

Exploring Premenstrual Dysphoric Disorder (PMDD) in the Work

Context: A Qualitative Study

Abstract:

This study aims to explore women's experience of premenstrual dysphoric disorder (PMDD) in the workplace, and identify if organizations can do anything to help.

Analysis of fifteen semi-structured interviews, using an inductive thematic analysis approach, revealed the most common symptoms women experience at work include difficulty in concentrating, self-doubt, paranoia, fatigue, tearfulness, a heightened sensitivity to the environment and people, outbursts, and finding social interaction particularly difficult during this premenstrual "episode" phase. It is these symptoms that contribute to observed presenteeism and absenteeism in the work context. After symptoms disappear (with onset of menstruation), women reported feelings of guilt and engage in over-compensatory behaviors such as working longer hours and taking work home during the remainder of the menstrual cycle (i.e. post-episode phase).

Women alternate between these phases every month, which over time, accumulate and have additional consequences. Women are leaving the workforce through voluntary and/or involuntary turnover, sometimes giving up on careers entirely. The interviews also highlighted that organizations need greater awareness and support mechanisms in place for helping female employees with this condition. These findings could be of interest and have relevance to researchers, employers, policy makers, and health professionals.

Key words: premenstrual dysphoric disorder (PMDD); presenteeism; absenteeism; turnover; career; organizational awareness and support

Introduction

It has long been known that many women experience some form of premenstrual complaint [1] that can interfere with performance [2]. For many women premenstrual symptoms are unproblematic. For others at the opposite end of the continuum, symptoms can be debilitating. According to American College of Obstetricians and Gynecologists (ACOG) [3], women with Premenstrual Syndrome (PMS) will experience at least one affective symptom (such as depression, angry outbursts, anxiety, irritability, confusion, withdrawal) and one somatic symptom (such as breast tenderness, abdominal bloating, headache, swelling of extremities) during the five days before menses and relief within four days of menses causing identifiable disruption to social or economic performance. It is estimated 20-40% of premenopausal women have PMS [4]. However, approximately 3-8% of women [5] have a highly severe form of PMS called Premenstrual Dysphoric Disorder (PMDD). The exact cause of PMDD is unknown; PMDD remains an under-researched area. More research is still needed to fully understand the etiology, including how it affects women across their life domains.

PMDD is a recognized clinical mental disorder [6] and involves the presence of several psychological and physical symptoms. Symptoms include four primary: 1) discernible lability; 2) anger, irritability, or increased interpersonal conflict; 3) depressed mood, feeling hopelessness; 4) tension and anxiety; and six secondary symptoms: i) decreased interest in usual activities; ii) concentration problems; iii) lethargy; iv) insomnia or hypersomnia; v) feeling out of control or overwhelmed; and vi) physical symptoms (such as joint or muscle pain, feeling 'bloated') [6]. For a PMDD diagnosis, five or more symptoms (one of which must be primary) should

present during the luteal phase for at least two consecutive months, recorded using prospective daily ratings, and disappear a few days with menses [6]. These symptoms must also be severe enough to significantly interfere with functioning at home, school, and/or work.

The impairment in functioning is an important criterion of PMDD and evidence of fluctuations in cognitive functioning over the menstrual cycle has been observed. For example, women with PMDD have been shown to experience greater impaired cognitive performance in recall and memory tasks compared to women without PMDD [9], including working memory tasks during the luteal phase [10]. Significant associations between premenstrual symptom severity, irritability, and functional impairment have been recorded [10], which for some working women can result in impaired functioning at work.

Research has shown women in the US with PMDD have greater impaired work productivity [11] as well as higher absence rates [12,13] compared to women with minimal or moderate premenstrual symptom severity. Such effects are not unique to women in the US but have also been found in other countries and cultures. For example, Heinemann and colleagues [14] explored female employees in Austria, Germany, Spain, and Brazil and found significantly higher absence rates in women with PMDD compared to those with mild or no symptoms (>8 hours per menstrual cycle; 14.2% vs 6.0%) and higher average number of days of reduced performance compared to women with mild or no symptoms (5.60 vs 1.13 days). Such impairments not only affect the woman's work outputs but also have associated lost outputs and cost implications for the organization [15], society and economies [5]. Trying to help these women is therefore important and beneficial for us all.

The above research has highlighted the problem of lost productivity and absenteeism within a work context. The aim of the present study was to conduct an exploratory investigation into the experiences of women with PMDD at work, to understand what influences these kinds of outcomes, as well as exploring whether employing organizations could do anything to help their female staff who may have PMDD. The qualitative interview method was used in this study as it permits a convenient way to explore situations in-depth, allowing researchers to gain sufficient understanding of the situation of interest from participants' first-hand experiences [16] in a one-to-one session.

Method

Participants

Adult women with PMDD, either in employment or with employment experience, were recruited using adverts posted on social media sites. Women were required to have already received a clinical diagnosis of PMDD from a health professional (e.g. physician/GP, gynaecologist, psychologist) to be eligible to participate. Fifty-seven women responded to advertisements and fifteen eventually participated. Participants (see Table 1) were aged between 25-49 years, predominantly in their thirties (53%), British (53%), worked in a variety of sectors, and were receiving some form of treatment for PMDD (80%). They had received their PMDD diagnoses 6 months to 4 years prior to the interview. Just over half were employed full-time but some were working part-time (33%) or unemployed (13%) due to their PMDD.

Procedure

All participants were sent an information sheet and consent form for the study. Consenting participants completed a background questionnaire before the interview. Semi-structured interviews were conducted via telephone or Skype. Following an interview guide to ensure consistency, interviews began with an introduction and general questions about their experience of PMDD serving to build rapport and help participants feel comfortable sharing specific experiences. Participants were then asked a series of open-ended questions to explore two main areas: 1) experiences of working with PMDD; and 2) perceptions of what, if anything, organizations could do to help. Probe questions were used to elicit more detailed information where appropriate. Participants were thanked and debriefed at the end of the interview.

Interviews were conducted until saturation was reached. All interviews were conducted in English, digitally recorded and transcribed verbatim. Interviewed lasted between 21.55-55.54 minutes.

Ethical approval for this study was granted by the [Ethics Committee - REMOVED FOR REVIEWING PURPOSES].

Analysis strategy

A realist philosophical position was adopted, allowing personal ideas, opinions and understandings to be theorized in a relatively straightforward way and suited to exploratory research [17] such as the present study. Within this position, researchers analyzed transcripts using an inductive (bottom-up) thematic analysis approach following Braun and Clarke's [17] guidelines. After becoming highly familiar with the text and creating initial codes, themes were searched from collating codes by the researchers, which upon review of initial themes, final names of the themes and sub-

themes were developed. Data was extracted and analyzed at the explicit (semantic) or surface level, meaning researchers did not need to go beyond the raw data to theorize about underlying meaning [17]. An advantage of this is a reduction in the degree of inference necessary by the researcher, serving to produce low-inference descriptors and higher trustworthiness and credibility of the results [18] that more accurately reflects the data and participants' meaning, not the researcher's. Each researcher analyzed the data individually before collectively discussing their themes to ensure consistency of interpretation. Any differences between the researchers were discussed and agreed.

Results

Two main themes were developed. First, the pattern or phases of PMDD work experiences over the course of the menstrual cycle and the longer term. Women often referred to the difficult luteal phase when symptoms present as an "episode", and as found in previous studies, it is during this episode when reduced presenteeism and increased absenteeism occur. However, after symptoms subside with menses, women spoke about the episode repercussions involving feeling guilty and engaging in over-compensatory behaviors at work until the next episode. In the longer term, these patterns and phases resulted in many women leaving jobs (voluntarily and involuntarily) and careers. The second theme reflects the role of the organization and what women felt should be done to help manage their symptoms whilst at work, which was mainly increasing their awareness and support for their employees with PMDD. These themes are described in more detail below using quotes to illustrate the themes.

Phases of PMDD at work

The Episode Phase

During what women referred to as an “*episode*”, premenstrual symptoms were experienced in numerous ways within the work context. Participants described how their performance at work was affected because they could not concentrate, their memory was poorer, and they experienced increased levels of fatigue. They missed deadlines and were unable to perform their work as normal (i.e. decreased *presenteeism*).

Common experiences were negative thoughts, including significant self-doubting and ‘paranoid’ beliefs at work:

“The worst thing about PMDD and your working life is your self-doubt. The illness gives you lots of self-doubt and then you go to work and then you doubt yourself.”

Women often thought colleagues were talking about them and perceived them as being unable to do their job. Communications could often be misperceived as negative or a personal attack on them:

“Messaging someone is really dangerous because you never know how they are saying it and so when I am just in this emotional mental state I will take everything that they type out as just attacks on me or I take it really personally.”

Many women described having heightened anxiety, leading some to feel out of control and overwhelmed in work situations. Some participants described feeling

claustrophobic, and one woman even experienced panic attacks due to heightened sensitivity to the environment, which were very unpleasant and sometimes unbearable:

“Another one of my symptoms is heightened sensitivity to noise and light. So just being in the working environment I find very difficult.”

Women described feeling intolerant and impatient to minor occurrences. They have “*Jekyll and Hyde-like*” mood swings and their general low mood at work could often result in outbursts and feeling tearful:

“I have to really, really monitor my mouth because I get really, really grouchy. I am very, very irritable and I have a lot of mood swings. It doesn’t take much to really just tick me off during that week and I really have to keep everything under control and try to stay by myself...[...]...but if I have my hell week and I have [work-related assessments] coming at the same time then by the end of the day I am pretty much going to be in tears. It really does...it’s bad sometimes.”

The most frequently noted problem was an inability to interact socially. Women described how they could not comfortably be around other people and had to stay away because they would be overly sensitive and become annoyed very easily. One woman spoke frankly of this, “*I would sometimes snap at customers or snap at my employees*”. These women conveyed how they would ignore colleagues, customers, and sometimes shout inappropriately at people during this time, including their boss. Women knew and could anticipate when this difficulty was coming, as did

colleagues, and it caused conflict and tension at work. Women often felt unable to cope or perform normally, resulting in taking *absence* from work:

“Often the feeling of being overwhelmed with everything and I can’t cope with it and I can burst into tears, which lasts hours. In this job and my last job I have had to go home on several occasions because I can’t stop crying.”

Absence rates varied between 3-5 days per month for some, including taking time for health appointments relating to PMDD. Some women even contacted work before their episode to declare absence as they predicted not being able to perform or perceived it better for others if not there:

“When I knew that, you know, when I got up and my joints were aching and I was, you know, about to fight my dog hell before I even got out the door, I have absolutely taken a mental health day and said, ‘you know what, I’m going to take a vacation day and stay home today because it is not going to do anybody any good for me to leave the house today.’”

The Post-Episode Phase

After premenstrual symptoms subside, they were typically replaced with feelings of *guilt*. Participants described reflecting on their actions and regretting anything said or done that they felt was inappropriate or out of character. These feelings of guilt appear to push these women to *overcompensate* in their work when they are feeling well enough to do so:

“[on] my good days, I am extraordinary productive, like I go over the top, I feel like I need to overcompensate for my bad days cause I feel guilty, like I don’t want my bosses to think that I’ve given up you know?”

Many apologized to colleagues or managers. They started work earlier, left later, took on extra shifts or worked through lunch breaks to try and make up for their less productive time. These women want to show that it is not really ‘them’ during this time and they are capable employees. By working extremely hard, these women hope employers and colleagues will appreciate they have a problem and not simply an excuse not to work:

“If they need the night off, I have no problem; I will pick up extra work. I close the back of my work a lot, which means it just requires a lot more cleaning up. I stay later and they rely on me for that and with bartending cause they know that I am very thorough with my cleaning and I really put in the effort that I feel like because I do that, when I don’t do as good of a job they understand that it must be something really is going on because I’m normally such a hard worker.”

Turnover and career impact

Participants spoke of the accumulative effects of these cyclical PMDD patterns at work in the long term. Women talked about their inability to hold down a job because of having PMDD. Some women chose to leave their jobs (voluntary turnover) because they could not cope whilst others were asked to leave by their employers (involuntary turnover). One woman expressed her anger at being asked to

permanently leave work in her early twenties, *“It wasn’t right and they tried to put it down to depression and said ‘maybe you should take medical retirement’”*.

Consequently, many of these women felt their careers had been significantly impacted due to the effects of PMDD: *“I haven’t got a career because I couldn’t hold one down”*. Some women felt that certain jobs and career choices were unavailable to them because of the symptoms that present every month. Several women had given up on work or full-time work altogether, which in turn has had other psychological impact. One woman described that it had *“impacted on what I perceive as my ability to get back to work”*.

The Role of the Organization

Better Awareness

The most consistent problem raised for women was lack of organizational awareness about PMDD. Women felt that employers had no knowledge of PMDD or how to deal with it. Most of the women interviewed who chose to inform work about their PMDD described negative reactions. Some managers did not want to know about such hormonal issues and were unsympathetic to requests related to PMDD (e.g. time off for doctors appointments). Consequently, women felt angry and pressurized. One woman shared her manager’s responses, *“‘oh you have got such a lot of hospital appointments and how long is this going to go on for?’ and I feel pressurized”*. Some received disciplinary action, and despite seeking help from their human resource departments, were unable to get the help they needed. This contributed to several women giving up their jobs and careers.

Other women had very positive experiences when confiding in colleagues and managers. After informing others about PMDD, some managers asked for more

information about the condition and to have meetings about what can be done to help. Informing colleagues also seemed to help as these women felt it enabled others to understand them and work around their difficult times:

“Most women I’m sure would never feel comfortable letting their workplace know this...[...]... But I told my boss, all my bosses and all of my co-workers know, and it’s actually helped cause I can come in and I will say ‘I’m in my bad time, I apologise, I’m gonna work my hardest to not affect, make this affect you’ and everyone has been truly understanding...[...]... Yeah, I feel lucky for that but I wish every woman had that opportunity in their workplace”

That being said, women who were open were still wary about saying too much as they did not want to be judged, seen as unprofessional or wanting special treatment. Several participants had even decided not to disclose their condition to their employer or anyone at work. Fear of stigmatisation was one reason for this, as well as generally finding it difficult to explain to others about this personal condition and admit that they will have re-occurring problems at work due to mental ill-health.

Better Support

Participants highlighted the importance of having support and legal protection when speaking about their PMDD and employment. Women felt that treating PMDD as a disability and receiving similar support mechanisms (such as flexible working, allowing working from home) could help those trying to work with PMDD:

“I honestly think it could be something like, almost in the same way you would with a disability. So I would manage somebody who has an illness that would cover them under the Disability Discrimination Act, and I think if you could apply those same principles to something like PMDD, so that you make reasonable allowance for somebody that you know you’ve made adaptations when required and you support them with appointments and stuff like that, then that will find the balance.”

Importantly, women reported that they would benefit from having someone at work they could speak to about PMDD. Someone who understands appropriate health and legal policies to assist where necessary was advocated. Some women thought including menstrual problems on medical occupational health questionnaires would be helpful as it would provide an avenue for women who suffer from PMDD to be open and honest, as well as showing that employers are aware of PMDD and willing to offer help and support.

Discussion

This study explored the experiences of PMDD in the work context. Consistent with previous research, [11-15] marked reductions in performance were experienced during premenstrual “episode” phases, resulting in reduced presenteeism and higher engagement of absenteeism. The main contributing symptoms included difficulty in concentrating, self-doubt, paranoia, feeling fatigue, outbursts, teary, having heightened sensitivity to the environment and finding social interaction particularly difficult, which for some were too overwhelming. However, the study also suggested that the impact of PMDD might extend beyond the premenstrual phase. Women

developed feelings of guilt and once symptoms have passed and would attempt to compensate for their behavior by working longer hours, taking work home or extra work. In the longer term, women discussed the accumulative effects of these symptoms and patterns, which included many women choosing to leave their jobs or being asked to by their employer (i.e. turnover). Women noted that their confidence levels and perceived ability to work are impacted by PMDD and consequently, some considered give up on careers altogether (depicted in figure 1).

(INSERT FIGURE 1 HERE)

Previous research [19] exploring management strategies for premenstrual distress in women with PMS revealed some parallels with the present study. For example, coping through ‘self-regulation’ of premenstrual distress was one strategy involving the avoidance of potential stress and conflict, and escaping relational demands and responsibilities so women could have time to care for themselves. By doing this, women were attempting to manage their environment to prevent or minimize triggers during their premenstrual phase. In the present study, similar actions were shown in the work context including avoiding people, taking time off work, or leaving their jobs to relieve the stress. Whilst these strategies have been found helpful in previous research [19], for women in the present study, avoidance in the work context appeared to be accompanied with negative self-perceptions (e.g. guilt, lowered confidence in their ability to work). These perceptions may play a role in the over-compensatory behaviors shown in the post-episode phase, for example, which may not always lead to positive results (discussed in more detail below).

Research exploring cognitive appraisals of premenstrual distress in women with PMS may provide further insight into the present study's findings. Ussher [20] explored perceptions and experiences of premenstrual anger and distress and found similar feelings of guilt and reactionary behaviors to those shown in the present study. Ussher proposed that these feelings and behaviors reflected a form of 'self-policing' and 'self-induced punishment' - the mechanism through which society conforms [21]. She suggested that women exhibit a 'rupture' in their self-silencing during their premenstrual phase, which is significant because a woman's role is seen as containing her feelings within, taking care of herself, and maintaining the important feminine role as the nurturer. A break in this during the premenstrual phase results in feelings of guilt and blame, perhaps not being a 'good' woman or demonstrating what they consider appropriate behavior. Increased self-surveillance following this premenstrual phase was also found by Ussher as women were unable to live up to the norms and expectations of their role. In the present study, women's feelings of guilt could stem from their perceptions of being "unreliable" or 'bad' because they should always be in control and reliable as a woman and or female employee. Although being a reliable and good employee is likely to be shared by most employees, regardless of gender, the reactions of these women to these ruptures from the ideal could provide some explanation as to the similar thoughts and behaviors found in our sample.

However, the over-compensatory behaviours themselves may play a role in symptom severity and these work outcomes. Attempts by women to try and cope with, or live through, their symptoms may highlight potentially damaging work patterns. When feeling better and more able to perform during the post-episode phase, women worked much more intensely than what is expected of them (e.g. working

longer hours, taking work home), suggesting they may be engaging in a poor work-life balance during this time. Poor work-life balance has been shown to contribute to poor mental health and work outcomes [22]. Such high effort levels and working hours are unsustainable in the long-term and evidence shows high work demands are related to increased stress [23] that if not managed properly can lead to health impairment [24]. An individual's resources will deplete during this high-intensity working, and may potentially leave these women more susceptible to premenstrual distress. With every successive menstrual cycle, resources may further deplete leading to greater difficulty in managing symptoms resulting in withdrawal and continuing to engage in disruptive behaviours and actions. It is possible that such behaviours and coping strategies, although potentially helpful in the short-term, in the longer-term may be a contributing factor to the turnover and career impact shown here. More research examining this proposition is needed. For example, future research exploring work-life balance and work demands on premenstrual symptom severity and work outcomes could be useful. In particular, longitudinal research that follow these women over time and examines the possible relationships between these factors would be advantageous.

The need for more organizational awareness and support for employees with PMDD was also identified. Participants felt awareness and support for their PMDD was lacking in workplaces and this appeared to influence the amount of disclosure to employers as fear of negative reactions, perceptions, or stigma associated with mental ill-health were anticipated. As with other chronic diseases, management and facilitation play an important role that can often include having reasonable adjustments at work to facilitate employees who may be living with conditions that might make work difficult at times without this understanding and flexibility. For

women with PMDD, it seems that at certain times in their menstrual cycle, this greater flexibility, understanding and support by employers would be beneficial. Perceived organizational support (POS) is a key environmental work factor for employee well-being, performance and turnover [25]. Previous research suggests work environmental stressors, such as job stress, may contribute to premenstrual symptom severity [26] and women with PMS experience higher stress levels when premenstrual [27]. For women with PMDD, unsupportive work environments may place them under greater stress, augmenting symptom distress, and in turn, contribute to the negative behaviors and consequences observed. Several suggestions were made to address this, such as allowing flexible working, working from home, including menstrual problems on occupational health questionnaires, and having a contact person in the organization to talk to about PMDD-related issues. Many women advocated allowing similar allowances and legal protection to other debilitating conditions. From this, future research examining the role of the working environment, POS and awareness of PMDD within organisations is recommended.

Another strategy used by women with PMS to cope with premenstrual distress was through an 'inter-subjective experience' involving getting support from others, such as family members, friends and colleagues [19]. In the present study, some women sought support at work from managers and colleagues, which although was received by some, unfortunately, for the majority was either negative or absent. Some participants did not believe disclosure to their employer as an option because of the perceived lack of awareness and support for PMDD, and the potential to be stigmatized about their condition. It has been known for some time that women often do not seek help for their premenstrual problems [28,29]. However, given that women in the present study suggest greater awareness and support is needed within

organisations, women with PMDD (or premenstrual problems) may be more inclined to disclose their difficulties and seek help and support if they felt more awareness and support was present within their employing organization.

In general, the findings of the present study may support the view that rather than being a passive ‘victim’ of the condition that cannot be changed, the ways in which women with PMDD perceive themselves, their role, and how they react could be influencing their experience of premenstrual distress at work. This perspective is in keeping with the material-discursive-intrapsychic model [30], which attempted to understand the interrelationship between premenstrual symptoms, perceptions, and behaviours of women with PMS. The multifactorial model suggests some women may have a biological augmented sensitivity and vulnerability during the premenstrual phase (the ‘material’), that is only experienced as ‘PMS’ and problematic if life stressors and other environmental factors (for example, work stress) are coupled with the culturally constructed view of PMS and femininity involving self-sacrifice, self-degeneration, and the need for women to suppress desires and independence (the ‘discursive’), together with unhealthy perceptions and attributions for symptoms (namely, women blaming themselves, feeling guilt, depression, shame) (the ‘intrapsychic’ factors). Although the model was generated to explain PMS, it may help explain and understand the present study’s findings, including the role of the organisation. Future research testing this model within PMDD could be worthwhile.

Several limitations of this study should also be acknowledged. Firstly, whilst small sample sizes are appropriate for conducting in-depth qualitative research, it is possible the sample here does not reflect experiences of all women with PMDD. Recruitment was via online advertisements in English meaning only women using

these select sites that could understand and speak English were able to take part. Women were also required to have already received a diagnosis of PMDD from a health professional. It is possible that participants may not have had PMDD or been mistaken in their diagnosis. Ideally, research would confirm PMDD through prospective daily ratings for two consecutive months but, unfortunately, it was not feasible for this study. The study also required participants to retrospectively talk about their work experiences, which may have been subject to memory distortions or errors. However, large degrees of consistency were found across interviews providing some confidence in the results and their generalizability. Research addressing these limitations is needed including longitudinal research on large samples from different cultures, for example.

Overall, this is the first study, to the authors' knowledge, to explore and present evidence of the experiences of women with PMDD in the work context, and how they feel organizations may help them and other with PMDD. The findings suggest several phases that women with PMDD may be experiencing, each appearing to encompass certain feelings and behaviors associated with particular times in their menstrual cycle. These phases occur cyclically and over time, the accumulation of these experiences may result in negative outcomes such as leaving or losing their jobs and harmful career impact. Increased awareness and support for female staff with PMDD was regarded as necessary by organizations and should be similar to those of other debilitating conditions. These findings and interpretations have potentially significant implications and guidance for employers, policy makers, health professionals, researchers and other key stakeholders. Hopefully this study will stimulate further discussion, research, and positive action on this area rather than controversy, stigmatization, or continued ambivalence.

Declaration of Interest

The authors report no conflicts of interest.

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Tables

Table 1

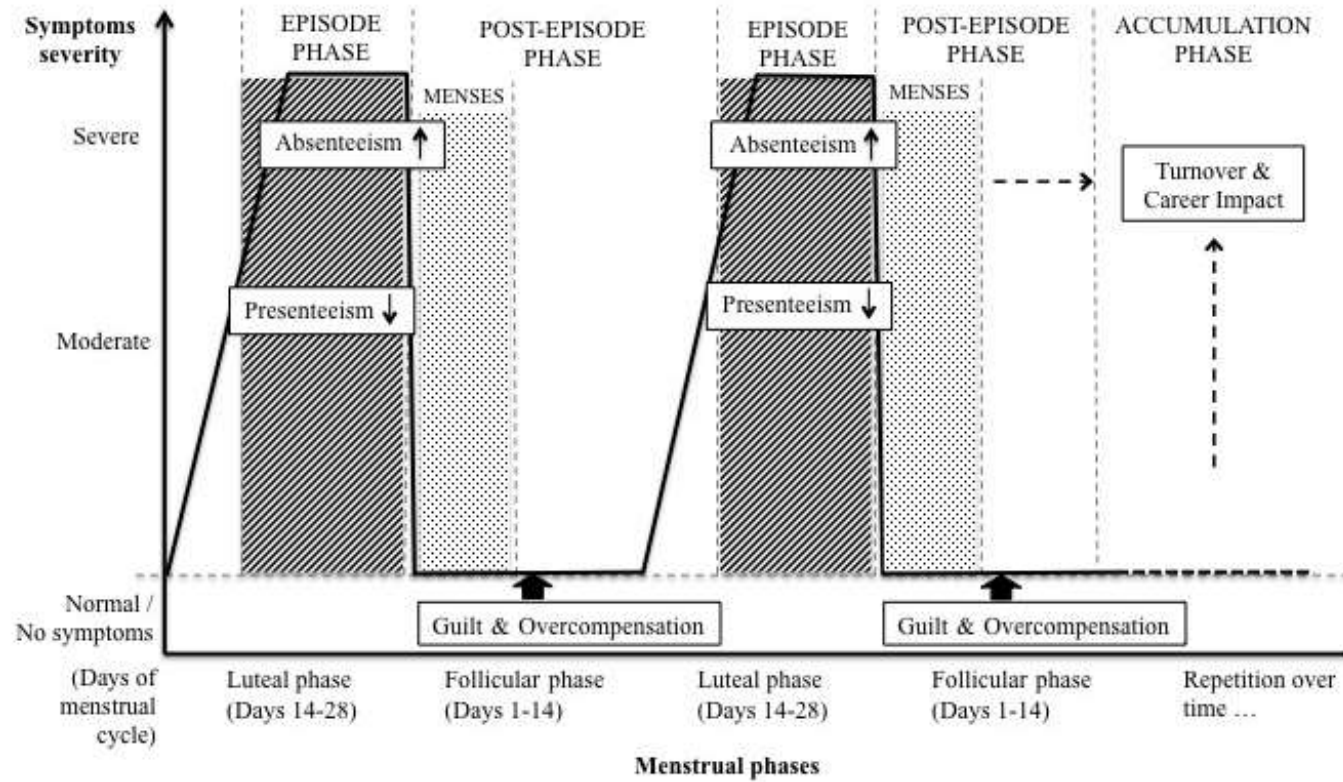
Participant Characteristics ($N = 15$)

	<i>n</i> (%)
Age (yrs)	
20-29	4 (27)
30-39	8 (53)
40-49	3 (20)
Nationality	
American	6 (40)
British	8 (53)
Australian	1 (7)
Did not disclose	2 (13)
Employment status	
Full-time	8 (53)
Part-time due to PMDD	5 (33)
Unemployed due to PMDD	2 (13)
Employment sector	
Health and Social Care	3 (20)
Hospitality, Tourism and Sport	2 (13)
Retail and Sales	1 (7)
Charity	1 (7)
Accountancy, Banking and Finance	2 (13)
Creative Arts and Culture	1 (7)
Teaching and Education	1 (7)

Transport and Logistics	1 (7)
Did not disclose	3 (20)
Receiving treatment	
Yes	12 (80)
No	2 (13)
Did not disclose	1 (7)
Treatment	
Medication (e.g. SSRIs)	6 (40)
Medication and other	1 (7)
Medication and therapy	1 (7)
Medication, therapy and other	4 (27)
Surgery (Hysterectomy, oophorectomy)	2 (13)
Other	5 (33)
Diet	4 (27)
Exercise	1 (7)
Light therapy	1 (7)
Holistic therapies	1 (7)

Figures

Figure 1. Phases of PMDD and work outcomes



Current knowledge on the subject:

- Premenstrual dysphoric disorder (PMDD) is a severe form of PMS that significantly impairs the lives of between 5-8% of women.
- The working lives of women with PMDD are significantly affected with higher rates of absenteeism and lower productivity compared to women with no or mild premenstrual symptoms.

What this study adds:

- The working lives of women with PMDD are not only affected during the luteal phase.
- During the “episode” phase, main symptoms influencing presenteeism and absenteeism include from poor concentration, self-doubt, paranoia, feeling fatigue, outbursts, teary, having heightened sensitivity to the environment, finding social interaction particularly difficult.
- Post-episode phases involve feelings of guilt and over-compensatory behaviors such as working longer hours, taking work home, which may be affecting work-life balance and depleting the women’s resources.
- Women alternate between symptomatic episodes and post-episode phases, resulting in higher turnover rates (voluntary and involuntary) and career impact in the long term.
- Organizational awareness of PMDD and support mechanisms similar to those for other debilitating conditions are largely absent but advocated to help.