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The prevalence, impairment, impact, and burden of premenstrual dysphoric disorder (PMS/PMDD)

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Abstract

Currently it is estimated that 3–8% of women of reproductive age meet strict criteria for premenstrual dysphoric disorder (PMDD). Assessment of published reports demonstrate that the prevalence of clinically relevant dysphoric premenstrual disorder is probably higher. 13–18% of women of reproductive age may have premenstrual dysphoric symptoms severe enough to induce impairment and distress, though the number of symptoms may not meet the arbitrary count of 5 symptoms on the PMDD list.

The impairment and lowered quality of life for PMDD is similar to that of dysthymic disorder and is not much lower than major depressive disorder. Nevertheless, PMS/PMDD is still under-recognized in large published epidemiological studies, as well as assessments of burden of disease. It is demonstrated here that the burden of PMS/PMDD as well as the disability adjusted life years (DALY) lost due to this repeated-cyclic disorder is in the same magnitude as major recognized disorders.

Appropriate recognition of the disorder and its impact should lead to treatment of more women with PMS/PMDD. Efficacious treatments are available. They should reduce individual suffering and impact on family, society, and economy.

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1. Introduction

Premenstrual syndromes (PMS) are quite prevalent among women of reproductive age. Dysphoric symptoms are among the most prevalent and bothersome premenstrual symptoms and are often the reason for treatment seeking. Currently it is repeatedly cited that 3–9% of women report having dysphoric PMS severe enough to seek and warrant treatment (Angst et al., 2001; Johnson, 1987; Merikangas et al., 1993; Ramcharan et al., 1992; Rivera-Tovar and Frank, 1990; Sveindottir and Backstrom, 2000; Wittchen and Hoyer, 2001; Woods et al., 1982).

Even though the etiology of PMS is still unknown (Halbreich, 1995; Halbreich, 1999), several treatment modalities have been shown to be effective (Halbreich, 1996; Muse et al., 1984; Steiner et al., 1995; Yonkers et al., 1996). Despite the prevalence of the disorder, the availability of treatment and media exposure, many lay people and professionals are still unaware of its impact on the individual, her family and environment. A comprehensive report by the World Health Organization (WHO) and the World Bank concerning the burden of disease and lost productivity from a multitude of physical and mental disorders (total of 483 disorders) (Murray and Lopez, 1996) did not include PMDD or PMS. The WHO World Health Report for 2001, which was dedicated to mental health, did not mention PMS/PMDD either, even though it listed updated 2000 disability rates for about 90 disorders, including 14 neuropsychiatric illnesses (World Health Organization, 2001).

To our knowledge there are only few reports that included data on premenstrual work or family impairment. An increased number of sick days in women with PMS was reported (Hellman and Georgiev, 1987), but not completely confirmed in women who did not seek treatment for PMS and also did not report impaired work performance (Andersch et al., 1986; Busch et al., 1988; Campbell et al., 1997). Impaired work productivity in women with PMS was reported (Chawla et al., 2002). This impaired productivity was perimenstrual and continued also during the early follicular phase. Despite the reported reduced productivity there was no increase in health care utilization and work absenteeism in that report. Premenstrual impairment may be more severe at home, influencing marital relationships and homemaking, as compared to social and out-of-home occupational impairment (Brown et al., 1998; Frank et al., 1993; Hylan et al., 1999; Kuczmierczyk et al., 1992; Ryser and Feinauer, 1992; Winter et al., 1991). Our group previously demonstrated that treatment-seeking women with PMDD had impaired functioning and social adjustment during the late luteal phase and these measures were improved following treatment with selective serotonin reuptake inhibitors (SSRIs) (Pearlstein et al., 2000; Yonkers et al., 1996).

Here, prevalence of PMDD and dysphoric PMS will be assessed: the effects of PMDD on impairment, social adjustment, and quality of life will be compared to the effects of other, more recognized affective disorders. It is documented that the impact and burden of PMS/PMDD is on a similar magnitude to other disorders and should be accordingly addressed.

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