PMDD | POLICY COUNCIL

Because Premenstrual Dysphoric Disorder Is Too Serious to Ignore.

What is PMDD?

PMDD is a severe premenstrual disorder characterized by debilitating emotional, behavioral, and physical symptoms that emerge during the luteal phase of the menstrual cycle (the one to two weeks before menstruation) and improve within a few days after menstruation begins. Unlike ordinary premenstrual symptoms, PMDD causes significant functional impairment — disrupting work, relationships, and daily life. It is recognized as a depressive disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

PREVALENCE

PMDD affects millions of menstruating individuals worldwide. Common prevalence estimates range from 3% to 8%, although a 2024 systematic review found that 3.2% of participants met criteria for confirmed PMDD. Approximately 4.2 million Americans are estimated to have the disorder, although national estimates vary depending on diagnostic methods and population assumptions. Despite its prevalence, PMDD remains underrecognized and frequently misdiagnosed. Patient advocacy organizations report substantial rates of misdiagnosis, often involving bipolar disorder, major depressive disorder, or borderline personality disorder, contributing to prolonged delays in effective treatment.

DIAGNOSTIC CRITERIA

Diagnosis is based on the cyclical timing, severity, and nature of symptoms, confirmed through prospective daily symptom tracking over at least two menstrual cycles. A provisional diagnosis may be made before tracking is complete. DSM-5 criteria specify that at least five symptoms, including at least one core mood symptom, must occur during the final week before menstruation, improve within a few days after menstrual onset, and become minimal or absent during the following week. Core symptoms include marked mood changes, irritability or anger, depressed mood, and anxiety or tension. Symptoms must cause clinically significant distress or functional impairment and cannot merely reflect the premenstrual worsening of another disorder.

MENTAL HEALTH IMPACT

The mental health burden associated with PMDD is severe. A 2022 study published in *BMC Psychiatry*, involving 599 respondents reporting prospectively confirmed PMDD, found that 34% reported a lifetime suicide attempt, 72% reported active suicidal ideation, and 51% reported nonsuicidal self-injury. Although these findings come from a self-selected sample and should not be interpreted as population-wide rates, they demonstrate the serious mental health risks associated with the disorder. PMDD also frequently co-occurs with other psychiatric conditions, and its cyclical presentation can complicate recognition, diagnosis, and treatment.

SOCIOECONOMIC IMPACT

Premenstrual disorders carry substantial social and economic consequences. A 2025 study of more than 15,000 women in Sweden found that individuals with premenstrual disorders, including PMS and PMDD, had a 40% higher risk of sick leave and a 27% higher risk of unemployment compared with unaffected women. Research also documents the significant strain PMDD can place on intimate relationships, family functioning, and quality of life. These findings demonstrate that severe premenstrual disorders are not merely personal health concerns but broader public health and economic issues requiring systemic attention.

CURRENT TREATMENT LANDSCAPE

Evidence-based treatments include selective serotonin reuptake inhibitors (SSRIs), which may be prescribed continuously or intermittently, and certain combined hormonal contraceptives. Cognitive behavioral therapy (CBT) and Dialectical Behavioral Therapy (DBT) can also help manage symptoms. For severe, treatment-resistant PMDD, additional options include medications that suppress ovarian hormone cycling, such as gonadotropin-releasing hormone (GnRH) agonists, generally prescribed with hormonal add-back therapy. Some may choose to undergo an oophorectomy—the removal of the ovaries and fallopian tubes—for total symptom eradication. Despite established treatment guidelines, limited clinician awareness, inconsistent training, and barriers to specialized care can delay accurate diagnosis and effective treatment. Many patients consult multiple healthcare providers before receiving appropriate care.

THE CASE FOR POLICY ACTION

Despite its recognition in the DSM-5 and ICD-11 (code GA34.41), PMDD remains insufficiently understood. Significant questions persist about its biological mechanisms, individual variation, long-term health effects, and optimal treatment. Although federal research has contributed to scientific advances, there remains a need for greater investment, coordinated research priorities, improved medical education, and more consistent access to evidence-based care. The PMDD Policy Council advocates for expanded federal research, stronger PMDD education in medical training, and improved access to diagnosis and treatment — because the scientific evidence demonstrates a serious public health burden, and the need for action is urgent.