

Premenstrual dysphoric disorder and its psychological affectation in the workplace

Trastorno disfórico premenstrual y su afectación psicológica en el ámbito laboral

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Abstract:

Premenstrual dysphoric disorder (PMDD) is a mental disorder that is rare or studied because it becomes disabling for the woman who presents it in various areas of her life. At present, psychotherapeutic treatment is an essential part along with the pharmacological one and can be carried out intermittently during the menstrual period.

This article aims to report some factors suffered by women with PMDD within their work performance, which must generate emotional, physical, and social strategies so that each menstrual cycle can cope with the various consequences of this condition. The findings made it possible to identify complications in women in physical conditions such as extreme pain, tachycardia, dizziness, nausea, vomiting, decrease in blood pressure, decrease or loss of appetite, sleep disorders, lack of libido, and fatigue, among others. Moreover, on an emotional level, it can present irritability, crying, social withdrawal, guilt and worthlessness, anxiety, depression, suicidal ideation or intention, stress, or Burnout Syndrome.

Keywords:

Menstrual dysphoric disorder, work, stress.

Resumen:

El trastorno disfórico premenstrual (TDPM) es un trastorno mental el cual es poco frecuente o estudiado debido a que vuelve incapacitante para la mujer que lo presenta en diversas áreas de su vida. En la actualidad el tratamiento psicoterapéutico forma parte esencial junto con el farmacológico y se puede llevar de forma intermitente durante el periodo menstrual.

En el presente artículo se pretende informar algunos factores que padecen las mujeres con TDPM dentro de su desempeño laboral las cuales deben generar estrategias emocionales, físicas y sociales para que cada ciclo menstrual pueda sobrellevar las diversas consecuencias que les genera esta condición. Los hallazgos permitieron identificar complicaciones en la mujer en condiciones a nivel físico como dolor extremo, taquicardia, mareo, náuseas, vomito, disminución en la presión sanguínea, disminución o pérdida del apetito, trastornos del sueño, falta de libido, fatiga, entre otros. Y a nivel emocional puede presentar irritabilidad, llanto, retraimiento social, sentimientos de culpa e inutilidad, ansiedad, depresión, ideación o intención suicida, estrés o Síndrome de Burnout.

Palabras Clave:

Trastorno disfórico menstrual, trabajo, estrés.

INTRODUCTION

Menstruation is a periodic desquamation in women with cyclical hormonal changes that have variations such as weight, appetite, libido, and body temperature. In general, the symptoms occur in 80% of the reproductive age of their premenstrual period. Premenstrual symptoms range from somatic symptoms, breast tension, abdominal distension, mild fluid retention, constipation or diarrhea, headache, or psychological symptoms. According to Zanin et al. (2011), the classic menstrual cycle in women lasts

28 days in 40%, and long and irregular cycles appear in 60% of the world population. According to Zerpa (2005), premenstrual syndrome and other menstrual disorders are alterations of the normal menstrual cycle, and in most cases, they present from adolescence as part of reproductive development. However, it is essential to rule out the presence of disorders. Organic, obtaining as a benefit the start of a suitable start treatment. According to Campagne (2013), a psychometric instrument does not give a diagnosis; it must cover various factors since some authors do

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not distinguish between the appearance of typical symptoms, those of premenstrual syndrome, or premenstrual dysphoric disorder.

According to the DSM-5 (cited in Quiñones, 2021), premenstrual dysphoric disorder consists of the expression of symptoms such as anxiety, irritability, and dysphoria that occur suddenly in the menstrual phase of their cycle, which remit at the beginning of menstruation or shortly after. After.

In the Journal of Gynecological Endocrinology, according to Stute (2017, as cited in Añazco 2021), in the first consultation for the onset of the premenstrual dysphoric disorder, aspects such as menstrual history should be covered: frequency, duration, heaviness, pain, regularity, amenorrhea, last period, pregnancy, history of premenstrual syndrome, age of onset, time, severity, absence of after menstruation, the symptom-free interval during the follicular period, deterioration, interference with work, education, social and family settings, range of less than 3-5 days; underlying medical problems worsening before the onset of menstruation, tolerance to previous or ongoing hormonal treatment, willingness to use contraception, and inquiry for suicidal thoughts.

The Premenstrual dysphoric disorder is shown with characteristics of a clinical condition which, at an emotional level, is accompanied by crying, loss of appetite, lack of libido, fatigue, sleep disorders, irritability, social withdrawal, feelings of guilt and worthlessness, thoughts of death in extreme cases (Monroy, 2021).

PMDD has a 3% to 8% prevalence in women of reproductive age, which considers profound alterations or consequences in daily activities such as work, self-care, personal relationships, or sentimental relationships. As for the quality of life, it is at the same level of affectation as a depressive or bipolar disorder (Quilez, 2019). According to Vega (2019), the main problem for women with PMDD is that the pathology is already established, so when diagnosed, it must meet the criteria for effective intervention, how to provide consistent information from the physical and mental health service, updated and local, where the significant repercussions of the condition are manifested, such as quality of life, problems in some mental sphere, depression, academic performance, somatosensory amplification, and work absenteeism.

In an experimental study, according to Quilez (2016), where a control group and a group with premenstrual dysphoric disorder were presented, the result was that women diagnosed with PMDD had a lower percentage of work activity and even had temporary sick leave. The control group indicated that some women had no diagnosis or the presence of other conditions, such as premenstrual syndrome, which in some regions is still considered normal.

In terms of maternity, high protection is maintained before the constitution and law. However, it is essential to change the perspective that reflects other aspects that affect the health of working women in terms of preventive health policies (Ramírez, 2019).

Given the preceding and considering that premenstrual dysphoric disorder is a manifestation of symptoms before and during the menstrual period, mainly psychic such as depression and anxiety, among others, of severity in which the woman does not carry out her activities usually during several days, therein lies the importance of reviewing this condition, which although it is something that generates an impact on the events of women's lives, the symptoms, diagnosis, and consequences are still unknown to maintain adequate treatment and in turn quality of life.

METHOD

The search for information in this article was based on the review of various databases corresponding to Web platforms responsible for collecting research, articles, postgraduate completion papers, dissertations, and theses of a scientific nature where they are used, reviewed, and referenced to inform the educational and general population.

Some platforms used were Google Scholar, Dialnet, Redalyc, Latindex, and SciELO Mexico. In which the keywords of premenstrual dysphoric disorder, stress, and cognitive behavioral techniques were used as reference filters.

Regarding inclusion criteria, the population was based on information from the female sex. However, regarding the use and application of techniques, they can be used for both sexes. The review in terms of time was mainly based on 2017 onwards, but the theoretical foundation of previous years was used when finding insufficient content. The analysis of results had a theoretical and descriptive method.

RESULTS

Premenstrual Dysphoric Disorder (PMDD) is the pathological exacerbation of the somatic and psychic changes that occur during the normal female cycle's luteal phase, producing physical and mental disability and problems in family, work, and social relationships. This last condition is essential to consider it a disease. The most appropriate definition of the syndrome according to Gaviria (1999, as cited in Márquez, 2012, pp. 42), who states this disorder is "...a set of emotional, behavioral and somatic symptoms that appear at the end of the phase luteal disease and that are resolved with menstruation." Historically, the changes during the menstrual cycle's luteal or progesterational phase have been controversial according to the different sociocultural contexts. Although it seems like a pathology of recent medical connotation, the first descriptions of luteal phase dysphoric disorder were made by Hippocrates. 70% of the world population suffers from it, according to the World Association of Gynecology and Obstetrics (2012).

Psychological effects of premenstrual dysphoric disorder
Stress

The World Health Organization (2004, cited in Lorenzo, 2019) defines stress as "the set of physiological reactions that prepares the body for action." Dr. Cano, president of the Spanish Society of Anxiety and Stress (2006 cited in Lorenzo, 2019), defines stress as a process that begins before a set of demands from the environment in which the person must answer according to her resources. When the demand is excessive, the individual will generate adaptive reactions that imply a physiological activation, such as anxiety, stress, anger, and depression.

Stress refers to Ramírez (2019) as a condition that covers the physical, emotional, social, and moral part of the person, whose origins or consequences are of a structural type, mainly referring to social relationships and the individual. Seen as a process, stress will vary in the life of the human being since each person considers whether or not some adverse circumstance is a stressor, which will have as a characteristic in both the high probability of becoming ill and the resources that will be put into practice to master, tolerate or reduce discomfort.

The impact of the symptoms due to the high discomfort associated with women in their daily occupations, family, or social environment decreases their physical, cognitive, and emotional well-being. A considerable percentage of women experience lifestyle changes, including food, sexual life, and sleep, among others (López-Mato, 2000).

Burnout syndrome and its relationship with premenstrual dysphoric disorder

Burnout syndrome is a psychological and emotional affectation with high discomfort and absenteeism. Currently, there is only one universal decision. However, in a consensus, we can consider it, according to Ávila (2010), as a response to chronic work stress with negative consequences in aspects such as the individual or organizational, in which individuals or people maintain a limited ability to generate coping strategies that generate greater functioning.

Burnout is a subjective negative experience because it depends on each human being in terms of sensations, feelings, emotions, and cognitions, generating behavioral and physiological reactions that are harmful to health or work performance. A more up-to-date definition is a proposal by Maslach et al. (as cited in Ávila, 2010), who consider it a syndrome with an extended response mode due to chronic stressors that affect various areas of the person's life, especially in a personal and work level, which characterize some dimensions of chronic stress such as physical and emotional exhaustion, a feeling of depersonalization that can be conceived as a feeling of distortion that causes distancing and low professional achievement. Some risk factors for Burnout syndrome among women may be the order of the family structure; that is, people with children are more vulnerable to Burnout due to the family's involvement; sometimes, it may be used as an enhancer to deal with emotional problems and conflicts. Manzano (as cited in Martínez, 2010) argues that the greater the number of children, the higher the stress level derived from the various responsibilities involved.

Regarding gender, women are more vulnerable to professional burnout; variables complicate this due to distorting factors, for example, women with low-decision jobs, family demands, education, and economic income. It can also include the level of involvement in the tasks, which causes even greater professional burnout, limited coping skills, affect imbalance, the type of work, and personality, which influence responses and consequences.

Some psychological variables related to Burnout Syndrome are self-esteem and self-efficacy, the last one defined by Bandura in 1977 (cited in Darrigrande & Duran, 2012) as beliefs about one's abilities to organize and execute training courses. Action to produce achievement. It has been shown that efficacy can influence the development of Burnout Syndrome levels directly and indirectly. Burnout syndrome can be increased as a consequence or cause of the premenstrual dysphoric disorder, according to Juárez et al. (2014), mainly in the following aspects: it maintains a predominance of dysphoric symptoms such as emotional exhaustion, it maintains a greater alteration in mental and behavioral symptoms than in the physical ones, the condition shows a more significant alteration in the workplace and its occupation, the symptoms are They are presented in "normal" individuals who do not present any pathology or psychosocial alteration and a marked decrease in the effectiveness of work performance produced by negative attitudes or behaviors affecting their performance and productivity.

Within the labor context, Darrigrande and Duran (2012) consider it extremely important to identify preventive factors for Burnout Syndrome and its relationship with PMDD: communication should be encouraged, isolation avoided, solidarity and support maintained among peers, especially in stressful situations. Foster expectations based on reality since it will avoid high frustration levels if the need is not met due to some environmental circumstance, considering that it is essential to meet personal goals. Carry out a routine of physical exercises, such as aerobic activities and walks, which will stimulate or benefit the body in the face of PMDD conditions and promote the release of endorphins and mental health. Promote the recognition and expression of emotions to identify stressful situations that invade or impair the ability to face stressors and encourage a harmonious work environment and teamwork, which distributes teamwork equitably and fosters community at work.

Symptom management for the premenstrual dysphoric disorder is a great challenge because it is based on pharmacological and lifestyle strategies, which García (2010) divides into four: Physical activity: This modifies endorphin levels, which are responsible for mood and physical symptoms in people. Diet: diet reduced in sugars, salt, alcohol, caffeine, and carbohydrates. Calcium and magnesium supplements maintain verifiable and favorable clinical effects of a reduction in water retention and improvement in behavioral changes of PDD. Psychotherapy: The cognitive-behavioral approach within psychotherapy has shown more significant results in this type of patient than in

impulse control. Non-pharmacological treatment will give the same importance as pharmacological since it will be in the daily care and management of the person with PDD, which should promote quality of life and decision-making that generate well-being.

Treatment and use of cognitive behavioral techniques in premenstrual dysphoric disorder

The cognitive behavioral approach can be used for premenstrual dysphoric disorder; various strategies can be applied as a preventive method and during crises so that the person with PMDD can generate strategies or emotional tools that lead to the effectiveness of obtaining solving problems or psychological difficulties that arise in different areas of their lives, especially personal, family and work, as well as increasing their assertiveness in decision-making during these periods and social harmony and quality of life. The essential characteristics of a therapeutic intervention consist of identifying relevant objectives of change, operationalizing them, measuring their magnitude (intensity, frequency, duration), and establishing the parameters related to time and procedures (Trujillo, 2017).

Training in impulse control and emotional self-control

Self-control refers to establishing impulses and reactions appropriately. Genise (2014) defines it as the ability to regulate impulses involuntarily and will aim at personal balance, increase problem-solving ability, manage emotions, and regulate behavior. In women with PMDD, the following techniques can be taken into account to improve emotional self-control:

- Training and regulation in managing emotions: controlling emotions is not the division of negative or positive emotions. Instead, it is the knowledge, use, and control over them.
- Progressive relaxation: reduces pulse tension and blood pressure, as well as decreases perspiration and respiratory rate. Using this technique correctly has the same effect as a drug to reduce anxiety.
- Breathing: breathing exercises reduce anxiety, depression, irritability, anger, self-control, fatigue, and muscle tension.
- Meditation: causes states of deep relaxation in a short time.
- Imagination: uses thought for the treatment of physical symptoms and self-control. The thought that we are incapable will make the problem more difficult and block the possibility of seeking resources to face the difficulties.
- Autogenic training: systematized program of the body and mind, effective and fast to the verbal ordering of relaxation to return to balance or a state of normality.
- Detection of thought and rejection of irrational ideas typical of cognitive behavioral therapy.
- Coping techniques are intended to relax, reduce anxiety and stress, and provide a greater capacity for

self-control in situations or experiences that generate tension.

- Assertive training: designed to acquire assertiveness, it is also usually effective in reducing anxiety derived from pain, interpersonal relationships, partner relationships, or family problems.

Psychoeducation

Cummings (2008, as cited in Vidales & Velasco, 2016) describes psychoeducation as the fusion of behavioral counseling with health psychology and the psychotherapy process. Psychotherapy is applied to a group or individually with the same diagnosis or condition, it can be structured or open, and this will depend on the needs of each patient. The psychoeducation program should incorporate the following elements: diagnosis treatment, management of the condition, compliance with the medical-psychological regimen, and prevention against progression or relapse. Patients must suffer or experience similar conditions or symptoms to generate empathy and solidarity among them and thus facilitate group and individual management of the condition or problem.

The psychoeducational programs will be carried out in a time limit that will contemplate the number of sessions that oscillate between 5 and 24 sessions and the space for the number of women from 4 to 12. A marked advantage of the group psychoeducation process is the low cost which does not affect the high effectiveness compared to individual psychotherapy (Cummings 2008, cited in Vidales & Velasco, 2016).

Control in self-injurious behaviors in extreme cases

From the perspective of Ayala and Riveros (2021), PMDD produces severe psychological effects such as anxiety disorders, anguish, depression, stress, guilt, desolation, substance abuse such as alcohol, depersonalization, adaptation problems, deterioration of self-esteem, coping problems, loss of contact with his family, power, autonomy, and confidence. The use of self-injurious behaviors may cause suicidal ideation or intent. The most used techniques within therapeutic interventions are for cases of dysfunctional self-injurious behaviors; the objective will be to achieve and avoid what they do not want, as in the case of replacing dysfunctional behaviors with a more appropriate one, with which you want to eradicate the behavior, framing self-stimulation in a stipulated time and space, working with anticipation of stressful situations for the woman, preventing altering or triggering this type of behavior.

Identification of automatic thoughts and dysfunctional beliefs (A-B-C Ellis)

Dysfunctional emotions and beliefs have cognitive functioning in women who suffer from PMDD. Therefore, identifying dysfunctional thoughts and attitudes is an adequate method or strategy to implement. Automatic thoughts refer to superficial cognitions; these regularly appear in consciousness, are accessible, and sometimes constitute a habit for the person. The

automatic thought often occurs without awareness, so the woman needed support locating the thought through written records, specifically when the thought is related to disturbed moods. Many women think that the event is related to feelings of discomfort. This thought will be external since it comes from social relationships, interactions, or internal, related to the disease or discomfort like all the symptoms you present during PMDD. Ellis's A-B-C model (1962,1979, as cited in Caballo, 2001) applies to these situations, where A= activating event, B= beliefs, and C= consequences of emotional reactions. Automatic thoughts are made up of memories, perceptions, and affections that are related to the self-image or self. The change consists of identifying and separating helpful thoughts and exchanging them for irrational or demotivating ones that generate a negative mood or discomfort.

Martha Davis Diaphragmatic Breathing

The lung capacity used is only one capacity; the upper part of the lungs is most often used. According to Davis et al. (2010), this diaphragmatic breathing technique will achieve adequate oxygenation preventing the person from hyperventilating due to a crisis of pain, anxiety, or stress. As the first objective of the technique is to direct the air to the lower part of the lungs, lying down and opting for a straight posture, we will place one hand on the belly and the other on the chest. The air is maintained for 5 seconds, and we exhale. As a second objective, the air will move to the middle of the lungs and finally to the upper part, raising the chest and tucking the abdomen towards the center. Hold your breath for a few seconds and exhale. The practice of this technique is two times a day for 10 minutes; when there is perseverance, the technique can be done standing or walking, the above expanding the therapeutic possibilities of this technique.

DISCUSSION AND CONCLUSIONS

Through the theoretical review that has been carried out in the article, it is intended to describe the psychological affectation of premenstrual dysphoric disorder (PMDD), maintaining an emphasis on the emotional scope of the women who present it, in addition to the impact on their work area, It also contains a brief description of techniques with a cognitive behavioral approach which can be used to carry out in patients with PMDD, due to the results that the techniques and strategies shown in patients with various disorders. There is a lack regarding the relationship of its application. However, the reviewed and argued foster an open the door to learning and praxis of the relationship with the approach. This article can be a contribution and theoretical-empirical evidence of this continuation of the proposal because although there are few, other articles prove it. Supporting that the cognitive-behavioral approach is effective in psychotherapeutic and psychological treatment since it has scientific support, it is aimed at resolving current situations; it maintains training for daily life, it optimizes problem-solving, there are no side effects, it is it adapts to different psychological

and psychiatric needs and disorders, decreases dysfunctional thinking and increases self-control and relaxation techniques for dysfunctions (Puerta & Padilla, 2018).

It is also possible to appreciate the degree of emotional affectation that one has within the premenstrual dysphoric disorder, which can generate difficulties in the workplace, coming from factors such as stress and extreme cases of Burnout syndrome, the complication lies in coping with the degree of pain and irrationality of thought, with the work activities that must be carried out in women who suffer from it.

At present, the empirical and research evidence remains limited since there is a more significant number of information on the presence of premenstrual syndrome, which differs and is not the same as PMDD due to the degree of affectation in the person's life, assertiveness, self-efficacy, decision-making, ability to solve problems in daily life and the diversity of areas where problems develop in women: work, education, personal, family, couple, among others. PMDD, being a presence of a more complex condition, has yet to be studied.

Another limitation is the misinformation and lack of psychoeducation in the field of sexuality since the acceptance of pain in the menstrual cycle process is still considered taboo or a "normal" condition. Given this excessive tolerance, some patients lack information on the premenstrual dysphoric disorder, how the diagnosis is created, what health professional generates it, the multidisciplinary treatment in which it has to be attended, and the coping techniques for the symptoms.

Multidisciplinary treatment is the most effective for patients with premenstrual dysphoric disorder; medicine, psychology, nutrition, and psychiatry are essential for greater effectiveness.

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