Elite Learning Podcast

Hormones and Mental Health: Menstrual Tracking Insights

Colibri Healthcare

Hormonal fluctuations affect mental health in ways that are still widely misunderstood and underdiagnosed. This episode unpacks the science, the clinical tools, and what better-informed care looks like.

Listen time: ~60 minutes • Audience: RNs, APRNs, NPs, mental health providers, primary care clinicians • Listen now: elitelearning.com/ce-podcasts

Featured Voices

Host: Dr. Candace Pierce, DNP, RN, CNE, COI
Faculty with Elite Learning by Colibri Healthcare, nurse educator, and advocate for women's health and clinical education.

Guest: Dr. Erica Ramey
Mental health clinician, educator, and specialist in reproductive psychiatry and hormone-related mood disorders.

What You'll Learn

- The four phases of the menstrual cycle and their mental health-relevant hormonal effects
- How estrogen, progesterone, allopregnanolone, serotonin, and GABA interact to influence mood
- Why some people experience dramatic cycle-driven mood changes while others do not
- The clinical distinctions between PMS, PMDD, and premenstrual exacerbation (PME)
- How to use prospective menstrual tracking as a diagnostic tool
- Pharmacological and non-pharmacological treatment strategies for PMDD
- How medical gaslighting and training gaps contribute to a 20-year diagnostic delay

Key Takeaways

- The menstrual cycle is data, not drama. When tracked and interpreted correctly, it can shorten diagnostic windows and redirect treatment.
- PMDD affects an estimated 31 million women globally, yet most go undiagnosed for an average of 20 years after symptoms begin.
- Hormone levels in PMDD are typically normal. The issue is neurobiological sensitivity to normal hormonal fluctuations, not abnormal levels.
- Bipolar 2, GAD, treatment-resistant depression, and ADHD are among the most commonly misattributed diagnoses that may actually be cycle-driven.
- To diagnose PMDD, at least two months of prospective daily symptom tracking is required. Recall alone is not sufficient.
- SSRIs work differently in PMDD than in depression. They can be effective within 1-2 days and used only during the luteal phase.
- Sleep is the foundation. If sleep is poor, nothing else gets better, regardless of diagnosis or treatment.
- Only about 40% of U.S. psychiatry residency directors consider reproductive psychiatry significant enough to include in training.
- Cycle tracking should be integrated into care for patients with mood disorders, ADHD, autoimmune conditions, and suicide risk.

The Menstrual Cycle at a Glance

Phase	Timing	Mental Health Relevance
Follicular	Days 1-13	Estrogen rises; serotonin and dopamine increase. Best mood, energy, focus, and cognitive performance.
Ovulation	Day 14	Brief estrogen peak; libido and mood peak for most. Some may experience a mood dip as estrogen drops sharply.
Luteal	Days 15-28	Progesterone rises then drops sharply. Last 7-10 days carry highest risk for PMS, PMDD, and PME symptoms.
Menstruation	Day 1 of period	Hormonal trigger passes; significant symptom relief for those with PMDD. Cycle resets toward follicular phase.

PMS vs. PMDD vs. PME: Getting the Diagnosis Right

	PMS	PMDD	PME
Definition	Common premenstrual symptoms without significant impairment	DSM-5 depressive disorder with severe premenstrual symptoms causing functional impairment	Worsening of an existing psychiatric condition in the premenstrual period
Impairment	Mild to moderate; does not significantly disrupt functioning	Significant impairment in relationships, work, school, or role functioning	Destabilization of an otherwise managed condition
Treatment	Lifestyle: exercise, calcium, sleep, stress reduction	SSRIs (luteal phase), hormonal therapy, CBT, lifestyle measures	Dose adjustment of existing medications during luteal phase; close monitoring

PMDD DSM-5 Diagnostic Criteria

To meet criteria, 5 or more of the following 11 symptoms must occur in the week before menstruation, remit within days of onset, and cause significant functional impairment. At least one must be a core affective symptom.

Core Affective Symptoms (at least one required):

- Affective lability (mood swings)
- Marked irritability or anger
- Depressed mood
- Significant anxiety or tension

Additional Symptoms:

- Difficulty concentrating
- Fatigue or low energy
- Changes in appetite (including cravings or overeating)
- Sleep changes (insomnia or hypersomnia)
- Feeling overwhelmed or out of control
- Physical symptoms: bloating, breast tenderness, water retention

Note: Symptoms must be tracked prospectively for at least 2 cycles to confirm diagnosis. The gold standard tool is the Daily Record of Severity of Problems (DRSP).

Menstrual Tracking as a Clinical Tool

- **Minimum ask:** First day of menstruation each cycle. This alone allows clinicians to plot symptoms against cycle timing.
- **Ideal tracking includes:** Cycle dates, mood symptoms (irritability, depression, anxiety, suicidal ideation), sleep changes, and degree of functional impairment.
- **Gold standard tool:** Daily Record of Severity of Problems (DRSP). Aligned with DSM-5 criteria. A 30% or greater increase in symptom severity in the luteal phase is clinically significant.
- **Apps to consider:** Clue, Ovia, Flo, or the built-in health app. Choose based on what the patient will actually use consistently. Always review app privacy policies before recommending.
- **Key clinical question:** Do symptoms follow a predictable cycle pattern? Do they remit after menstruation begins?

Populations Where Cycle Tracking Is Especially Important

- Women with treatment-resistant depression or bipolar 2 disorder
- Patients with ADHD (cycle phase significantly affects symptom severity and medication effectiveness)
- Women with autoimmune or inflammatory conditions
- Patients with a history of self-harm or suicidal ideation
- Women new to mental health care in their late 30s or early 40s (consider perimenopause)
- Anyone with a substance use history (late luteal phase increases self-medication risk)

Treatment Approaches

Pharmacological:

- SSRIs/SNRIs (luteal phase dosing): Effective within 1-2 days in PMDD due to GABA normalization, not serotonin upregulation. Can be taken only during the second half of the cycle.
- Continuous SSRI use: An option for patients who prefer consistent dosing or have comorbid mood disorders.
- Dose adjustment for PME: Temporarily increasing the dose of an existing medication during the luteal phase may reduce exacerbation.
- Hormonal contraceptives: Can suppress cycle-related fluctuations but may affect mood variably. Counsel patients individually.
- GnRH agonists: Reserved for severe, refractory PMDD. Suppress ovarian function entirely.

Non-Pharmacological:

- Sleep: The foundation of mental health. No treatment works well without adequate sleep.
- Exercise: Strongest non-pharmacological evidence base. Reduces symptoms via neurotransmitter activity and inflammation reduction.
- Calcium supplementation: ~1,000-1,200 mg/day has evidence for PMS and PMDD symptom reduction.
- Reduce alcohol: Especially in the luteal phase. Alcohol worsens mood dysregulation and does not produce the calming effect patients seek.
- CBT: Effective for managing cognitive and behavioral responses to cycle-related mood changes.
- Cycle-informed scheduling: Encourage patients to plan demanding tasks, social commitments, and difficult conversations in the follicular phase when possible.

⚠ Suicide Risk and Cycle-Informed Safety Planning

- Suicidal ideation and attempts are more likely in the late luteal phase (approximately 4 days before menstruation onset).
- If a cycle-related pattern is identified, schedule therapy appointments to align with the highest-risk week.
- Build safety plans proactively. Identify support contacts and give them a heads-up about the anticipated difficult week.
- For patients in substance use recovery, engage sponsors or support networks in advance of the luteal phase.
- Predictability is protective. If we can anticipate the risk, we can plan around it.

Medical Gaslighting and the 20-Year Diagnostic Gap

- "This is just part of being a woman." Normalizing severe symptoms delays diagnosis and treatment.
- Women are often told hormone levels are normal and therefore nothing is wrong. But PMDD is about sensitivity to normal hormonal changes, not abnormal levels.
- Symptoms beginning in adolescence are frequently dismissed or attributed to personality, stress, or anxiety.
- Siloed care (OB/GYN, psychiatry, primary care) means no one specialty takes ownership of the hormone-mood connection.
- Only ~40% of U.S. psychiatry residency directors consider reproductive psychiatry important enough to include in training.
- Closing the gap requires asking about cycles, validating symptoms, and integrating tracking into routine care across all specialties.

Do This Next

- Start asking patients about their menstrual cycle as part of every mental health intake, not just to rule out pregnancy.
- Introduce prospective cycle tracking at the first visit. Even just the first day of menstruation is a meaningful starting point.
- Familiarize yourself with the DRSP (Daily Record of Severity of Problems) and how to interpret it against DSM-5 PMDD criteria.
- Review your current patients with treatment-resistant depression, bipolar 2, or ADHD through a cycle-informed lens.
- Counsel patients on luteal-phase lifestyle adjustments: sleep, alcohol reduction, exercise, and realistic scheduling.

Clinical Terminology Toolkit

Follicular Phase: Days 1-13 of the cycle. Estrogen rises, supporting serotonin and dopamine activity. Associated with improved mood, energy, and cognition.

Luteal Phase: Days 15-28. Progesterone rises then drops sharply. The highest-risk window for PMS, PMDD, and PME symptoms.

Allopregnanolone: A metabolite of progesterone that normally produces a calming GABA effect. In PMDD, this response is paradoxical, causing anxiety and dysphoria instead.

DRSP: Daily Record of Severity of Problems. The gold standard prospective tracking tool, aligned with DSM-5 PMDD criteria.

PME: Premenstrual Exacerbation. A predictable worsening of an existing psychiatric condition during the premenstrual period.

Luteal-Phase Dosing: Prescribing SSRIs only during the second half of the cycle for PMDD. Effective within 1-2 days due to GABA normalization rather than serotonin upregulation.

Neurobiological Sensitivity: The mechanism underlying PMDD. Hormone levels are normal; the individual's brain responds more intensely to normal hormonal fluctuations.

Conversation Starter

"The next time a patient mentions mood changes that seem to come and go, ask them about their cycle. That one question might be what changes their quality of life."

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