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Periodic Madness: Identifying and Treating PMS

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PERIODIC MADNESS: IDENTIFYING AND TREATING PMS

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Last week I picked up my copy of *Premenstrual Syndrome* by Ronald V. Norris, M.D. and browsed through it. Having been a patient of Dr. Norris in Boston and having been interviewed for his book the following year, I paid particular attention to the case study of the Mormon woman in Salt Lake City who had experienced recurring cyclic headaches, depression, irritability, and fatigue. Her marriage had been strained, and she had suffered pain and unexplained low self-esteem—in spite of her productivity and satisfying life as a homemaker and freelance writer. Dr. Norris described the troubled life of this Mormon woman and her otherwise happy family, in subsequent sections of his book.

Somehow, I find it ironic that the very woman described in such painful terms in a physician's book is now standing at a podium at the Institute of Religion—where I once served on the board of the LDSSA. For me (who once thought I was crazy) to be asked to address such an astute group of mental health professionals is a twist that I would not have predicted fifteen years ago. But then my husband, Mike, was a member of a student ward bishopric, and I was plugging along as his dutiful, supportive wife. With each passing month, I developed headaches, fatigue and mood swings that were predictable enough to be a way of life.

While serving on the LDSSA board, I was waiting for a missionary and writing frequent letters to him. I have often thought how interesting, yet disquieting, it would be to reread those letters, and see in my own handwriting what this missionary (who subsequently became my husband) observed as cyclic changes in my thinking, behavior, and outlook on life.

After I married, graduated from the university, and embarked on my career as a home economics specialist and journalist at the *Deseret News,* the mood swings worsened—especially after giving birth to my first child. I stayed home with the baby and wrote a weekly newspaper column, but had increasing difficulty meeting my deadlines because of intensifying headaches, depression, fatigue, and irritability. Some days I felt out of control, and there seemed to be no explanation because my life was so very full, so, I sought medical help. My obstetrician, who is an active Latter-day Saint, prescribed an antidepressant. He said the birth of that baby had caused a biochemical imbalance in my brain. The medication was very expensive and gave me temporary relief from the symptoms, but not long-term relief. Soon I was experiencing the mood swings again.

Then came the birth of our second child, subsequent postpartum depression, a move into our first home, and an untimely calling to be Relief Society President at the age of 25. After two years of full-time monitoring of compassionate service, opening socials, visiting teaching districts and three boards (this was before the consolidation schedule), my husband was promoted, and we moved to the Seattle area.

Within the year we moved again—this time to Washington, D. C. I became pregnant with our third baby. My symptoms worsened, and my ill health put a strain on my marriage. Here was this young father who thought he had married a woman with a sense of humor, a positive outlook on life, a high energy level

and productivity, and even a degree in home economics! She should certainly be able to keep a house clean, put nice meals on the table, and be a responsible wife and mother. Unfortunately, he witnessed each of these traits slipping away. After a bad "spell," I would ask how he had the patience to live with me. He would always say—"You know, I think I can handle this, as hard as it is for both of us, because I always know you'll bounce back."

In Washington D.C., I continued to seek medical help. I remember paying $400 for lab tests, only to be told that my blood chemistry was normal, and that my physical exam showed nothing unusual; so if I had these mood swings, I should see a psychologist. That bothered me. I had thought of myself as a person who had self-control and self-direction. The need for psychotherapy didn't fit my agenda.

My experience with psychotherapy was not too helpful. I would call the therapist's office on a really bad day and say, "I don't know what is the matter with me. I am feeling dreadfully low and shaky for no reason. I need to come in and talk to somebody." The receptionist would say, "Well, sure. The next available appointment is in ten days." She would book me and I'd show up ten days later, having a totally different outlook on life, feeling marvelous, and the therapist and I would both wonder why I was there.

After five years away from Salt Lake Valley, we returned to our hometown with three small children. With each child birth, I had become worse. I was questioning my value as a wife, mother and a person, because I would have two or three horrible weeks each month, then an inexplicable recovery for a week before the blackness would set in again. I began to fear for my sanity. I couldn't control the swings. When I felt well, I felt so well that I couldn't cry if I tried. I wondered, "Am I crazy?" Something inside me said "No, there's something wrong with your body chemistry, but how could that be true if specialists across the country hadn't caught it."

One day, in an hour of despair, I called the University Medical Center, the Department of Reproductive Endocrinology. They couldn't see me for three months. I said, "I don't think I can wait three months." My feelings about myself, and what I perceived as my husband's and children's feelings about me, had created enough pain in my life that I couldn't continue. I am sure that I was not actively suicidal, but I sometimes fantasized about driving around Parley's loop on a rainy day and accidentally slipping off the cliff. I told the receptionist, "You must refer me to someone who can see me sooner. I can't go through this any longer." She referred me to a specialist who was able to see me the next week. When I described my symptoms, he said, "That's PMT. Have you ever heard of Premenstrual Tension?" I hadn't. "Let me first reassure you that this problem is not in your mind. It is a very real biochemical problem, probably a hormone problem, and there is a treatment that works." Since there was (and is) no blood test for PMT, the timing of my symptoms, and other factors, confirmed the diagnosis.

That twenty-minute visit to a doctor's office was a turning point in my life. Imagine my elation, to hear a doctor validate what I had known all along, in spite of other doctors' skepticism.

Unfortunately, the treatment he recommended was a hysterectomy. His theory was—the way to treat a menstrual problem is to put an end to menstruation. That made sense, but we had wanted more children. Still, I believed I wasn't the best mother to the three we had because of my medical condition, and I thought I had no choice but surgery. But I asked, "Isn't there anything else I can try?" He said, "Well, you might try vitamins, but I can assure you they won't work." I went to the medical library to read up on the B vitamins and took massive amounts for a couple of months, but had no relief at all. I called the doctor and said, "Schedule me for surgery. I can't go through this one more month."

That was four years ago. I had the surgery at LDS Hospital. This part of my story is something I seldom share, but it is appropriate with this group. The night

before surgery, I had had all the preliminary exams and interviews, the doctor had visited and was very hopeful about the prognosis. He left, and in a moment, the room seemed lighter. I was struck with the realization that, whatever the outcome of this surgery or whatever else happened to me, I would have a part to play in bringing hope into the lives of other women who had the problem.

I thought surgery would be the turning point. Unfortunately, several weeks after the surgery and the dangerously high doses of estrogen that were surgically implanted in my body as a follow-up treatment, I realized that the course I had taken (which had given temporary relief) was not the ultimate solution. In fact, I continued with what I now know is PMS, Premenstrual Syndrome. Severe headaches, depression, irritability, mood swings, a sense of being out of control, fatigue, clumsiness, mental confusion—all the symptoms I had before had returned, only with greater severity. Not only that—I was no longer able to have children. I was angry; I felt betrayed again by the medical profession.

At that time, I was writing a weekly column for the *Deseret News* on psychological case studies. One week I wrote about PMS. Within a week of the publishing of that brief article buried on page C-11, among the grocery ads, I had about a hundred phone calls or letters. Journalists don't often get that kind of response to articles, especially an avalanche of phone calls and letters saying, "Help me. You just wrote the story of my life. Who are you? What is PMS? Where can I find help?" Though I had limited answers based on limited experience, something told me to take down the names and phone numbers of these women. I said, "Let me contact you when I have more information. I wasn't about to tell all of them they needed a hysterectomy. Since this was a Salt Lake City newspaper, most of my readers and callers were Mormon women. They had the same cyclically-timed symptoms and the same feelings of guilt about not measuring up to the high standards set for them.

I kept that list and, Type A personality that I am, I kept going up to the University Medical Library, barely understanding what I was reading. After a few months, I saw an article in the *Journal of the American Medical Association* about PMS and a clinic in Boston that was soon to open. The treatment did not involve surgery and the medication (progesterone) was benign. I ran home and called Dr. Norris. I bombarded him with questions. He was very kind, in fact, he was travelling through the West the next week, and made arrangements to meet me. I interviewed him and wrote another article, which brought a few hundred more urgent calls and letters.

I flew to Boston for medical care at the country's first PMS clinic. While there, I wondered how could I have PMS if I no longer had a menstrual cycle? Dr. Norris explained that PMS originates in the brain, not in the reproductive organs. Therefore, I was still treatable. After my screening and diagnosis, I went through a lengthy recovery period during which I was regulated by medication, and I learned and implemented the necessary dietary and lifestyle changes. Regaining control of life was exhilarating.

Well, I could have lived happily ever after, except that I still had a list of the names of a few hundred women awaiting my help. Those women couldn't all fly to Boston. Then I heard about a doctor at the University of Utah who specialized in the hormone problems of women and had shown an interest in PMS. I scheduled an appointment, not as a patient, but as a healthcare consumer advocate. I didn't interview him, I interrogated him. I wanted to know his background and credentials; I wanted to know why he cared about PMS and what he was willing to do about it, and if he was sincere. He wanted to know about my case study. He was very curious, but as most scientists would be, somewhat skeptical. We met regularly, and he treated me as a colleague. This was a surprising and welcome change, considering my history with doctors and the fact that I was a lay person. With the help of this Dr., William R. Keye, and a few other

zealous PMS patients, I founded a PMS support group in Utah which, after time, led to the formation of the National PMS Society. Assisting in the national group was PMS recovery patient, Lindsay Lakie, from North Carolina.

Soon thereafter, Dr. Keye and other clinicians developed a medical program for the evaluation and treatment of PMS. I was asked to be the clinic administrator. The Utah PMS Center is now in its third year of operation and has recently moved into the LDS Hospital System. (Another irony, considering that LDS is the hospital facility where so many of my family's PMS-related problems were treated.) Salt Lake City was one of the forerunning cities in the recognition and treatment of PMS. Probably more women were helped here in the early 80's than anywhere west of the Mississippi.

Together, my colleagues, fellow PMS sufferers, and I have learned some interesting things about Premenstrual Syndrome:

1. PMS impacts on self-image and, consequently, impacts on friendships. As a Mormon woman with PMS, I didn't have many close friends. This wasn't the type of problem most women would want to talk about in Relief Society. The symptoms of PMS don't fit the "ideal Mormon woman syndrome." To feel so depressed and lethargic that you can't keep your house clean or enjoy your children, but having to fake being able to do it anyway puts one in a genuine state of conflict. I hasten to say that after being so involved in women's healthcare I have numerous close friends now, many of whom also have PMS. We have a great time helping each other and openly discussing the realities of life.
2. Not all women have PMS. There are several different kinds of women: those who don't have PMS, and they are grateful; those who don't have PMS and wish they did, because it would be a neat explanation for their difficulties; those who do have PMS, but don't know it; those who have it and know it, but won't admit it to anyone or do anything about it. Then there are those courageous few who have PMS and are seeking and finding appropriate help.
3. PMS impacts on marriage. In our community, there is a high degree of commitment to marriage. Families victimized by PMS also have a high commitment to marriage. For all the turmoil these couples go through—the marriages usually survive.
4. PMS impacts on children. One of Dr. Keye's patients gave him a picture her preschool daughter drew of her at both phases of her cycle. One looks like a wicked witch, the other, a fairy queen.

   My mother had severe PMS. She functioned on 'half-a-cylinder' three weeks out of the month. Then during her good week she'd feel guilty about the previous three, so that the whole month was somewhat of a drain. As a result of those experiences, I had resolved, early in life, to have an experience different from my mother's. I would be active in the Church, because the Church would bring me all the happiness that she, being inactive, had not had. And since my mother had never felt well enough to be an accomplished homemaker, I made up my mind to obtain a degree in home economics. Unfortunately, my career decisions didn't change my genetic inheritance.
5. PMS is probably hereditary. As you interview your clients, from what we have learned at the PMS Center, you ask about their childhood, their mother's, and their own mothering style. The PMS problem seems to be hereditary. Is PMS a learned behavior or a biochemical event? Doctors don't know even yet what causes the disorder, let alone what cures it. But there are some common points of agreement that are building blocks for understanding. The current definition of PMS is a clustering of physical, emotional, and behavioral symptoms that are somehow linked to biochemical changes in the brain, recurring cyclically, month after month, in the premenstrual phase. Classically, there are one or two symptom-free weeks per month.

One of most common questions a patient asks is, "How do I know when my symptoms are severe enough to require medical help?" To me the answer is simple. If the symptoms are significantly disruptive to the quality of a woman's life, she needs a doctor. We're not pioneers crossing the plains, who have to put up with our sorry lot. We don't have to live with this. There is help available. And there are many things women can do on their own to bring relief, such as eating a balanced diet, reducing stress, and exercising.

The Mormon woman sometimes has difficulty complying with these recommendations, since it's hard for her to admit to having a problem such as PMS in the first place, and since she often puts herself last in the nurturing department.

Even for women who have a symptom-free phase each month, there are residual discomforts all month long. A woman who suffers for fifteen to twenty years from a chronic, biochemical problem that causes her behavior to change is going to lose trust in herself and have some difficulty even during her good time. The proposed etiologies of PMS, none of which have been proven, but all of which are potential causes—include everything from intolerance to environmental antigens, altered neurotransmitters, pituitary dysfunction, biochemical disturbances, and intolerance to stress.

After two years and two-thousand clients, physicians at the Utah PMS Center have begun to wonder if each of these components doesn't play some part in the explanation of PMS. Perhaps there are several different syndromes under the PMS umbrella.

A hundred or more symptoms have been associated with premenstrual syndrome, but we'll discuss the more commonly reported ones. Ninety-eight percent of the patients in Dr. Keye's first study reported fatigue, frequent headaches, (all types—migraine, tension, sinus—) bloating, decreased urination, breast tenderness, increased appetite, acne, and anxiety. May I add that this is anxiety for which there is no explanation. A woman may have a comfortable life, a loving husband, wonderful kids, freedom from financial problems; she may even have a fulfilling career. She likes her neighbors. But she wakes up some mornings with an overwhelming sense of anxiety and gloom. An equally inexplicable symptom is anger. The children are great; they play in the sandpile, bring home good report cards, practice their instruments, and she'd just as soon scream at them as look at them, blowing up over things that didn't bring a second glance the week before. Depression, sensitivity, rejection, guilt, pessimism, feelings of being overwhelmed—these symptoms are common during the luteal phase of the menstrual cycle for women with PMS. Dissatisfaction with one's appearance, loneliness, and rapid mood changes are also symptoms.

The most commonly reported behavioral changes (sometimes reported by the husbands) are nagging, craving sweets, restlessness, poor concentration, withdrawal from friends and community, taking the phone off the hook, locking the door, dimming the lights, and going off alone into a corner of the house.

Hysteria sometimes occurs. As you may know, hysteria comes from hyster, the Greek word for uterus. Someone long ago made a connection between a woman's cyclic physiological changes and behavioral extremes. Other symptoms are decreased judgment, increased sleep, intolerance, and mental confusion—you may walk into the kitchen and wonder what on earth you are doing there. Obvious interpersonal difficulties result. Suicide is a reported tendency.

Clearly if female patients are reporting these symptoms in a cyclically timed pattern, it is certainly worthwhile to question them further about PMS.

Dr. Keye learned in his first study of 256 PMS patients at the University of Utah, that PMS symptoms can begin at puberty, childbirth (the most common time of onset), following a life crisis, during amenorrhea (the cessation of the period), following a tubal ligation. Birth-control pills can make PMS worse, as can

emotional stress, increased age, and even tranquilizers.

Fifty percent of the women in Dr. Keye's study reported PMS symptoms in their thirties. Most of them had three, four, or five children. When Dr. Keye shows these statistics across the country, he gets some snickering from colleagues who are unaccustomed to seeing women with so many children. But if childbirth can bring on or exacerbate PMS, I wonder if more women in the Church community suffer from PMS. The majority of women began having symptoms post-partum. The second largest group reported symptoms at puberty, and the third most frequently reported cause was stress. The average patient in the study suffered more than eleven years, before finding help, had symptoms fourteen days out of the month, and had seen more than three doctors for care. Most of the patients in Dr. Keye's study (81%) were married, and most were still on their first marriage. Forty percent of all women of childbearing age are reported to have symptoms, with ten percent suffering to the degree that they are in trouble and in need of medical help. That ten percent represents about 20,000 women along the Wasatch Front.

Those with a history of toxemia during pregnancy or post-partum blues have an even greater chance of having PMS, and a more severe case of it. One of the most dramatic bits of research we encountered was a study in Great Britain in 1959 involving autopsies on 100 deceased women. Scientists studied hormone levels in the uterus to see where each woman was in her menstrual cycle at the time of death. Statistically, 50 percent of those women should have died during their follicular phase (or the time of well-being according to the PMS definition), days one through fourteen, and 50% should have died in their luteal phase, days fourteen through twenty-eight (the difficult time for women with PMS), but no matter the cause of death—accidents, suicide, or natural causes, 84 to 92 percent of these women died during their luteal phase, those crucial two weeks before menstruation. Something very real is going on at that time. Dr. Hammond will now explain the psychological implication of PMS.

D. Corydon Hammond

The question of how to evaluate PMS is crucial to treatment. As we present at conferences around the country, I believe we are one of the foremost sites in the United States in the development of innovative protocols and methods for evaluating Premenstrual Syndrome. When you advertise that you work with PMS, you tend to primarily attract the moderate to more severe sufferers. Therefore, most of the women that we see are disturbed psychologically, sometimes severely. Approximately two-thirds of the women we screen have been suicidal, and at least one-fifth have made a suicide attempt.

The diagnostic issue that we must determine is whether we have a woman with major psychiatric disorder, PMS, or a psychiatric disorder which is intensified by PMS. Research has shown that retrospective patient reports of symptoms coinciding with the luteal (premenstrual) phase of the menstrual cycle are very inaccurate and cannot be trusted. Therefore, we must depend on prospective charting of symptoms. We use a special premenstrual calendar on which patients chart their emotional, behavioral and physical symptoms by degree of intensity for a couple of months. If we find a premenstrual clustering of symptoms, with a symptom-free period (or decline in severity of symptoms) in the follicular phase (immediately following cessation of menstrual bleeding), then we have evidence of the likelihood of a premenstrual disorder. We will also gather a social history, spouse interview, conduct marital and personality testing at both phases of the menstrual cycle, and analyze medical results. If a premenstrual pattern does not exist, but perhaps there is evidence of marital discord, psychopathology, or medical disorders, we still want to determine the nature of the problem and refer for appropriate care.

My work in the specialty of evaluating and treating sexual dysfunction has made me comfortable in working with

specialists from other disciplines, and in this sense, has been good preparation for working with premenstrual syndrome. Non-physician mental health workers should not be trying to evaluate this condition by themselves. Similarly, physicians lack the skills they need to evaluate the psychological and marital symptomatology of patients with moderate-severe PMS. This is a complex medical-psychological problem requiring thorough evaluation by an interdisciplinary team. Medical evaluation is essential. For example, one woman complained of premenstrual headaches as one of her primary symptoms. Evaluation found that she did not have PMS, but that she did have a brain tumor.

Our formal evaluation includes completing a PMS calendar; thorough physical examination and lab tests; mental status examination, Minnesota Multiphasic Personality Inventory, and a marital screening instrument, all of which are administered at both phases of the menstrual cycle; spouse interview to determine his perceptions and to assess the impact on the children and family system and a patient background history. The background history includes assessment of secondary and tertiary problems related to work, family, social interactions, etc. The medical history includes information about infertility, miscarriages, pregnancies, menstrual history, and use of medications and contraceptives. We want to know the age at onset of PMS, the duration of symptoms, how the condition has progressed, and if it has become worse at some of the typical times, such as following the birth of children.

The PMS calendar is individualized in the sense that the emotional, behavioral and physical symptoms that are most prominent for each individual patient are selected by them to be rated for two months. They are rated daily, with a rating of zero meaning the sympton is not present, and the severity rated from one to seven (severe). Symptoms may include things like craving for sweets, dizziness, fainting, violence, backache, hostility and anger, depression, anxiety, insomnia, or feeling overwhelmed.

The usual pattern of symptoms in patients with PMS shows a symptom free period after cessation of bleeding, followed by an increase in the presence and severity of symptoms after ovulation, becoming worst immediately before the start of menses. Another frequent pattern is seen in the patient with a psychological disorder that is accentuated by PMS. This patient will show a baseline of a moderate level of problems (marital discord, depression, thought disorder, anger) which are exacerbated in the week or two before menstruation. If any of you have worked in inpatient psychiatric settings, you are probably familiar with the phenomenon of many women being admitted premenstrually, and beginning their periods shortly after hospitalization. Finally, some patients think they have PMS, and even hope that PMS may be the explanation to their baffling problems, but upon careful evaluation we can find no relationship between their symptoms and the menstrual cycle. Not all women have PMS. I suspect less than 20% of women have PMS sufficient to cause them such distress, and that likely only 5%-10% of women experience this syndrome in the severity we commonly encounter at the PMS Center.

We conceptualize the symptoms that are charted on the PMS calendar as primary symptoms. However, we also evaluate secondary problems that have stemmed from the primary symptoms: low self-esteem, feelings of inadequacy, withdrawal from family and friends. A woman may withdraw from her children because she never knows when she will explode. She knows that she becomes so paranoid and hypersensitive that her behavior is unpredictable, and so she also begins to avoid friends and withdraw from associations at work. This, of course, further accentuates her depression. Another secondary problem is guilt. When you have just been a shrew for two weeks and terribly hurt people that you love, it is difficult to immediately get over this depression and guilt. Thus many women with

severe PMS will continue to have some of these symptoms even during their "good" times.

Tertiary or third level problems also occur after a while, for example, when PMS begins to interfere with occupational and educational activities. A major producer for a national television series was filming last year in a nearby state. She came to the PMS Center when she was essentially incapacitated at the film site. Marital problems are also typical tertiary problems. As marital therapists, we should routinely ask questions about whether some of the symptoms get worse at certain times of the month. Have any of you seen couples where you make some progress for two or three weeks and everything looks optimistic, and then suddenly everything blows up again? Parent-child relationships, child and husband abuse, financial problems—all of these areas can eventually be influenced by PMS.

In the area of marital adjustments, we have used the Locke-Wallace Marital Adjustment Test because it is a brief and rapid screening tool. The Spanier Dyadic Adjustment Scale would be another such instrument. The mean score on the Locke-Wallace for average couples is 100. Well adjusted couples score 135, and couples in problematic relationships score below 100. In our PMS population, at a "good" time of the month (follicular phase), couples scored 103—just above average. However, during the premenstrual phase, the score dropped to 71. As any of you know, who have used this instrument, when you have a couple who scores 70, you have a lot of therapeutic work to do. In over a dozen years of experience in marital and sex therapy, I have never seen marital adjustment test scores that are as low as some we see in PMS patients.

In studying marital adjustment during the menstrual cycle, in PMS couples we generally see the degree of conflict and anger intensify, communication decline (as the patient and her spouse withdraw from each other), shared activities dramatically decrease, decision making patterns shift with the woman becoming more dominant, and usually the sexual interaction declines. Commitment to the relationship also decreases in the luteal phase. Often the woman indicates that if she had to do it over, she would not marry at all, and men often indicate that they would marry someone else. At a good time of the month, one-third of our couples had below average marital adjustment. Premenstrually, however, 81% rated their marriage below average.

I believe that marriages where significant PMS is present are heavily influenced by an intermittent reinforcement schedule. Most of you remember from your experimental psychology classes that intermittent reinforcement is the most powerful type of reinforcement schedule. In PMS marriages we have intermittent reinforcement in two ways. The good times often keep the marriages together and maintain some degree of hope. After all, things aren't absolutely terrible. For half the month, the relationship may be fairly good. However, after a couple of good weeks, just as optimism is being encouraged and they are beginning to draw closer, everything falls apart again. Thus pessimism is reinforced about whether the marriage will ever get better. With the birth of subsequent children, the couple may be further tied to the relationship by both the children and their closer feelings due to the absence of PMS symptoms during pregnancy. But, PMS is frequently exacerbated following the birth of each child. The PMS marriage can be a relationship of tremendous ambivalence, moving toward and away from each other. Spouses are often afraid to get too close. Their trust level is often very low as they anticipate what have become inevitable blow-ups. Many of the relationships need marital therapy, with a focus on anger management training, conflict resolution training, and general marital communication and enhancement work.

Some of our most fascinating results have been in examining the Minnesota Multiphasic Personality Inventory at the two phases of the menstrual cycle. The vast majority of MMPI's were highly valid at both testing times in the menstrual

cycle. On the ten clinical scales, there were significant increases premenstrually on eight scales (Hs, D, Hy, Pd, Pa, Pt, Sc, Si) at a .001 level of probability or beyond. It is not uncommon to see women appearing very normal on the MMPI in the follicular phase, having no T-scores over 60. Then, two weeks later, they may be in the 75-95 T-score range on five or six scales.

As another way of evaluating the MMPI's, we rated them for overall level of psychological disturbance. They could be rated normal, mild, moderate, or severely disturbed. A psychologist colleague and friend, Dr. Gary Jorgensen, blindly rated them along with me. Our inter-rater reliability was .96. In the follicular phase ("good" time), 44% were moderate or severely disturbed. In the luteal phase, 92% showed moderate to severe disturbance psychologically! On the basis of our findings, I expressed the belief at the 1984 American Psychological Association annual meeting that we can no longer ethically test women psychologically without asking them if their symptoms may vary with their menstrual cycle. This has important implications for court and child custody evaluations.

There is much we don't know about PMS. My own sense is that we will eventually discover multiple etiologic factors, which may include genetic, neuroendocrine, immunologic, and also psychological and background factors. There is some preliminary evidence that early sexual abuse may be a predisposing factor, and we certainly need to screen this population for psychological-sexual trauma.

One of the most effective treatments appears to be natural progesterone suppositories. We see improvement in about four-fifths of the women taking natural progesterone, although it certainly does not eliminate all symptoms in all women. For many, it helps control and modulate the symptoms; for a few it seems to have little effect. Other drug treatments also appear effective part of the time and are the subject of experimentation.

Psychological treatment and support also appears vitally important. These patients are often at risk for suicide and generally feel overwhelmed with anxiety, anger and depression. One of my innovations for them has been the use of self-hypnosis training as a self-management skill. Self-hypnosis can often be used for ego-strengthening and for anxiety and anger management. In a preliminary group of PMS patients trained in self-hypnosis, at six month follow-up they rated self-hypnosis as being almost exactly as effective and helpful as progesterone. Support groups can also provide encouragement, hope, and a sense of universality, as well as supplying education about diet and exercise. And, as we already noted, after experiencing the ravages of PMS on their marriage for ten or fifteen years, many couples need relationship enhancement work, in addition to individual help.

In closing, let me request, please, that you ask about premenstrual syndrome. Questions about the relationship of the menstrual cycle to symptoms should be just as routine as inquiries about suicidal ideation, sexual dysfunction, or marital distress. Then, when PMS is suspected, refer the patient to an interdisciplinary team for careful evaluation. I believe you will encounter PMS in your patients far more than you might anticipate. In four different studies of female patients with a history of major affective disorder, two-thirds of them were found to have premenstrual syndrome.

Patty Cannon.

Symptoms of PMS seem to stem from a variety of sources: the day of menstrual cycle, life stress, sleeping, eating, and exercise patterns, plus compliance with medical treatment. If a woman has only mild PMS, cutting out caffeine and sweets and taking up jogging may help her to manage the symptoms nicely. Dr. Leathanna Dalton in London, who has treated 30,000 women with PMS during the last thirty years, visited Salt Lake City in the Fall of '83. We had been having difficulty with a few patients who were not

doing well on the standard PMS treatment protocols, and her first question was: "What are these women eating? How often are they eating?"

So I called them all up and asked. The answers: sweets, salty foods, and caffeine; not much in the way of protein and complex carbohydrates. They were skipping meals. Fasting can be as hard on these women as eating junk food. If these women eat six small meals per day consisting chiefly of proteins and complex carbohydrates, they will do much better regardless of medication. "Food is medicine," says Dr. Dalton.

At the Utah PMS Center, we begin with patients by showing educational videotapes, giving nutritional information, giving them support and counseling when necessary, and having them chart symptoms in a menstrual calendar. Patients who come to our clinic do not receive medication until the diagnostic visit, which occurs once the patient has had a complete physical, psychological testing, and has charted symptoms for 6-9 weeks. Without such screening, it's pretty tough for a physician to make a definitive diagnoses.

D. Corydon Hammond, Ph.D.

A lot of physicians have read one journal article on PMS and are anxious to prescribe medication. I think these patients need very careful evaluation, not a shoot-from-the-hip diagnosis. One woman I treated a few months ago had gone to her gynecologist, told him she might have PMS, and on the basis of reading one article—he changed her birth control pill to one with more progesterone. Well, that is a synthetic progestogen, not natural progesterone. There is a subtle chemical difference which can make a rather dramatic difference to the patient. Also many times, progesterone will be prescribed in doses that are unlikely to be helpful.

Patty Cannon.

Many people are alarmed by hormone therapy of any sort because of some of the obvious things we learned about synthetic estrogens. Two studies in Great Britain demonstrated that progesterone was no more useful than placebos. Dr. Dalton was concerned because for thirty years she has been prescribing this medication with good results. So she went to the researcher and asked to see how the studies were designed. She determined that the studies had been improperly designed, and in some cases, the participants didn't even have PMS.

Psychotherapists will appreciate hearing about the woman who went to her therapist and described her ups and downs. "Well," he said, "let me tell you something, you are either crazy or you are not crazy, but you are not crazy part of the time."

Other than the factor of multiple child birthing experiences, the Mormon woman should really be the last one to develop the symptoms associated with PMS. With a sensible health code and a strong supportive family life, the severely suffering Mormon woman very likely has a medical problem. Women who complain of severe premenstrual symptoms, marked psychological reactions, disturbed interpersonal relationships, or other unusual circumstances need and deserve the evaluation of a multi-disciplinary team to bring about proper recovery.

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