Loving the "Hormone Hostage"

Principles for Couples Coping with Premenstrual and Menopausal Conditions

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This article provides information on premenstrual and menopausal conditions as well as how these hormonal concerns impact relationships. Millions of male baby boomers will soon be joining their spouses in a journey through perimenopausal/menopausal. In order for marriages to thrive, therapists will need to provide tools that will enhance spousal understanding and sensitivity during this time. The authors' objective is to provide guidance to couples as they navigate these changes and provide principles that may enable them strengthen their marital bond.

As a couple, we became personally interested in this topic when Carolyn began experiencing some fairly significant perimenopausal symptoms. It became imperative to understand her physiological changes, and also how it impacted her emotionally, psychologically, and spiritually. We have discovered it to be not only an experiential process, but an experimental one as well. As we talk with other couples dealing with hormonal fluctuations, we find that this journey may begin with PMS in the teenage years, move into perimenopausal symptoms as early as age thirty-five, and on through menopause at the average age of fifty-two, before finally reaching post-menopause. Hormonal fluctuations occur throughout much of a woman's lifespan, requiring numerous adjustments and accommodations both personally and relationally.

As we become more familiar with this topic, we believe God has something significant in store for couples and the Church. After we conducted one workshop on this topic, Carolyn was approached by a woman who said, "I am going to pray that the Lord takes all these hormonal problems away from you." The more Carolyn thought about that, the more she considered Paul's words to the Corinthians: "God the Father, who is full of mercy and all comfort. He comforts us every time we have trouble so that when others have trouble we can comfort them with the same comfort God gives us" (2 Corinthians 1:3b-4). We don't believe God chooses to remove everything that is uncomfortable. Rather, He takes us through difficulties so we can benefit while we are in it and afterwards. It would be great if God wanted to take this all away tomorrow, but that may not be His plan. Suffering is God's graduate school of life and if you want to mature spiritually, we believe suffering is necessary, and it may come in many different forms. Hormonal problems may be one of your challenges in life and perhaps for your husband, as well.

Williamson and Sheets (1989) in their delightful parody *Raging Hormones*, defined a "Hormone Hostage" as "any woman who for two to fourteen days each month becomes a prisoner of her own raging hormones and turns her life and the lives of those around her into unholy premenstrual netherworld". But "who is the "hostage" when hormones are out of con-

trol? Both partners can be impacted. More than once we have heard a husband comment, " I have been a hostage to my wife's hormones for years."

To begin with, it is important to understand some basics about mood and the menstrual cycle. About 97% of reproductive-age women do report at least a mild degree of mood changes premenstrually. Sex hormones impact the mood of a vast majority of women, but about 20-40% have complaints that can be classified as moderate premenstrual symptoms or Premenstrual Syndrome (PMS) (Lyles, 2000). However, 2-10% of women suffer from severe or disabling symptoms premenstrually, which has been defined as premenstrual dysphoric disorder (PMDD) (Logue & Moos, 1986). PMDD usually begins when a female is in her teens to late twenties. Interestingly, however, treatment often is not initiated until she is in her thirties. Physical symptoms associated with PMS include acne, backache, bloating, fatigue, headache, and sore breasts. Emotionally, it can cause depression, poor concentration, difficulty handling stress, irritability, tearfulness, and a change in sexual desire.

Many of these same PMS symptoms are also present when a woman enters perimenopause (the transition between fertility and the last menstrual period), which can begin as early as age thirty-five but generally begins in the mid-forties. There is also some overlap in symptoms with regard to perimenopause and menopause (when periods have actually ceased for a year), as one may notice irregular menstrual patterns, hot flashes, and night sweats, corresponding to changes in estrogen levels. Other common symptoms include: vaginal inelasticity and/or dryness, urinary incontinence, insomnia, fatigue, loss of concentration and memory lapses, skin changes, and formication (a perception of skin crawling, a prickly feeling, or a feeling of bugs biting you). There can also be mood swings, and fluctuations of sexual desire and response (Nachtigall, 1998). Although it has not been shown to be directly related to menopause, depression is common, as well as dizziness, heart palpitations, and anxiety. If a person is predisposed to headaches, they can become worse during this time.

In Appendix B in the back of the DSM-4 (p.715), you'll find the criteria for Premenstrual Dysphoric Disorder (PMDD). These are listed in Figure 1. The unusual aspect of this diagnosis is that the criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive cycles. This is the only DSM diagnosis that requires systematic documentation. The reasoning for prospective versus retrospective ratings is that researchers have discovered that once women begin menstruation, they typically forget how they felt two or three days before. When they begin their period, perspectives and perceptions often change. If women charted their symptoms retrospectively, they may not arrive at the same perception about their symptoms. When one notes two consecutive cycles of fairly high symptom ratings, it provides some insight on the severity of PMS or whether it may even be PMDD. Sometimes more than two months of evaluation are necessary, because many women often experience differences between ovaries. When one ovary drops an egg they experience more severe PMS. The following month with the other ovary, the symptoms are not as bad. Women may have an every other month type of situation in terms of severity of mood changes.

In terms of differential diagnosis, look for the symptoms being worse in the luteal phase (from ovulation to menstruation) with a marked level of impairment. Twenty to twenty-five percent of women also meet the criteria for dysthymia during the first half of the cycle, which means there are co-morbid conditions taking place (Cohen, et al., 2000). Thirty percent of those with PMDD also have a history of

major depressive disorder. This is significant because 45-70% of women with PMDD develop major depressive disorder over the course of their lifetime vs. 15-20% of women in general (Lyles, 2000). What this indicates is that a woman with PMDD is three times as likely to develop major depression if her condition is not properly recognized and treated. Many women have more suicidal ideation, attempts, and psychiatric hospitalizations during the luteal phase. In fact, it is not unusual for psychiatric hospitals to note an increased use of sanitary products with many women shortly after they are admitted for suicidal ideation or a suicidal attempt. Within a day or two after they are admitted, they begin their monthly period.

We are not sure what causes PMDD, but female sex hormones need to be present to trigger PMDD and PMS symptoms, although they do not cause it. The symptoms represent an abnormal response to normal hormonal changes. Women with PMDD appear to have a disturbed ability to metabolize or process serotonin (Rapkin, et al., 1987), which is the neurotransmitter that seems to regulate moods. A lack of serotonin, or more specifically, a lack of receptor sensitivity may cause depression or affective lability. Since the luteal phase involves a decreasing level of estrogen, this may cause receptors to be non-responsive to serotonin. The ability to synthesize serotonin seems to be a very significant factor in mood regulation. It is interesting that men synthesize serotonin at rates about fifty-two percent greater than women (Liebenluft, 1999). This may explain why men do not experience depressive symptoms in the same way women do.

With that as a background, allow us to present several treatment principles that are important for couples to take into consideration as they attempt to cope with these hormonal conditions.

1) Partner with your spouse in the treatment process. ***Husbands LOVE your wives as Christ loved the church and GAVE Himself for her*** **(Ephesians 5:25).** Men are an essential component in the treatment process. They can certainly help to make things better or they can clearly make matters worse. We have talked to a number of women about what they need or what is it they wish their spouse would do for them when they are premenstrual, or when they are experiencing some specific perimenopausal symptoms. We have received a myriad of responses, but many are comments like, "Take the kids away and expect nothing from me except that I take a bath and curl up with a heating pad." "Direct the children in their responsibilities so that I don't have to think all the time." "If he would not always ask me things, like where is the milk, which is always in the refrigerator, but if he would see ahead to areas where he could pitch in and help." "If he would sympathize and listen and be concerned instead of trying to give me simple solutions." "Take me seriously without placating me." "I'll be there for you- we will get through this, don't react when I react." "The nicest thing my husband could do is let me sleep in just for one day." "Stop and hug me during a temper tantrum, not just run away or disagree just to disagree." "Hug me more in bed or just hang out." "Hold me until I say stop, not when you get tired, bored, or disinterested." "Offer to massage my back with no TV or other noise." *What men often miss is when a woman seems to be the most unlovable may be when she most needs to be loved.*

To emphasize the importance of supporting your spouse even when you don't want to, I'm reminded of an illustration from the 2000 Olympics in Sydney, Australia. The fellow who was voted the most outstanding Olympic male athlete for the United States was Rulon Gardner, a huge dairy farmer from Wyoming who won the gold medal in the Greco-Roman

wrestling's Super Heavyweight Division. He defeated Russia's Alexander "The Great" Karelin, a wrestling legend who hadn't lost in over 250 matches spanning thirteen years. Greco Roman wrestling utilizes the upper body to perform a series of holds and throws in an attempt to outscore or pin your opponent. Karelin was considered unbeatable and had a move that was actually named for him in which he was able to put an arm lock around his opponent's waist, and then, because his knees were double jointed, he was able to get the leverage necessary to pick the person up over his head and basically drop over backwards. His opponent had the choice of moving his head and getting pinned or breaking his neck. Rulon Gardner defeated this fellow 1-0 and won a gold medal. Afterwards people asked him, "How did you do this?" "How did you manage to avoid getting put into that hold?" He said, "Well, the only way I could figure to do this was to stay so close to him he couldn't get any leverage on me." As we think about this in the context of hormone fluctuations, it is interesting. Getting close is not only what a woman needs, but it also serves as a protective function for the relationship.

Figure 1

Depressive Disorder Not Otherwise Specified: Premenstrual Dysphoric Disorder

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, begin to remit within a few days after the onset of follicular phase, and were absent in the week post menses, with at least one of the symptoms being either (1), (2), (3), or (4).

1. Markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts.
2. Marked anxiety, tension, feelings of being "keyed up," or "on edge."
3. Marked affective lability (e.g. feeling suddenly sad or tearful or increased sensitivity to rejection).
4. Persistent and marked anger or irritability or increased interpersonal conflicts.
5. Decreased interest in usual activities (e.g. work, school, friends, hobbies).
6. Subjective sense of difficulty in concentrating.
7. Lethargy, easy fatigability, or marked lack of energy.
8. Marked change in appetite, overeating, or specific food cravings.
9. Hypersomnia or insomnia.
10. A subjective sense of being overwhelmed or out of control.
11. Other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain .

B. The disturbance markedly interferes with work or school or with social activities and relationships with others (e.g. avoidance of social activities, decreased productivity, and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least 2 consecutive cycles.

Reference: Diagnostic and Statistical Manual of Mental Disorders (DSM IV), 4th Edition, 1994.

Research in the area of touch can be very instructive to men during this time as an encouragement to get close to your spouse. As you touch your wife, and as you touch in general, you are actually altering your brain cells to make yourself calmer. Touch has been shown to reduce tension, elevate moods, enhance self-esteem, and perhaps even strengthen the immune system (Fisher, 1993). Touching can increase serotonin levels to some extent, this sense of touch releases the neuropeptide hormone oxytocin (Crenshaw & Goldberg, 1996). Oxytocin is the chemical that helps induce labor and stimulate lactation. It is also released during orgasm and helps couples feel more connected (Meston & Frohlich, 2000). When you give or receive touch, your body releases a certain amount of oxytocin and helps to produce a much-needed sense of well being for both persons.

2) *Collect* as much *information* as possible and be an advocate for your own health care. There is no one "magic" answer, pill, exercise, diet, prayer, or solution. Just remember, a remedy or intervention that works for one person doesn't always work for someone else. The endocrine system is enormously complex ("we are fearfully and wonderfully made") and it is also individualized. What works well for somebody may only be effective for a short period of time. For someone else, however, that remedy may actually exacerbate some symptoms. Each treatment has to be hand-tailored to a specific person. This is why collecting as much information as possible is imperative, which includes information on any medications or supplements currently being taken. During this period of time when one's hormones seem "out of control," there is a good chance that even the side effects of a medication will impact you. As you gather information, it helps to have someone (a physician, therapist, or spouse) who can help you sort through the symptoms and options.

3) If you seek *Professional Help*, find someone you can trust and is prepared to try different alternatives, not just offer cookbook answers. There are many areas in which physician supervision may prove useful, including: finding a correct diagnosis, the elimination of other medical problems, for a referral to other professionals (including psychological or nutritional help), to prescribe medication as needed, and to get medical advice on the use of over-the-counter medications. It may be an internist, an OB/GYN, or even an endocrinologist. Look for someone who is willing to work with you through this process clearly, communicate your options, and even be willing to experiment in order to find the best approach.

In this section on Professional Help, we will briefly summarize various medication options.

Serotonergic Medications - The drugs that appear to be most effective in the treatment of PMDD are the serotonin-oriented medications. These would include the Selective Serotonin Reuptake Inhibitors or SSRI's (such as Prozac, Paxil, Zoloft, Celexa, and to a lesser extent Luvox) as well as serotonergic type medications like Serzone, Anafranil, and Effexor. Usually they are prescribed in a relatively low dosage and the research studies seem to show significant improvement in women who need them (Freeman, et al., 1999; Steiner, et al., 1995). SSRIs also appear to have a much faster onset of action when used to treat PMDD than when used to treat depression (Brown, 1996). With SSRIs and depression, it can often take four to six weeks before a therapeutic response is seen. When used to treat the serotonin deficient condition of PMDD, women may respond within two to three days. Women tend to respond better to SSRIs than men do (which may relate to the gender difference in serotonin synthesis referred to earlier). Younger women respond better than older women, because estrogen is nec-

essary to synthesize the serotonin. Thus, a menopausal woman who is not on some form of estrogen replacement therapy will not respond effectively to SSRIs. Another option for women that may reduce the impact of adverse side effects is treating the condition mid-cycle. Some research indicates that it may even be more effective than full cycle treatment (Freeman, et.al., 1999; Wikander, Sundbland, & Andersch, 1998). Thus, a woman might try taking an SSRI about 10-14 days before her period begins so that she has the therapeutic effect during the time in which she is most "premenstrual," then discontinues it after menstruation begins.

Benzodiazepines - Interestingly, some people have found some benefit from Benzodiazepines in low doses during PMS (e.g. Xanax, Valium, Librium, or Tranxene) (Smith, et al., 1987). Obviously, these medications are subject to possible drug dependence and would not be recommended for those who already struggle with substance abuse.

Birth control pills - Very useful and effective at a low dose for some women, especially if PMS is not too severe. In fact, many people will try this method first before moving to other prescription medications. Estrogen apparently is quite helpful in the treatment of depression. Progesterone, on the other hand, can increase depression, so when treating PMDD, estrogen loaded birth control pills may be more effective than those with higher levels of progesterone.

Hormonal Therapies – Estrogen, Progesterone, Testosterone, DHEA, and many other forms of hormonal supplementation or replacement are utilized in a variety of combinations and with an array of conflicting research results. While vitally important to this topic, the specifics of this treatment are beyond the scope of this article.

Medications for symptom relief - Many of the following medications can be useful to treat specific symptoms, such as NSAIDs for cramps (Advil, Motrin, Anaprox, Ponstel), Parlodel (bromocriptine) for breast pain, diuretics or "water pills" for bloating (Aldactone), and prescription analgesics for severe headache or cramps.

4) ***Diet and Nutrition*** **can help improve or worsen your symptoms. Weight gain and /or body changes are a natural developmental process during midlife.** Methods that worked at one point in life may now be completely ineffective, since one's hormones impact metabolism and body mass. For Carolyn, one of the biggest factors that changed her diet was her experimentation with testosterone supplementation. For example, half of the month she needs to be on a high protein diet, while the other half she needs a lot of carbohydrates. In general, with PMS you need to eat more frequently but not overeat; do not eat less than 1200 calories per day; eat slow-burning foods (lean protein, green veggies); eat whole grains - "look for brown foods;" drink more water; and avoid sugars, caffeine, alcohol and salty food. One helpful and easy to understand book that describes the nutritional components of various foods is *PMS-What It Is and What You Can do About It* (Sneed, 1988). If you have a client struggling with concentration problems, they could gain help and insight from this book. However, as one moves into perimenopause, the symptom patterns often become scattered or intensifies, and it becomes much harder to define dietary rules. Occasionally, a woman may need help trying to avoid particular foods during certain times of the month, or she may be watching her caloric intake because of body weight inconsistencies. But - nothing will make her angrier than her husband telling her, "I don't think you should have that chocolate." If she craves the sweet, he is going to have to figure out a more empathic way to tell her, because she will not want somebody counting her calories for her. This can be difficult for husbands, because men like to offer solutions. However, a hus-

band's perception of a clear-cut answer is not always the only solution.

5) *Exercise* is important. It controls weight and helps alleviate other physical, emotional, and psychological problems. We know that exercise is useful in treating depression, but it can also increase one's energy and productivity, decrease appetite, and function as a stress reducer. In addition, people who exercise regularly tend to have more positive attitudes. Exercise improves the body's ability to metabolize sugars, and is effective in decreasing fat and improving weight maintenance.

6) *Proper Sleep*, which is impacted by hormonal changes, is necessary to maintain coping skills and cognition. If you don't get enough sleep, you can't think or cope properly. If necessary, talk with your doctor about sleep problems. Neurotransmitters are naturally produced during sleep. If you are not getting enough sleep, you are lacking these natural chemicals, which are mood regulators. Some people find that something as simple as over-the-counter Nytol (basically Benadryl) will make all the difference in the world. However, you may find you need a physician to prescribe a sleep aide. As women age, many experience early morning awakening. It is a frustrating time to be awake because everything seems to be worse in the middle of the night. There are a couple of things that can help. One of them is God's Word. Consider Psalms 4:8, "I will lay me down in peace and sleep, for you, O Lord, will cause me to dwell in safety." David probably wrote that when Saul was pursuing him. Sometimes, in the middle of the night, you may feel particularly vulnerable. Safety encompasses more than someone attacking you physically. The other truth about sleep is the profound benefit of awakening your husband and asking him to pray for you. Fortunately, the Holy Spirit interprets our groanings and utterances because that is mostly what goes on at 4a.m. Sometimes, when insomnia is overwhelming, ask your husband, to pray for you from the Word of God. Internally, the words are calming, and they can induce sleep. Husbands, pray with your wives. Not only does it invite the Lord to intercede, it serves to provide a vital sense of security for women when they can feel most insecure and unsure.

7) Many *"Natural"* Remedies are available that may improve symptoms. Be aware of individual differences, limited supported research, and quality control problems. Many people prefer a "natural" approach, but even these products can have significant unpleasant side effects or produce allergic reactions (Bendich, 2000). But they may be effective for some women. Chasteberry (Vitex Agnus) is an herbal supplement many women find helpful in treating PMS (Laurizen, et.al., 1997). Some have found Vitamin B6 (pyridoxine) to be useful in improving mental health. Magnesium can help to decrease chocolate cravings (Walker, et al., 1998). Calcium is very important, not only for PMS treatment, but also as one moves into perimenopause and menopause. In fact, it should be increased at this time. Calcium, however, decreases magnesium absorption, so eat foods that have a high magnesium/calcium ratio like millet, corn, wheat, potatoes, and cashews. Evening Primrose Oil (Efamol) reduces prolactin sensitivity, which can be helpful from ovulation until the onset of menstruation. Increasing complex carbohydrate consumption can increase serum tryptophan levels, which makes more serotonin available (Pearlstein, 1996). We do know that progesterone does not help women who have PMS. It tends to increase nervous tension, irritability, mood swings, swelling and fatigue. St. John's Wort, while helpful with some people who tend to become depressed, is not consistently effective for PMS. With regard to most herbals, there are both purity concerns and obviously

some drug interaction concerns.

8) *Stress Management* is imperative because hormone factors exacerbate an already stressful time of life. Evaluate and maintain some perspective on the "majors" versus the "minors" of life. Stress is defined as the body's response to a perceived threat or demand. When a person is particularly premenstrual, or even perimenopausal, what would normally be a non-threatening conversation or request, can be perceived as a threat or demand. Daily events that are normally 2's and 3's on a scale of 1 to 10, rate higher, further exaggerating stress. There are many things we can do to alter our distorted perception, including how we spend our time. Find some time to be alone. Maybe spend a quiet evening with your husband, and then with your family. Avoid stress eating, as you will feel worse later, and don't skip exercise. Avoid social commitments that are personally demanding, such as dinner parties that require elaborate preparations. Try being more productive during other parts of your cycle so that you can take more time to relax when premenstrual. If you can, schedule vacations for the first two weeks after your period. Arrange carpools and other such commitments on a rotation that frees you from responsibility when you're premenstrual. If you have young children at home, arrange someone to occasionally babysit them at this time.

9) Develop a *Support Network* that may include husband and trusted friends with whom you can be honest and who will listen first, then respond. These people are not in your life to "fix it." Husbands may also consider developing a support group with other men who will encourage one another to be supportive at home. Carolyn has a close Christian friend who will always listen to her without reacting, even when she says ugly or unkind things. One day Carolyn railed on and on, and her friend finally said, "You don't want to do that. It's beneath your dignity." It was a gentle rebuke – don't go there. Men, it is important for you to develop a support network because if you are finding it difficult to love your wife and yet you know that is what she needs, partner with another husband. Meet for lunch and share your frustrations. He can help you be accountable. When men have close intimate contact with other men, it ultimately results in developing more intimacy with their wives.

10) Develop a sense of *Humor* and expose yourself to things that encourage it. In Proverbs, we see the benefits of humor. "A happy heart will make the face cheerful, but heartache crushes the spirit." (15:13); "...the cheerful heart has a continual feast." (15:15); "A cheerful look brings joy to the heart and good news gives health to the bones. (15:30) Also in 17:22, it says, "A cheerful heart is good medicine but a crushed spirit dries up the bones." Perhaps humor will even prevent osteoporosis. During this time of life, there are many ways we can learn to laugh at ourselves and our plight. If we don't learn this lesson, we may end up hurting each other instead. Consider an appropriate time to share one of the following greeting card poems with your spouse. For example, here's one called "I Miss You." "I can't forget your gentle touch, I can't forget your smile, so if I can't recall your name, it's only for awhile. I know you think I'm crazy but it's just my monthly phase. So, darling, don't decide we're through, just give me a couple of days." Or how about "Just For You." "If we're to have a romance, there is something you should know. I want to share it with you because I love you so. You can send me to the moon with just one perfect kiss, but I'll send you to hell and back when I have PMS" (Williamson, 1989). Maintain your sense of humor. It will help to keep you sane during the "crazy times."

11) *Spiritual Maturity* will greatly impact your ability to cope and main-

tain a perspective on pain, problems, and reality. Discover "anchor verses" which fit your symptoms and print them on cards for those times you encounter challenges. PMS, PMDD, Perimenopause, and Menopause are not "spiritual problems" and yet there can be considerable guilt over anger, depression, and irritability. We do know that unresolved spiritual problems can, in fact, make these conditions worse. Ruth Meyer has written an apropos book entitled, *31 Days of Praise,* which deals with painful things in life and how to cope. In your spiritual walk, don't neglect the Psalms. It expresses all the emotions of the human heart. It is important to claim certain verses and write them out for future use. David wrote Psalm 71:1 when he was older but it applies many times to the ups and downs of a woman's cycle. "In you, O Lord, do I put my trust. Let me never be put to confusion." And Psalm 34: 4 states "I sought the Lord, and He answered me; He delivered me from all my fears." In the midst of what can seem like a hormonal roller coaster, these kinds of scriptures can be held onto and offered in prayer to the Lord.

12). ***"This too shall pass..."*** **Hormone difficulties may seem temporary from a lifespan perspective, but they are not a "quick fix."** Someone once said, "Marriage is a life long process of trying to correct a mistake." We do not always possess the best reasons for marrying, but it is lifelong process of making the best of a situation and learning to love each other "in sickness and in health." Intimacy, much like spiritual maturity, can be developed through adversity. As we partner together and commit to move through the inevitable struggles we will face, the marriage that perseveres will be blessed.

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