NCLEX-RN · 2026 TEST PLAN · PSYCHOSOCIAL INTEGRITY

Premenstrual Dysphoric *Disorder*

A cyclical, hormonally-triggered depressive disorder (DSM-5-TR) marked by severe affective and somatic symptoms during the luteal phase that resolve with menses. Distinct from PMS by functional impairment, severity, and SSRI responsiveness.

Luteal phase onset | Mental Health · OB/Gyn overlap | SSRIs = First-line | High suicide risk window

SECTION 01

Definition & Overview

DSM-5-TR · Depressive Disorders

- **Cyclical depressive disorder** with severe mood and somatic symptoms in the **luteal phase** (≈1–2 weeks before menses) that resolve within a few days of menses onset and are minimal/absent post-menses.
- **PMDD vs PMS:** PMDD requires **marked functional impairment** in work, school, or relationships. PMS is bothersome; PMDD is **disabling**.
- Diagnosis requires **prospective daily symptom tracking for ≥2 cycles** — not retrospective recall.

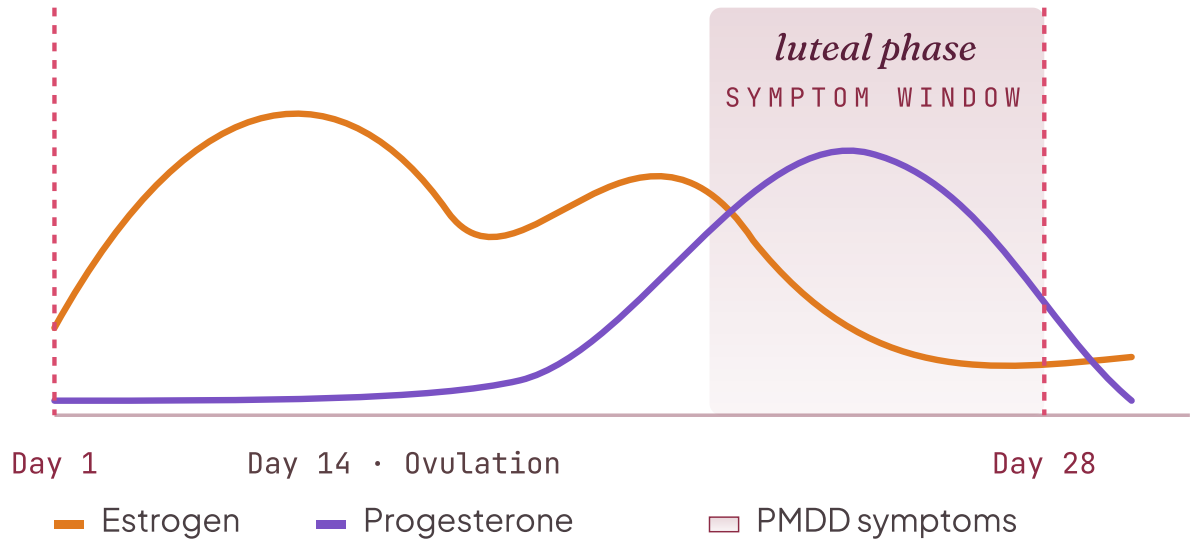
3–8% of menstruating individuals affected

≥5 symptoms required in final week before menses

2× higher lifetime suicide attempt risk vs general population

CYCLE MAP

When symptoms strike



Symptoms emerge after ovulation, **peak premenstrually**, and remit within a few days of menses — leaving a symptom-free follicular phase.

SECTION 02

Pathophysiology — Simplified

Abnormal CNS sensitivity, NOT abnormal hormones

1. Normal ovulation → physiologic rise in **progesterone** and its neuroactive metabolite **allopregnanolone (ALLO)**.
2. In PMDD, the brain has an **abnormal sensitivity to ALLO** at the `GABA-A` receptor → paradoxical anxiety/irritability instead of calming effect.
3. Concurrent **serotonin (5-HT) dysregulation** during the luteal phase → mood instability, irritability, cravings, depressed mood.
4. **Genetic predisposition** (variants in the ESC/E(Z) complex) modulates this hormone-brain sensitivity → familial pattern in PMDD.
5. Onset of menses → progesterone & ALLO drop → symptoms resolve within days → **follicular phase = symptom-free**.

NCLEX CLARIFIER: Hormone *levels* in PMDD are typically NORMAL. The disorder is one of abnormal central nervous system **response** to normal hormonal fluctuations — not a hormone deficiency or excess.

SECTION 03

Signs & Symptoms

DSM-5-TR · ≥5 symptoms, ≥1 from affective core

Core Affective (≥1 required)

- **Marked affective lability** — sudden tearfulness, mood swings, rejection sensitivity
- **Marked irritability or anger** — interpersonal conflict, "rage" episodes
- **Marked depressed mood** — hopelessness, self-critical thoughts
- **Marked anxiety, tension, "on-edge"** feeling

Behavioral & Somatic

- Decreased interest in usual activities
- Difficulty concentrating · "brain fog"
- Lethargy, easy fatigability, low energy
- Marked appetite change, food cravings (carbs/sweets)
- Hypersomnia or insomnia
- Sense of being overwhelmed or out of control
- Breast tenderness, bloating, joint/muscle pain, weight gain

RED FLAGS — ESCALATE CARE IMMEDIATELY

- **Suicidal ideation, plan, or intent** — risk is significantly elevated during the luteal phase
- Self-harm behaviors or new-onset reckless behavior
- Severe interpersonal conflict raising domestic violence concerns
- Inability to attend work, school, or care for dependents
- Symptoms that *do not* remit with menses → re-evaluate for MDD, bipolar II, or PMDE (premenstrual exacerbation of another disorder)

SECTION 04

Priority Nursing Interventions

Safety → Assess → Plan → Educate

SAFETY **Assess suicide risk every visit** — directly, using validated tools (C-SSRS). Risk is highest in the luteal phase.

ASSESS **Initiate prospective daily symptom tracking** (DRSP or paper diary) for ≥2 cycles to confirm cyclical pattern.

ASSESS Screen for **comorbid MDD, GAD, PTSD, bipolar disorder** — high overlap; impacts pharmacologic choice.

PLAN Co-create a **luteal-phase safety plan**: warning signs, coping skills, social supports, crisis numbers, means restriction.

ADMINISTER Administer prescribed **SSRI** (continuous or luteal-phase dosing) and **monitor for suicidal ideation**, especially in patients <25.

EDUCATE Counsel on **aerobic exercise 30 min, 4–5×/week**, sleep hygiene, stress reduction, reduced caffeine/alcohol/sodium.

REFER Refer for **CBT**, peer support (IAPMD), and reproductive psychiatry if severe or treatment-resistant.

MONITOR Monitor **functional impairment, weight, BP, mood, sleep, sexual function**, and treatment response cycle-by-cycle.

SECTION 05

Pharmacology

First-line · Adjunct · Severe-case options

SSRIs SELECTIVE SEROTONIN REUPTAKE INHIBITORS

FIRST-LINE

EXAMPLES	**Fluoxetine, sertraline, paroxetine, escitalopram** (FDA-approved for PMDD: fluoxetine, sertraline, paroxetine CR)
MECHANISM	↑ Serotonergic transmission; rapidly enhances ALLO synthesis at GABA-A receptors — explains **fast onset in PMDD** (days, not weeks).
DOSING	**Continuous** (daily) OR **luteal-phase only** (start ~14 days before expected menses, stop with menses). Luteal-phase dosing is *unique to PMDD*.
SIDE EFFECTS	Nausea, headache, insomnia/somnolence, sexual dysfunction, ↓ libido, jitteriness. Monitor for serotonin syndrome and SI.
NURSING	Black box: **suicidality in <25 y/o**. Never abruptly discontinue continuous dosing. Take with food. Avoid combining with MAOIs, triptans, tramadol, St. John's wort.

Drospirenone / Ethinyl Estradiol COMBINED ORAL CONTRACEPTIVE

MECHANISM	Suppresses ovulation → flattens hormonal fluctuations. Drospirenone has antimineralocorticoid + antiandrogenic effects helpful for bloating/mood.
REGIMEN	**24/4 regimen** (Yaz) is FDA-approved for PMDD; shortened pill-free interval reduces hormone withdrawal.
SIDE EFFECTS	**VTE risk**, hyperkalemia (drospirenone), headache, breast tenderness, mood changes, breakthrough bleeding.
CONTRAIND.	**Smokers ≥35**, history of VTE/stroke/MI, migraine with aura, uncontrolled HTN, hepatic dysfunction, breast cancer.
NURSING	Teach **ACHES warning signs** (Abdominal pain, Chest pain, Headache, Eye changes, Severe leg pain). Monitor K^+ with drospirenone + ACE-I/ARB/K-sparing diuretics.

Leuprolide GNRH AGONIST

USE	Reserved for **severe, treatment-resistant PMDD** after SSRI ± OCP failure.
MECHANISM	Continuous GnRH stimulation → pituitary downregulation → **medical menopause** (no ovulation, no cyclical hormones).
SIDE EFFECTS	Hot flashes, vaginal dryness, mood changes, **bone density loss**, ↓ libido.
ADD-BACK	**Estrogen + progestin add-back therapy** needed if used >6 months to prevent osteoporosis.
NURSING	Baseline + serial DEXA. Counsel on menopausal symptoms and contraception (not contraceptive in early cycles).

Adjunctive Supplements EVIDENCE-SUPPORTED ADD-ONS

CALCIUM	**1,200 mg/day** — reduces mood and physical symptoms.
VITAMIN B6	**50–100 mg/day** (do *not* exceed 100 mg/day — risk of peripheral neuropathy).
MAGNESIUM	200–400 mg/day — may help bloating, breast tenderness, mood.
CHASTEBERRY	(Vitex agnus-castus) — may reduce physical symptoms; avoid with hormonal contraceptives, dopamine agonists/antagonists.

SECTION 06

NCLEX Test Traps

High-yield distinctions

	✗ DISTRACTOR	✓ PRIORITY
1	"SSRIs take 4–6 weeks for PMDD relief, just like depression."	SSRIs work in **days** for PMDD via rapid ALLO/GABA modulation — distinct mechanism from MDD response.
2	Diagnosing PMDD from a retrospective single-cycle interview.	Diagnosis requires **prospective daily tracking for ≥2 cycles** (DRSP) — without this, defer the diagnosis.
3	Treating PMDD as a hormone deficiency — "her progesterone must be low."	Hormone levels are **typically normal**. PMDD is abnormal CNS *sensitivity* to normal cycles.
4	"Symptoms persist after menses → just severe PMDD."	Symptoms must **resolve within days of menses**. Persistent symptoms suggest **MDD, bipolar, or PMDE** — refer.
5	Reassuring a patient: "PMDD doesn't really raise suicide risk."	PMDD **significantly increases suicidal ideation and attempt risk**, peaking in the luteal phase — always assess.
6	Picking "any OCP" — assuming all combined pills treat PMDD.	Only **drospirenone/EE 24/4 (Yaz)** is FDA-approved for PMDD. Other OCPs may worsen mood symptoms.
7	Recommending high-dose Vitamin B6 (e.g., 300 mg/day) for symptom relief.	Cap B6 at **≤100 mg/day** — higher doses cause **peripheral neuropathy**.
8	Confusing PMDD with PMS on an exam item.	PMDD = **marked functional impairment** + ≥5 DSM symptoms + ≥1 core affective. PMS lacks this severity threshold.

SECTION 07

🟦 Patient Education

Empower · Validate · Equip

- 📝 **Track daily symptoms** across ≥2 cycles using a DRSP app or paper diary — bring to every visit.
- 💊 **SSRIs may work within days** for PMDD — different from depression. Don't stop abruptly if on continuous dosing.
- 🏃‍♀️ **Aerobic exercise 30 min, 4–5×/week** reduces symptom severity.
- 🛏️ **Consistent sleep schedule** — luteal-phase insomnia worsens mood symptoms.
- 🚫 **Reduce caffeine, alcohol, refined sugar, sodium** — all amplify mood lability and bloating.
- 🧘‍♀️ **CBT, mindfulness, stress reduction** are first-line nonpharmacologic strategies.
- 📞 **Crisis plan:** 988 Suicide & Crisis Lifeline; emergency contacts; means restriction during luteal phase.
- 💞 **This is real and treatable.** PMDD is a recognized DSM-5-TR disorder — not "just PMS" or "in your head."

SECTION 08

Memory Boosters

Mnemonics · Pattern recognition

MNEMONIC · CORE SYMPTOMS

DEPRESS

- **D** **D**epressed mood / hopelessness
- **E** **E**nergy ↓ — lethargy & fatigue
- **P** **P**hysical sx — bloating, breast tenderness
- **R** **R**age & irritability
- **E** **E**ating changes & cravings
- **S** **S**leep disturbance (hyper- or insomnia)
- **S** **S**wings of mood / anxiety / overwhelm

PATTERN · 5-5-2

- **5** **5+ symptoms** required (DSM-5-TR)
- **5–7** Days before menses = symptom window
- **2** **2 cycles** of prospective tracking to diagnose

Luteal = Lethal
Suicide risk peaks here — assess at every visit.

Fast SSRI
PMDD responds in days, not weeks — unique to this disorder.

Track → Treat
No tracking diary = no diagnosis.

Yaz = the OCP
Only drospirenone/EE 24/4 is FDA-approved.