The PMDD *Practice*

A division of **The PMDD Project**

A Guide for Occupational Therapists:

Supporting people with PMDD

Clinical Review Statement
This resource has been developed by The PMDD Project and reviewed by our Clinical Advisory Board for clinical accuracy and alignment with current evidence and guidelines.

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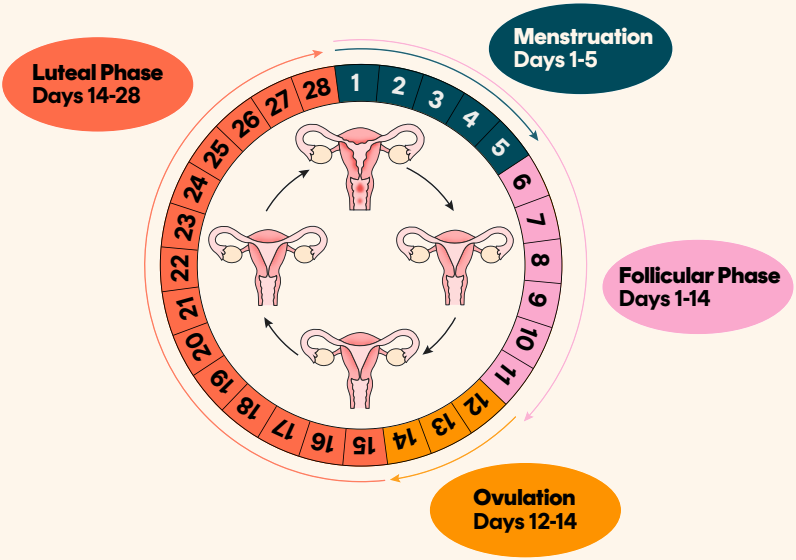
The PMDD Project Clinical Advisory Board

Occupational Therapists (OTs) play a vital role in supporting individuals with Premenstrual Dysphoric Disorder (PMDD) to improve occupational performance, participation, and quality of life.

OTs are uniquely positioned to support patients through a holistic, biopsychosocial and occupation-focused approach to address the cyclical and multifaceted impact of PMDD on daily functioning.

Understanding PMDD

PMDD is a severe, cyclical mood disorder occurring during the luteal phase of the menstrual cycle, around 1-2 weeks before menstruation[1], with symptoms peaking in the days before menstruation and resolving shortly after menstruation begins. It is distinguished from premenstrual syndrome (PMS) by the intensity of affective and cognitive symptoms and the level of functional impairment caused[2].



PMDD is not caused by abnormal hormone levels, but by an abnormal sensitivity to normal hormonal fluctuations, particularly progesterone and its metabolite allopregnanolone[2]. These influence GABAergic systems which affect inhibition and emotional regulation, and serotonergic systems which affect mood and cognition.

PMDD does not always begin at menarche.

For some patients, symptoms emerge later in life, for example after pregnancy, changes in contraception, periods of chronic stress, or during perimenopause.

Treatments for PMDD include lifestyle changes, psychological treatments such as CBT and DBT, selective serotonin reuptake inhibitors (SSRIs), hormonal treatments, and surgery to remove the uterus, ovaries and fallopian tubes (bilateral salpingo-oophorectomy). Support groups and complementary therapies may also be helpful.

Prevalence and comorbidities

PMDD affects approximately 3-8% of menstruating individuals and individuals experiencing PMDD wait 12 years on average to receive a diagnosis[3, 4]. PMDD can be confused with other conditions, such a bipolar disorder, depression, anxiety, borderline personality disorder (BPD) also known as emotionally unstable personality disorder (EUPD), or severe PMS.

PMDD frequently co-occurs with neurodevelopmental and mental health conditions including:

- Major depressive disorder
- Generalised anxiety disorder
- Post traumatic stress disorder (PTSD)
- Attention deficit hyperactivity disorder (ADHD)
- Autism spectrum disorder (ASD)
- Substance use disorders
- Dysmenorrhea and central sensitisation

Symptoms may mimic or exacerbate ADHD, depression or anxiety making diagnosis more difficult[5]. When a pre-existing physical or mental health condition worsens during the luteal phase of the menstrual cycle, this is referred to as premenstrual exacerbation (PME)[6]. Due to the overlap in symptoms of co-occurring conditions and PMDD, OTs should routinely screen for cyclical symptom patterns in relevant populations.

Core symptoms of PMDD

While symptoms vary from person to person, PMDD usually presents with a combination of emotional, cognitive, and physical symptoms.

Affective and Cognitive Symptoms:

Depressed mood, hopelessness, self-critical thoughts	Anxiety, tension, feeling "on edge"
Emotional lability and rejection sensitivity	Difficulty with concentration ("brain fog")
Marked mood swings, irritability, anger, interpersonal conflict	

Physical and Behavioural Symptoms

Fatigue, insomnia, or hypersomnia	Appetite changes and food cravings
Breast tenderness, bloating, headaches, joint/muscle pain	Reduced motivation, anhedonia, withdrawal from activities

Safety considerations

There is a significantly increased risk of suicidal ideation and behaviour, particularly during onset of luteal phase symptoms and transition out of the luteal phase. OTs should be alert to risk and support symptom awareness, crisis planning, referral and multidisciplinary collaboration.

Diagnostic criteria

PMDD is classified in the DSM-5 as a depressive disorder. Diagnosis requires prospective daily symptom tracking across at least two menstrual cycles[7].

A patient must experience at least five symptoms causing significant functional impairment during the luteal phase of most menstrual cycles, with at least one being an affective or cognitive symptom. Symptoms must not be attributable to other medical or mental health conditions or substance use.

Where PMDD is suspected, the patient should be referred to their GP or treating doctor for further evaluation along with any cycle tracking and symptom history available.

Occupational and Functional Impact

PMDD can significantly disrupt occupational performance across all domains of daily living including work, education, relationships, parenting, domestic tasks, financial management and personal care, significantly impacting a person's wellbeing, identity and quality of life.

The role of OT in PMDD support

OTs play a key role in identifying and addressing how PMDD impacts daily life across the cycle.

Many people with PMDD will have had experience of delays in diagnosis, misdiagnosis or negative experiences with accessing help. It is important to listen with empathy and validate their experience, so they feel heard and understood.

Key clinical considerations for OT practice:

- Screen for PMDD in clients with fluctuating mental health or function in ADLs
- Consider hormonal influences when assessing occupational performance
- Adapt interventions to reflect cyclical variation
- Prioritise safety planning where risk is identified
- Use a strengths-based, empowering approach

Assessment

A thorough assessment should include:

Occupational profile and roles, identifying occupations which exacerbate symptoms and exploring values, identity, and occupational disruption

Symptom and cycle mapping

Activity analysis across menstrual phases

Cognitive, emotional, sensory, and physical assessment

Sleep and fatigue assessment

Environmental demands and supports

Identifying strengths and protective factors

The Daily Record of Severity of Symptoms (DRSP) is a validated, clinical symptom tracking tool considered to be the "gold standard" for identifying patterns and supporting PMDD diagnosis.

Intervention

Interventions should be tailored to the individual, taking account of any comorbid conditions.

Examples of the broad range of interventions an OT could incorporate are included in this guide, however they do not represent the full scope of interventions possible.

Psychoeducation and symptom tracking

Supporting understanding reduces distress and increases self-efficacy. Tracking helps build awareness and guide intervention.

Together, these can help patients anticipate patterns rather than react to them, identifying early warning signs of luteal phase decline, and supporting the planning of occupations across the cycle.

Lifestyle and occupational balance

Creating flexible, responsive routines aligned with the menstrual cycle, balancing productivity, rest and leisure.

This can involve structuring high demand tasks in higher energy phases, building in lighter days or buffer periods in the premenstrual phase, creating coping plans for difficult days, and developing consistent daily routines for stability.

Activity pacing and energy conservation

Helping patients work with fluctuating energy rather than against it using planning, prioritising, activity grading, energy budgeting, recovery planning, identifying energy demands of activities, and reducing non-essential demands during luteal phase.

Occupational adaptation and activity modification

Enabling continued participation even in the presence of symptoms.

This can take the form of task modification to reduce demand, delegating or sharing responsibilities, using assistive tools or technology, changing timing of activities, adapting parenting tasks for difficult days, modifying exercise type or intensity across the cycle, and creating flexible expectations of performance.

Emotional regulation and coping skills

Supporting patients to manage intense mood symptoms using both bottom up and top down cognitive and psychological strategies.

These could include grounding techniques, distress tolerance skills, cognitive reframing, self-compassion practices, sensory based calming strategies, and developing crisis or safety plans if needed.

Cognitive and executive function support

Addressing common difficulties with concentration, memory, and decision-making with the use of external memory aids, breaking tasks down into step-by-step actions, reducing multitasking, use of visual reminders, adapting the environment, and reducing cognitive load in luteal phase.

Workplace support

PMDD often significantly impacts work functioning and is recognised as a disability under the Equality Act 2010.

OTs can support with workplace assessment and recommendations for reasonable adjustments, supporting communication with employers, supporting disclosure decisions, reducing presenteeism and burnout, creating structured work routines around cycle patterns, and supporting return to work planning if needed.

Identity, roles and self-concept

Helping patients maintain a stable sense of self despite cyclical changes through exploration of identity beyond PMDD, supporting role balance (e.g. worker, parent, partner), reinforcing strengths and capabilities, and building self-compassion.

Sleep support

PMDD frequently causes sleep disruption, and OTs can support patients to address sleep behaviours through sleep hygiene education, relaxation techniques, developing consistent sleep-wake routines, environmental optimisation and applying cognitive behaviour therapy for insomnia (CBT-I) principles where appropriate.

Sensory and environmental adaptation

Supporting sensory needs that may fluctuate across the cycle, particularly where there is a co-occurring neurodevelopmental condition such as ADHD or ASD.

This can involve identifying sensory triggers in luteal phase, reducing sensory overload by modifying the environment, using sensory tools, and planning sensory breaks during the day.

Health behaviour change

Supporting sustainable lifestyle habits that reduce symptom impact by goal setting and behaviour planning, using habit stacking and routine building, encouraging regular physical activity, healthy meal preparation, reducing or avoiding alcohol and caffeine, stress management, and problem-solving barriers to participation.

Risk management and safety planning

Severe mood disturbance in PMDD increases risk of suicidal ideation and behaviour, and careful risk management is needed to identify and monitor risk indicators, develop safety plans, crisis and escalation pathways, support access to appropriate services and collaborate with mental health teams.

Collaborative and multidisciplinary careplanning

PMDD often requires integrated care and liaison with GPs, gynaecologists and psychiatrists.

An MDT approach can facilitate medication adherence and routines, integrate psychological therapies, and coordinate care plans. OTs are well-placed to advocate for patient needs within healthcare systems.

Relapse prevention and long-term planning

Building sustainable strategies over time to help develop personalised PMDD management plans, identify early signs of relapse, adjust strategies over time, build confidence in self-management, prepare for life transitions such as pregnancy and perimenopause, and support long-term occupational goals.

Summary

PMDD causes significant impact on daily life. Its cyclical nature presents unique challenges for occupational performance, requiring flexible and individualised intervention.

OTs play a critical role in identifying patterns of impairment, supporting self-management and coping strategies, enhancing occupational participation and balance, and advocating for recognition and appropriate accommodations.

With the right support, individuals with PMDD can develop effective strategies to navigate their symptoms and engage in meaningful, satisfying occupations.

Sources

[1] NHS 111 Wales (n.d.), Premenstrual Dysphoric Disorder (PMDD), NHS Wales Health A–Z

[2] National Centre for Mental Health (NCMH) (n.d.), Premenstrual Dysphoric Disorder (PMDD), NCMH

[3] Liguori F, Saraiello E, Calella P (2021), Premenstrual Syndrome and Premenstrual Dysphoric Disorder's Impact on Quality of Life, and the Role of Physical Activity.

[4] International Association for Premenstrual Disorders (IAPMD) — n.d. — Facts & Figures — IAPMD

[5] Imhof, J. (n.d.), Neurodiversity: The Intersection of Autism, ADHD, and PMDD, (Professional blog/article) (6) National Institute for Health

[6] (n.d.), Premenstrual Exacerbation: Symptoms and Treatment, (Online health resource)

[7] National Institute for Health and Care Excellence (NICE) — n.d. — Diagnostic Criteria for Premenstrual Dysphoric Disorder — CKS

Need urgent support?

We know that managing PMDD can be incredibly difficult, and at times, the emotional weight can feel overwhelming. If you are experiencing severe distress, suicidal thoughts, or feel you are in crisis, please know that you are not alone and that support is available. You deserve to be heard and kept safe.

If you are in immediate danger:
Please call 999 or go to your nearest Accident and Emergency (A&E) department immediately.

Samaritans: Call 116 123 for free, 24/7 confidential support, or visit www.samaritans.org.
Shout: Text 'SHOUT' to 85258 for free, confidential, 24/7 text support.

Please note: This resource is intended for information and peer support; it is not a substitute for professional mental health care or crisis intervention. Please reach out to your GP, local mental health services, or the resources above if you need urgent help.

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References available upon request.

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