systems involved in mood, motivation, attention, and stress response. A rapid hormone shift may temporarily change how these systems work in a sensitive brain. This may help explain why SSRIs can improve PMDD faster than they usually improve major depression.

Genes stress and the nervous system

Research suggests that genetic differences may affect how cells respond to estrogen and progesterone. Stress, sleep loss, trauma history, neurodivergence, illness, and inflammation may change symptom severity, but none of these means a person caused PMDD.

Why stopping ovulation can help

PMDD depends on hormone change after ovulation. Some treatments help by changing serotonin signaling. Others aim to prevent ovulation or create steadier hormone exposure. This is why treatment is individualized and why one person's helpful birth control may worsen another person's mood.

What IAPMD emphasizes

Start with the cycle pattern use evidence and build a safety plan

IAPMD explains PMDD as a neurobiological sensitivity to normal hormone changes, especially after ovulation. It recommends daily tracking before making the diagnosis and separating PMDD from PME and medication-related mood effects.

Level	Examples	How to use this information
Strong evidence	SSRIs; selected ovulation-suppressing hormonal treatments; GnRH treatment for severe resistant PMDD.	Discuss risks, benefits, timing, and monitoring with a qualified prescriber.
Helpful support	Daily tracking, therapy skills, sleep protection, movement, regular meals, relationship planning, peer support, and a PMDD action or safety plan.	These steps may reduce harm and improve coping even when medication is also needed.
Emerging or limited evidence	Histamine or mast-cell approaches, specialized diets, many supplements, and individualized progesterone strategies.	Interesting does not mean proven. Use clinician guidance and track both benefit and harm.

Practical IAPMD strategies

- Use the DRSP or another daily tracker for at least two full cycles.
- Identify early warning signs, the hardest cycle days, and what usually helps.
- Make an action plan for work, parenting, relationships, medication, and extra support.
- Make a safety plan before the severe days, not during the crisis.
- Bring the tracker and treatment history to appointments. Ask the provider to explain whether the plan targets PMDD, PME, or both.

A note about first-line treatment

IAPMD describes SSRIs as a first-line medication option with strong trial evidence. They may be taken daily or only during the luteal phase for PMDD, depending on the patient. Hormonal treatment is more complicated: some formulations suppress ovulation and help, while others may worsen mood. Never start, stop, or change psychiatric or hormonal medication without a clinician.

What patients often need beyond medicine

Treatment should also address shame, relationships, missed work or school, parenting strain, and fear of the next luteal phase. CBT, DBT, ACT, compassion-focused skills, and peer support may help a person respond more safely when symptoms surge.



Lara Briden's clinical framework

Useful ideas to discuss while keeping the evidence level clear

Lara Briden is a naturopathic doctor and author. Her PMDD writing combines published research, clinical experience, and hypotheses that have not all been proven in PMDD trials. Her central idea is that premenstrual mood symptoms may not have one single mechanism in every patient.

Her main ideas

- Progesterone and progestins are not the same. Body-identical progesterone becomes ALLO; synthetic progestins do not behave identically in the brain.
- ALLO is usually calming, but a sensitive GABA system may respond with anxiety, irritability, or rage.
- Inflammation, histamine, mast-cell activity, and genetics may affect how well GABA receptors adapt. This remains an emerging theory, not a confirmed cause for every patient.
- Symptom timing may offer clues. Symptoms soon after ovulation may look different from symptoms that appear later as hormones fall, but timing alone does not prove a mechanism.
- General health matters. Sleep, movement, outdoor time, adequate food, protein, reduced alcohol, and treatment of other health problems may lower the total stress on the nervous system.

Tips she discusses and the safety reality

Idea	Why she suggests it	Important caution
Magnesium or taurine	May support calming GABA signaling and sleep.	Check kidney health, medicines, dose, and side effects with a clinician.
Vitamin B6	May support serotonin, GABA, and histamine processing.	Too much can cause nerve damage. Count B6 from every supplement.
Histamine approach	She proposes that histamine or mast-cell symptoms may worsen PMDD in a subgroup.	Antihistamines are not an established PMDD treatment. They can sedate, interact, or worsen brain fog.
Food experiments	She sometimes suggests adequate protein, reducing alcohol, and testing whether A1 cow's dairy affects symptoms.	Avoid restrictive diets without a plan. Track one change at a time and protect nutrition.
Iodine or vitex	She uses these selectively for certain symptom patterns.	Not universal PMDD treatments. Iodine can affect the thyroid; vitex can interact with hormones and medicines.
Body-identical progesterone	She proposes it may calm some patients or buffer late-cycle hormone withdrawal.	Prescription and monitoring are needed. It can worsen mood in some people and is not the same as proven first-line care.



Turning ideas into a safe plan

Track carefully change one thing at a time and review the results

A sensible way to test supportive changes

- Confirm the cycle pattern first. Do not treat every bad premenstrual day as PMDD.
- Change one variable at a time and keep tracking.
- Use a prescriber or pharmacist for supplement, antihistamine, hormone, and medication safety.
- Keep treatments that show a repeatable benefit. Stop and ask for help if mood, sleep, agitation, or safety worsens.

Questions to bring to your appointment

- Does my daily tracking look more like PMDD, PME, or both?
- Which treatments have the strongest evidence for my symptoms and medical history?
- Could a medicine, contraceptive, thyroid condition, anemia, sleep problem, substance, or another diagnosis be affecting this pattern?
- If we try a lower-evidence option, what benefit are we looking for, what risks should I watch for, and when should we stop?
- What should my support person do if I become unsafe during the luteal phase?

Get help now

If you may harm yourself or someone else, cannot stay safe, feel severely confused, or feel detached from reality, call or text 988 in the United States. Call 911 or go to the nearest emergency room for immediate danger. Do not stay alone with these symptoms.

Sources and further reading

1. IAPMD - What is PMDD and The Menstrual Cycle with PMDs

2. IAPMD - Treatments with Strong Evidence and DRSP

3. Lara Briden - Progesterone Mood and PMDD

4. Lara Briden - Natural Treatments for Premenstrual Mood Symptoms

Questions? Email info@mindsettmentalhealth.com or contact us through Spruce.

This handout is educational. It does not diagnose PMDD or replace individualized medical care.