

**A PHENOMENOLOGICAL STUDY OF THE RELATIONSHIP EXPERIENCES OF  
PARTNERS OF INDIVIDUALS WHO SUFFER WITH PREMENSTRUAL  
DYSPHORIC DISORDER (PMDD)**

by

Rose Anna Alkattan

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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### **Abstract**

Premenstrual Dysphoric Disorder (PMDD) is a debilitating disorder that adversely affects the lives of individuals and their intimate relationships. The purpose of this transcendental phenomenological study was to describe the lived experience of the partners of individuals who suffer from Premenstrual Dysphoric Disorder. The theories guiding this study were the interpersonal theory of suicide and the adult attachment theory. This study examined the overall relationship experience of partners of individuals suffering from PMDD and their cyclic attachment styles during the luteal and follicular phases of the menstrual cycle. A selection of three PMDD partners and three PMDD sufferers, who have been in an intimate relationship for six months or longer, were interviewed to measure the fluctuation in the overall relationship experience and cyclic attachment styles. Overall, the attachment styles of the PMDD partners may be affected because of the cyclic anguish of the PMDD sufferers during the luteal and follicular phases of menstruation. The fluctuating attachment styles of the PMDD sufferer can impact the PMDD partner's overall relationship experience.

*Keywords:* Premenstrual Dysphoric Disorder, PMDD partner, PMDD sufferer, luteal, follicular, ovulation, relationship experience, attachment style

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### **Dedication**

I am dedicating this to my amazing husband and PMDD partner, Jamil Alkattan for loving me and supporting me throughout this journey. To my extraordinary daughter, Veronica Dotson (Pretty Girl), thank you for being with me every step of this journey, I am honored to be your mother and I am so proud of you! I would also like to dedicate this to every PMDD partner and PMDD sufferer who endures this disorder every single month, I promise I will continue to serve and support this community with my whole heart. We Got This!

### **Acknowledgments**

First, I would like to thank God for ordering my steps and putting this work in my heart for His people. This work is in direct obedience to what God has defined as my purpose and assignment in life, and thus my heart is filled with gratitude for everyone who has contributed to this journey. I want to thank God for my daughter, Veronica, for bringing love and light to my life, even in my darkest moments. Being your mother is one of my greatest honors; you truly reflect God's love for me. I want to thank my husband and PMDD partner for supporting me through this journey every step of the way. Your loyalty and unwavering dedication to me have been my greatest support on this journey. I want to thank every PMDD partner who has struggled and continues to struggle with this disorder every month. I admire your strength and am privileged to serve you by spreading awareness and allowing you to be seen, heard, and validated. My goal is that this study gives PMDD partners hope in knowing they can have a healthy and supportive intimate relationship with someone who suffers from PMDD.

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### **List of Abbreviations**

Premenstrual Dysphoric Disorder (PMDD).

## Chapter One: Introduction

### Overview

Premenstrual dysphoric disorder (PMDD) is a cyclic hormone-based depressive disorder that occurs monthly, with symptoms arising during the luteal phase of the menstrual cycle and diminishing upon the onset of menstruation. According to *What is PME* (2019), PMDD is not characterized as a hormonal imbalance as it is frequently mistaken, yet it is the individual's adverse reaction to the increase and decrease of progesterone and estrogen occurring between menstruation and ovulation. One can think of this as an allergic reaction to the normal menstrual cycle that women go through during their childbearing years.

It is exhausting...You go through such a change in emotional state, and then you slowly come out of it...You then spend the next week apologizing to people that you've been weird with or upset with and then you carry on. Ultimately you just go through your life stumbling from one month to the next. ("The monthly torture," 2019, para. 5)

This devastating condition results in an individual having severe reactions, such as anxiety, depression, chronic fatigue, anger, irritability, and insomnia for approximately two weeks out of the month, which impact their interactions with their partners within their intimate relationship. These symptoms can adversely affect the relationship experience of the partners of these individuals who suffer from PMDD.

Unfortunately, partners of individuals with PMDD must endure the mental, physical, and emotional reactions of their partner suffering from this disorder. For half of the month, their intimate relationship is negatively impacted, and they must recover from the effects of PMDD in

time to potentially enjoy the normality of the relationship once the PMDD symptoms subside. Over time, the mental health of the PMDD partners can begin to deteriorate as they endure the cyclic emotional and mental turmoil associated with an intimate relationship with someone with PMDD. Consequently, this can diminish the overall relationship experience.

### **Background**

Premenstrual Dysphoric Disorder (PMDD) is a cyclical, hormone-based mood disorder with symptoms arising during the premenstrual, or luteal phase of the menstrual cycle and subsiding within a few days of menstruation. It affects an estimated 1 in 20 women of reproductive age. PMDD causes significant physical, emotional, and behavioral symptoms in the week or two before the onset of menstruation. These symptoms may include intense mood swings, irritability, depression, anxiety, fatigue, and physical discomfort. PMDD can significantly impact the well-being and daily functioning of individuals who experience it. Eldeeb et al. (2021) stated that PMDD is prevalent in 1.8% to 5% of women of childbearing ages and speculated that its potential cause is an acute sensitivity throughout the central nervous system during the rise and fall of hormones during the menstrual cycle. PMDD symptoms commence after ovulation during the luteal phase of the menstrual cycle and diminish within the initial days of menstruation. Research confirmed that five percent of menstruating women have been diagnosed with PMDD (Halbreich et al., 2003). PMDD is regulated by the menstrual cycle, yet the hormones within the individuals remain balanced. It is speculated that symptoms experienced within PMDD occur because of the brain's adverse reaction to the increase and decrease of estrogen and progesterone during the menstrual cycle.

### **Historical**

The symptoms associated with PMDD can affect an individual emotionally, physically,

and psychologically. PMDD has been attributed to irregular neurobiological responses to ovarian hormonal changes within the menstrual cycle (Schmidt et al., 2012). The cyclic nature of the symptoms is an additional obstacle. Once the PMDD symptoms have dissipated upon the onset of menstruation, the individual returns to normal functioning. This cycle occurs monthly, and the emotional, physical, and psychological impacts are debilitating.

### **Emotional and Mood Symptoms**

PMDD is a severe and incapacitating condition affecting many menstruating individuals. There is a distinct variance from typical premenstrual symptoms known as premenstrual syndrome (PMS) and PMDD. Patients often describe PMDD symptoms, including depression, anxiety, suicidal ideation, and insomnia, as commencing two weeks before menstruation (Kugathas & Kulkarni, 2022). PMDD can drastically impact emotions and the individual's overall well-being. For those experiencing PMDD, the emotional toll can be overwhelming and disrupt daily life and relationships. During the luteal phase of their menstrual cycle, individuals with PMDD may encounter intense mood swings, irritability, and feelings of sadness or hopelessness. There are two subsets of women with PMDD: predominant depression or irritability (Landén & Eriksson, 2003). These emotions can be so severe that they interfere with personal relationships, work, and other activities. Anxiety and tension are also common, amplifying the emotional turmoil. The sensitivity to the regular changes in estrogen and progesterone levels associated with PMDD is believed to trigger these emotional changes significantly. Living with PMDD can be isolating because others might not fully comprehend the intensity of the emotional turmoil experienced during this time.

PMDD significantly impacts mood, leading to emotional disturbances beyond typical premenstrual symptoms. PMDD can lead to intense mood shifts and irritability. Laboratory

studies have suggested that PMDD may be linked to low ischemic pain tolerance levels (Fillingim et al., 1995). The hormonal fluctuations during the luteal phase of the menstrual cycle trigger a cascade of emotional changes, resulting in intense mood swings, irritability, and a sense of being consistently stressed and overwhelmed. The mood fluctuations experienced by individuals with PMDD can be erratic, volatile, and severe. They felt inexplicably sad, hopeless, or emotionally sensitive, often leading to increased conflicts with others due to heightened irritability and anger. Anxiety and tension may escalate, making it challenging to cope with everyday stressors.

### **Physical Symptoms**

PMDD significantly affects individuals physically, with a range of symptoms that can be both distressing and debilitating. Current findings proposed that PMDD can be associated with hormones, while other research noted evidence suggesting that PMDD could be related to an individual's sensitivity to fluctuations of hormones, which might impact the neurotransmitter response to the triggered (Cunningham et al., 2009). These symptoms typically arise during the luteal phase of the menstrual cycle and subside once menstruation begins. One of the most common physical symptoms of PMDD is bloating and water retention, leading to a feeling of abdominal fullness and discomfort. Breast tenderness is also prevalent, causing pain and sensitivity in the breast tissue. According to Reed (2008), people with PMDD reported changes in their appetite and cravings, specifically during the luteal phase, which correlated to their symptoms of depression and changes in their mood. Headaches and migraines may occur, increasing the physical burden experienced during this time. Individuals with PMDD may also experience overeating (Momma et al., 2019). PMDD can lead to fatigue and a lack of energy, making it challenging to perform daily tasks and maintain a routine. Sleep disturbances are

common with individuals experiencing insomnia or disrupted sleep patterns, contributing to feelings of exhaustion and irritability. Appetite changes may occur, with some individuals experiencing increased food cravings, particularly for sweets and carbohydrates. This appetite change and hormonal imbalances can lead to weight fluctuations (Hamidovic, 2022).

In some cases, physical symptoms can be severe enough to cause temporary physical disability, affecting an individual's ability to engage in regular activities, work, or academic performance. PMDD can cause physical discomfort, such as breast tenderness, bloating, fatigue, headaches, joint or muscle pain, and changes in appetite or sleep patterns. The emotional toll of PMDD can extend to physical symptoms, such as fatigue, changes in appetite, and sleep disturbances. PMDD can be particularly challenging for those struggling to differentiate between the typical difficulties of life and the emotional intensity caused by the disorder. PMDD may be a risk factor for major depressive disorder, and PMDD sufferers have a 14 times high risk of developing major depressive disorder (Hartlage et al., 2001). The knowledge that these emotions are hormonally driven does not diminish their impact on daily life and emotional well-being. The combination of emotional and physical distress can create a challenging cycle where mood disturbances exacerbate physical symptoms and vice versa.

### **Impaired Functioning**

PMDD can severely impair functioning, affecting various aspects of an individual's life. The emotional and physical symptoms experienced during the luteal phase of the menstrual cycle can be intense and disruptive, leading to significant challenges in daily activities and relationships. Severe negative symptoms and functional impairment often indicate that the female suffers from PMDD (Kaiser et al., 2018). One of the primary ways PMDD impairs functioning is through its impact on emotions. The intense mood swings, irritability, and

heightened sensitivity can make it difficult for individuals to regulate their emotions effectively.

This emotional instability associated with impaired functioning can place additional stressors on intimate relationships and may lead to conflicts. Some speculate that increased connectivity in PMDD sufferers may result in improved emotional regulation; however, the outcome perceived indicated a probable alternative pathway for engaging cortical resources for emotional regulation in PMDD sufferers, and the physical symptoms of PMDD may hinder the sufferer's functioning (Freeman, 2003) Fatigue, headaches, and sleep disturbances can decrease productivity and concentration, affecting work or academic performance. Physical discomfort and bloating can further add to discomfort and hinder engagement in regular activities. Individuals with PMDD may find it challenging to engage in self-care practices or maintain a healthy lifestyle due to the disruptive nature of the disorder, which can lead to neglecting exercise, healthy eating habits, or other activities that promote well-being. The impairment in functioning can be exceptionally debilitating for those in professions requiring consistency and prominent performance levels. It may also impact daily responsibilities, such as caring for family members or fulfilling household tasks. Coping with PMDD can lead to increased stress and anxiety, exacerbating the symptoms and further impairing functioning, creating a cyclical pattern where the disorder affects one's ability to manage it effectively. The overall symptoms of PMDD can interfere with daily activities, work productivity, and personal relationships. The severity of symptoms may vary, but during the luteal phase of the menstrual cycle, individuals may struggle to perform at their usual level.

### **Psychological Impact**

The psychological impact of PMDD can be profound and far-reaching, significantly affecting an individual's mental well-being and overall quality of life. The emotional symptoms

experienced during the menstrual cycle's luteal phase can lead to various psychological challenges. Research indicates that depression and PMDD are closely correlated (Ajari, 2021). One of PMDD's most notable psychological impacts is its induced emotional turmoil. The intense mood swings, irritability, and sadness or hopelessness can be overwhelming and distressing. These emotions felt unmanageable, leading to increased stress and anxiety and may contribute to developing or exacerbating mood disorders, such as depression or anxiety disorders. The unpredictability of PMDD symptoms can lead to a sense of loss of control and helplessness. Individuals may struggle to differentiate between the genuine emotions they experience and those triggered by the disorder, leading to confusion and frustration. The psychological toll of PMDD can interfere with daily functioning, affecting work or school performance and impacting relationships. The strain on personal relationships due to emotional instability and irritability can lead to social withdrawal and feelings of isolation. The cyclical nature of PMDD can also disrupt an individual's self-esteem and self-worth. The recurring pattern of emotional distress can make individuals question their capabilities and feel inadequate, perpetuating negative thought patterns. PMDD can affect an individual's mental health, leading to increased stress, decreased self-esteem, and reduced quality of life. The cyclical nature of PMDD, with symptoms appearing before menstruation and subsiding afterward, can be distressing and affect overall psychological well-being.

Psychological, emotional, and physical PMDD symptoms and impaired functioning within an individual can cause adverse effects and undue stress on navigating intimate relationships. Beddig et al. (2019) discussed that to be diagnosed with PMDD, one must exhibit at least five symptoms within a year's time frame, which include anxiety, depression, fatigue, irritability, a loss of interest in activities that were once enjoyed, and a plethora of physical

symptom. This difficulty in suffering with such a wide variety of PMDD symptoms on a cyclic basis while maintaining an intimate relationship cultivates a negative impact on their partners.

### **Theoretical**

One of the most prevalent destructive characteristics of PMDD is difficulty navigating intimate relationships, which often leads to one or both partners desiring the end of the relationship, indicating a significant decrease in relationship experience. When relationship issues arise in conjunction with PMDD symptoms, individuals often act out of character by saying and doing things that damage their relationship and their PMDD partner. PMDD hinders women's ability to maintain a healthy level of cognition which causes them to struggle with memory and controlling emotional behaviors (Meza-Moreno & Itzel, 2021). Once the PMDD symptoms arise, the behaviors associated with coping with the disorder tend to mirror a varying attachment style. These behaviors include disassociation, fear of intimacy, isolation, clinginess, the need for constant reassurance, and the need for emotional closeness. Although each woman's symptoms during PMDD may vary, the most common symptoms are fatigue, depression, anxiety, suicidal ideations, confusion, forgetfulness, irritability, weight, and appetite changes (Eldeeb et al., 2021).

### **Social**

The symptoms that PMDD sufferers experience may inadvertently result in damaging actions toward their partners. The PMDD sufferer's most common harmful actions toward their partner include blaming, shaming, isolating, rejecting, and abandoning, which can cause a shift from a secure attachment style into an avoidant anxious one. The anxious attachment style in PMDD partners may appear as a fear of losing their partner, leading to relationship conflict, self-shaming, self-doubt, and insecurities (Cheche & Jackson, 2021). The inability to regulate the

attachment style during PMDD may lead to immense damage to the PMDD partners' relationship experience, which can leave the PMDD partners vulnerable to experiencing the aftermath of an avoidant or anxious attachment style monthly.

### **Situation to Self**

I am an individual who suffers from PMDD, and within my marriage, I see firsthand the damage that PMDD can have on the intimate relationship. My PMDD partner is my husband, who has experienced significant distress, which has impacted his overall relationship experience due to my diagnosis. Because the symptoms of PMDD are cyclic and monthly, my partner's relationship experience and attachment style varies. When the PMDD symptoms are present, his relationship experience decreases, yet when the PMDD symptoms are gone, his relationship experience improves.

The fluctuation of emotional distress over the years has impacted my intimate relationship. Consequently, my PMDD partner developed monthly symptoms of anxiety, depression, isolation, neglect, and abandonment when my PMDD symptoms were present. In addition, his relationship attachment style would alternate between a secure attachment when my PMDD symptoms were not present into an insecure attachment during the onset of my PMDD symptoms, which propelled me to perform this research on the lived experience of partners of individuals who suffer with PMDD. The philosophical assumption I brought to my research was the ontological assumption describing the multiple realities of the various PMDD partners. Not all the PMDD partners have the same responses to their partner experiencing PMDD symptoms, and thus I intended to report their range of experiences.

### **Problem Statement**

The problem was that partners of individuals who suffer from PMDD could potentially incur cyclical attachment styles in intimate relationships, which may lead to suicidal ideations. The onset of PMDD symptoms causes an adverse reaction to the partner, often without them realizing it until the symptoms are gone. Rosen (2022) discussed the difficulty that PMDD sufferers face in an intimate relationship because of their symptoms, such as negative intrusive thoughts, low self-worth, irritability, insecurity, and isolation or clingy towards their partner. With the rise and fall of these PMDD symptoms monthly, the partners are left in distress and desire to end the relationship as a means of survival. As a result of the ongoing suffering of PMDD partners, they may reach a point of contention and begin to display suicidal ideations and behaviors.

### **Purpose Statement**

The purpose of this transcendental phenomenological study was to describe the relationship experiences of PMDD partners. The theories guiding this study are the interpersonal theory of suicide and the adult attachment theory. The adult attachment theory originated with John Bowlby (1969), who believed that the attachment styles adopted during childhood correlated with the partners' interactions in an intimate relationship. By exploring the relationship experiences of PMDD partners, one can better understand the struggles and cyclic chaos they endure while attempting to maintain an intimate relationship with a PMDD sufferer.

### **Significance of the Study**

The significance of this study was to provide PMDD partners with valued information on the causes of their cyclic attachment styles and the potential risk of suicide throughout each month in an intimate relationship with a PMDD sufferer. The difference between this study and

other studies was in the potential insight into the causes of the PMDD partner's potential cyclic attachment styles during the presence and absence of the PMDD symptoms and the risk of suicide for the PMDD partners. With this knowledge and insight, tools for navigating an intimate relationship may become available for partners of those suffering from PMDD. This study describes the experience of cyclic attachment styles and the risk of suicide of the partners of individuals in an intimate relationship with a PMDD sufferer.

Once the PMDD partner experiences a shift in their intimate relationship due to the PMDD sufferers' monthly PMDD symptoms, their relationship attachment with their partner is affected (Wagner et al., 2020). Attachment anxiety was described as how the individual becomes engulfed in self-doubt and fear of abandonment and subsequently losing their partner (Sisi et al., 2021). In contrast, if the PMDD partner does not feel safe in the relationship due to the fluctuations of the emotional reactions of their partner, they may choose the alternate route of adopting an avoidant attachment style as a means of survival within the relationship. An avoidant attachment within a relationship indicates a level of distance and mistrust, resulting in the partner creating an atmosphere of independence and increased individuality. Intimate relationships predict increased mental health and life experience, yet if the presence of PMDD diminishes the effectiveness of this notion, many PMDD partners' lives will continue to be adversely affected.

PMDD is prevalent in one in twenty women worldwide, and how a PMDD partner navigates their relationship will significantly impact their mental, physical, and emotional well-being (Arikewuyo et al., 2020). In addition, the lack of a baseline understanding of the causes of their cyclic attachment style is often the cause of suffering and hopelessness that PMDD partners may face (Heshmati et al., 2022). With a deeper understanding, PMDD partners can equip

themselves with the knowledge and tools to maintain and thrive in an intimate relationship with a PMDD sufferer.

### **Research Questions**

This study described the in-depth experiences of the partners of individuals suffering from PMDD. Utilizing the interview questions, the researcher will examine the cyclic attachment style that exists during the luteal phase of the menstrual cycle in comparison to the attachment style once the PMDD symptoms have departed.

**RQ1:** What are the relationship experiences of the PMDD partners?

The challenges of each PMDD partner vary; therefore, the researcher explored the differences and garnered a common theme among them to gain insight into their experiences (Ordway et al., 2020).

**SQ1:** How do PMDD partners describe their potential cyclic attachment styles within their relationship with PMDD sufferers?

The attachment styles of PMDD partners change once the PMDD sufferer experiences PMDD symptoms, and as a result, the PMDD partner experiences an array of vicarious emotional, mental, and physical symptoms (Simpson & Rholes, 2017). This inquiry explored the symptoms the PMDD partners experience during the shift into PMDD in conjunction with their altered attachment style towards the PMDD sufferer.

**SQ2:** How do PMDD partners discover that their relationship experience with a PMDD sufferer can potentially place them at risk for suicide?

The relationship experiences of the PMDD partners can encompass behaviors that leave them susceptible to suicidal ideations with the dysregulated emotions and stress of the vicarious

symptoms they experience by being a partner of a PMDD sufferer (Righetti & Visserman, 2018). This question delved into the mindset, emotions, and behaviors associated with suicide.

### **Definitions**

1. *Premenstrual Dysphoric Disorder (PMDD)* - is characterized by significant emotional, physical, and behavioral distress during the late luteal phase that remits after menses onset (Beddig et al., 2019).
2. *Premenstrual Dysphoric Disorder Partner* – is an individual in an intimate relationship with someone with PMDD (Kazan et al., 2016).
3. *Premenstrual Dysphoric Disorder Sufferer* – is an individual suffering from PMDD (Ussher, 2003).
4. *Adult Attachment Theory* - the way an individual connects with their intimate partner in a relationship (Burke et al., 2016).
5. *Luteal Phase* - begins after ovulation and ends at the onset of menstruation (Van der Linden et al., 2015).
6. *Follicular Phase* - begins on the day of menstruation and ends at ovulation (Lacovides & Baker, 2014).

### **Summary**

PMDD is a devastating disorder to live with, and its impacts on the partners within an intimate relationship can be daunting. Reid and Soares (2018) caution individuals not to underestimate the debilitating nature of PMDD and the burden this causes mentally, physically, and emotionally for all parties involved. A PMDD partner instinctively desires to help alleviate the sufferer's symptoms, which is impossible because there is no cure. Researchers disagree regarding the etiology of PMDD, and research denotes clinically relevant biopsychosocial factors

contributing to premenstrual dysphoria and possible treatment (Giulio & Reissing, 2006). In addition to feeling helpless, PMDD partners frequently face mental and emotional abuse through no fault of their own except for the decision to be in a relationship with an individual suffering from PMDD. A PMDD partner experiencing a cyclic attachment style within their relationship can experience havoc in every area of their lives, and it can be devastating because there are days within the month whereby the PMDD symptoms are not present, and they get a glimpse into the relationship that they desire and deserve. There is much to be noted about the suffering of individuals with PMDD; the PMDD partners also suffer and are adversely impacted.

## **Chapter Two: Literature Review**

### **Overview**

This literature review identified the theoretical framework this research study is based upon and included an in-depth review of PMDD partners' relationship experiences. The PMDD classification has a basis in physical and emotional symptoms (Sun et al., 2023). The theories guiding this study were the interpersonal theory of suicide and the adult attachment theory. The interpersonal theory of suicide was chosen because it gave insight into the severity of the relationship experiences of PMDD partners. The adult attachment theory established by John Bowlby defines how an attachment style can influence the well-being of an individual within an intimate relationship. Instead of the fluctuations in moods and behaviors as PMDD symptoms rise and fall, the PMDD partner's attachment styles may be adversely affected. This chapter was designed to describe the relationship experiences of partners of individuals suffering from PMDD by exploring a conceptual framework in conjunction with supporting related literature.

### **Theoretical Framework**

The theoretical framework of this study consisted of the interpersonal theory of suicide and the adult attachment theory. Bowlby's attachment theory was initially utilized to treat children and has more recently been applied to adults (Bettmann, 2006). The interpersonal theory of suicide suggests that suicidal behaviors and desires occur when an individual experiences the feeling of being a burden and when their need for connectedness is unmet. The adult attachment theory impacts how an individual is attached to their partner within the intimate relationship.

## **The Interpersonal Theory of Suicide**

The interpersonal theory of suicide is a psychological framework that explains the factors contributing to suicidal ideation and behavior. Thomas Joiner, a leading researcher in suicidology, developed the interpersonal theory of suicide (Mandracchia et al., 2014). This theory proposes that a mix of foiled belongingness and despair can be dangerous and is a hazardous forecaster of someone's likelihood of suicide (Tucker et al., 2018). This theory suggests that three key factors must be present for an individual to have a heightened risk of suicidal behavior: thwarted belongingness, perceived burdensomeness, and acquired capability for suicide. The interpersonal theory of suicide suggests that when all three factors are present simultaneously, an individual is at a higher risk of attempting suicide (Preece et al., 2020). It emphasizes the importance of social connectedness, reducing burdensomeness, and addressing acquired capability through intervention and support. According to the interpersonal theory of suicide, the intersection of these three factors creates a heightened risk for suicidal ideation and behavior.

Smith and Cukrowicz (2010) noted that an acquired capability for suicide indicates an ability to endure physical discomfort to the point that one's self-preservation instincts are incapable of preventing an individual's suicidal actions. PMDD partners experiencing both thwarted belongingness and perceived burdensomeness may develop a desire for suicide, driven by the belief that death will resolve their feelings of isolation and burdensomeness. The acquired capability for suicide is a critical bridge between suicidal desire and engagement in suicidal behavior. Individuals with highly acquired capabilities are thought to be more likely to act on their suicidal thoughts because they have become desensitized to the fear of dying.

### ***Thwarted Belongingness***

Thwarted belongingness is a critical component of the interpersonal theory of suicide, emphasizing the profound impact of social connectedness on an individual's risk of suicidal ideation and behavior (Ringer & Anestis, 2017). Two dynamic constructs within the interpersonal theory of suicide are thwarted belongingness and perceived burdensomeness (Kyron et al., 2019). Thwarted belongingness refers to the subjective experience of feeling disconnected, isolated, or lacking a sense of belonging and social support from others. When individuals perceive a significant gap between their desired level of social connection and their actual level of social integration, it can lead to feelings of loneliness, alienation, and despair. The absence of meaningful relationships and a sense of belonging can contribute to a heightened sense of emotional distress and hopelessness. The feeling of being disconnected and isolated can erode an individual's resilience and increase vulnerability to suicidal thoughts.

Thwarted belongingness refers to a subjective experience of feeling disconnected, isolated, or lacking social support from others and the individual's perception of lacking a meaningful connection or belonging (O'Keefe et al., 2015). These individuals may experience feelings of loneliness, social isolation, and a sense of being disconnected from important social groups or relationships. When individuals perceive a significant gap between their desired level of social connection and their actual level of social integration, it can lead to feelings of loneliness, alienation, and a diminished sense of purpose. Thwarted belongingness contributes to individuals' desire to belong and relate to others.

### ***Perceived Burdensomeness***

Perceived burdensomeness is a significant factor in the interpersonal theory of suicide, revealing the psychological experience of feeling like a burden to others (Kim et al., 2019). It refers to an individual's belief that their presence or existence imposes hardships, difficulties, or

distress on their loved ones or society. This factor involves the belief that individuals hold about themselves being a burden to others. They felt that their existence is causing harm or inconvenience to those around them and that the world would be better off without them.

When individuals perceive themselves as burdensome, they may internalize a sense of guilt, shame, or self-blame. These perceptions can arise from a range of factors, such as mental health struggles, physical limitations, financial stress, or a perceived inability to meet the expectations and needs of others. The weight of this burden can intensify feelings of hopelessness and worthlessness and contribute to the risk of suicidal ideation.

Individuals with perceived burdensomeness may perceive themselves as useless, causing distress or inconveniencing their loved ones. The feeling of being a burden can intensify over time and increase the risk of suicidal ideation. Perceived burdensomeness refers to an individual's belief or subjective perception that their existence or presence in the lives of others imposes hardships, difficulties, or adverse consequences on those around them. It is a cognitive appraisal where individuals perceive themselves as a burden on their loved ones, society, or the world.

People experiencing perceived burdensomeness believe that their problems, needs, or emotional struggles create significant distress or inconvenience for others. They felt guilty, ashamed, or responsible for the burdens they believe they impose on others, leading to a diminished sense of self-worth and a negative view of their impact on relationships and society. Perceived burdensomeness is commonly associated with mental health issues like depression, anxiety, or suicidal ideation. The belief that one is a burden can contribute to feelings of hopelessness and despair, and individuals may see suicide to relieve others from the perceived burden they believe they represent.

### *Acquired Capability for Suicide*

Suicide is the prominent source of death in the United States, thus making it a public health issue that impacts the family, individuals, and communities where they reside. Approximately 46,000 individuals died because of suicide in 2020, 12.2 million seriously considered suicide, 3.2 million individuals had a suicide plan, and 1.2 million attempted the act of suicide, which equates to one death by suicide every 12 minutes (*Suicide prevention, 2022*). The prevalence of suicide-related behaviors creates an impactful burden on public health as it relates to the mental health considerations of others. This component differentiates individuals who have suicidal thoughts and those who engage in suicidal behavior. According to the interpersonal theory of suicide, acquired capability for suicide develops through gradual desensitization to physical pain and fear of death, resulting from repeated exposure to painful or fear-inducing experiences, such as self-harm or traumatic events, reducing the natural aversion to self-destructive behavior (Smith & Cukrowicz, 2010). This factor addresses the development of an individual's tolerance for pain and fear of death, making them more likely to engage in suicidal behavior. It is believed that repeated exposure to painful or life-threatening experiences, such as self-harm or risky behaviors, may desensitize an individual to the fear and pain associated with suicide, reducing their fear of death and increasing the likelihood of acting on suicidal thoughts.

Hopelessness is characterized as the emotions associated with the negative expectation of one's future (Hoh & Ismail, 2020). The feeling of hopelessness in an intimate relationship can be crippling. Hopelessness as a predictor of suicidal ideations is prevalent in individuals with a depressive disorder (Baryshnikov et al., 2020). In an intimate relationship, significant others seek

to improve the life of their partners, and the inability to do so can be torturous. Hopelessness in an intimate relationship can affect the nervous system of the partners as they navigate the physical and emotional burden of the emotions (Luca et al., 2019). Each month as the PMDD symptoms commence within their partner and they experience the shift in attachment styles, emotional, mental, physical, and behavioral patterns, their hope of relationship experience can be diminished.

### **Adult Attachment Theory**

John Bowlby (1969) developed the adult attachment theory, which established that individuals' attachment styles are developed in childhood and translated into adulthood in relationships. This theory proposes that the construct of attachment to one's partner is based upon the mindset developed as a child, which resonates with the cause-and-effect basis of what a significant other expects in any situation (Campbell & Stanton, 2019). For example, if a partner with a secure attachment style is in turmoil, one may initially seek to solve the problem independently and proceed by asking for assistance as needed. In contrast, an individual with an anxious attachment style will immediately cling to their partner in times of distress, and the avoidant attachment style will eliminate connection as a means of survival.

The adult attachment theory is primarily based on the idea that how one behaves in adult relationships is intricately linked to the attachment style developed during childhood (*How Attachment Styles*, 2022). As a child develops and views intimate relationships, they inadvertently begin to form what they consider normal. Emotions of attachment from childhood are directly correlated to the intimate relationships developed in adulthood. What was lacking in attachment during childhood will leave a void when the adult attempts to enter an intimate relationship. The adult attachment theory consists of secure attachment, anxious attachment,

dismissive avoidant attachment, and fearful avoidant attachment. The two primary attachment styles of avoidance and anxiety were linked to decreased relationship experience in emotional, sexual, and overall fulfillment (Moors et al., 2019). It is possible to alter one's attachment style based on the behavioral patterns of one's partner. When an adult is in conflict within their intimate relationship, they will resort to resolution and communication methods they viewed as a child, such as avoiding or actively engaging in conflict (McNelis & Segrin, 2019). The adult attachment theory identifies how an individual relates to and depends on others in an intimate relationship. The adult attachment theory inevitably shapes how individuals connect and interact with their partners in various scenarios.

### ***Dismissive Avoidant Attachment***

The dismissive-avoidant form of attachment is built upon the individual's independence and is not connected within the realms of the intimate relationship (Carvallo et al., 2006). Individuals who possess this attachment style crave independence more than being connected to others, which can be perceived as a means of avoiding connection and attachment. These individuals are most comfortable with themselves rather than being intertwined with another (Spence et al., 2020). When individuals possess this form of attachment, they inadvertently avoid connections based on an intimate and emotional level. Closeness to others brings them fear, and they avoid connecting with others to escape those uncomfortable emotions. These individuals may seem distant and preoccupied with their hobbies and interests, tend not to prioritize relationships, and often claim they are not ready to commit.

Intimate relationships are typically avoided with a dismissive avoidant attachment because the individual's primary focus is not to depend on others. According to attachment theory scholars, the security of providing an individual's sensitivity to another's needs is

foundational to their well-being, and those needs endure for one's entire lifetime (Dinero et al., 2008). With these attachment styles, the risk of failure and disappointment outweighs the benefits of a secure, attached, intimate relationship. The safest measure within this individual's view is to be alone; thus, they adopt an intensely independent lifestyle that minimally relies on the actions or emotions of another. The lack of dependence provides a haven for these individuals, as their worse fear is to depend on another and to be let down by unmet expectations.

### ***Fearful Avoidant Attachment***

The fearful-avoidant attachment style is a compilation of avoidance in conjunction with an anxious attachment (Besharat et al., 2014). This attachment style has a solid aversion to intimacy because individuals fear rejection. These individuals maintain a significant distance from their loved ones due to a lack of trust to protect themselves (Arianfar et al., 2022). Individuals with this attachment style see intimacy as a loss of independence. Since they see dependence or needing others as a weakness, they subconsciously find fault in their relationships. Avoidants want to be close to others but push potential intimate partners away to protect themselves. They often desire an intimate relationship yet fear what it entails simultaneously, which stems from a deep desire for an intimate relationship and the fear that they will be hurt or damaged (Reis & Grenyer 2004). Overall, fearful-avoidant attachment is associated with being isolated and emotionally distant.

### ***Anxious Attachment***

The anxious attachment style comprises individuals who crave physical and emotional closeness (Byrow et al., 2016). These individuals often worry that they will not be supported, have an intense need for validation and approval, and maintain a deep-rooted fear of

abandonment (Japutra et al., 2018). In intimate relationships, individuals fear they are not good enough and often worry about being betrayed or left by their partner. Being pushed away by their partner can make these people more anxious and increase their clinginess. This attachment style is one in which trust and jealousy issues reside in an intimate relationship, primarily because anxiously attached partners tend to be pessimistic and have an insatiable need for reassurance (Smyth et al., 2015). A lack of security and trust is embedded in their partner; consequently, they need consistent validation and reassurance within the relationship. Anxious attachment in individuals may push their partners away by being too possessive due to their insecure nature and fear of abandonment.

### ***Insecure Attachments***

The three types of insecure attachments are the dismissive-avoidant, fearful-avoidant, and anxious attachment styles. Many challenges are found within these insecure attachment styles, primarily in intimate relationships (Jinyao et al., 2012). Jealousy is most common among insecurely attached partners in an intimate relationship (Wegner et al., 2018). The inability to regulate emotions enough to enable secure responses to conflict is an issue among partners. Emotional dysregulation can be presented as being emotionally unavailable with the avoidant attachment style and displaying a lack of self-worth with the anxious attachment style. Communication and conflict remain difficult in an intimate relationship with an insecurely attached partner.

Some of the primary detrimental factors for an insecure attachment in an intimate relationship are the presence of aggression once emotions arise and the inability to regulate the intense emotions healthily (Miga et al., 2010). The dismissive-avoidant and fearful-avoidant attachment styles tend to disconnect emotionally from their partner out of fear of the emotional

turmoil within the relationship, leaving their partner in distress with the lack of knowledge of the current state of their relationship. In contrast, the anxious attachment styles communicate in a way that propels their intense desire to connect in ways that exhibit a needy, forceful, and anxiety-filled manner (Davies et al., 2009). Both communication styles of the insecure attachment styles cause immense damage because they do not lead to the healthy and safe processing of emotions.

PMDD partners have the unique experience of having a partner whose attachment style may shift from secure during the follicular phase when PMDD symptoms are not present into an insecure attachment style during the luteal phase when the PMDD symptoms are most prevalent (Sun et al., 2023). PMDD sufferers can shift into an insecure attachment style with the presence of PMDD, primarily based on their management of emotions in conjunction with the emotional, mental, and physical symptoms that they are experiencing. How PMDD sufferers cope with their symptoms will determine how they attach to their partners (Juang, 2021). Consequently, as PMDD sufferers' attachment styles change, so does the PMDD partners' attachment style to adjust to the shift in emotional connection within the relationship. This shift can be done in an unhealthy manner with the insecure attachment styles as the PMDD partner may become fearful-avoidant or dismissive-avoidant to protect themselves from the harmful emotions of experiencing their partner navigate the PMDD symptoms (Holmberg et al., 2010). In contrast, the PMDD partner may become anxiously attached to the sufferer out of fear of losing them. The worst fear for an anxiously attached partner is losing their emotional connection. The means of the anxiously attached partner reestablishing the emotional connection may be inadvertently done in a harmful manner of force or manipulation.

### ***Secure Attachment***

A secure attachment indicates that the partner in the relationship is trusting and open within the partnership, able to confidently articulate their needs and desires and receive that same information from their partner. Within this attachment style, an individual feels worthy of love and connected to the source of it within another individual (Zortea et al., 2021). People with this attachment style are comfortable with intimacy. They are dependable, trustworthy, and consistent partners who know how to communicate expectations and respond to what their partner needs. A secure attachment style leads to an overall relationship experience versus the anxious or avoidant attachment styles (Šlosáriková, 2021). A secure attachment style is a crucial indicator of overall relationship experience. This attachment style indicates that the individual has a positive image of themselves and their worth. Inevitably, this was created by their mothers' ability to create a childhood attachment of emotional security and safety in their most formative years (Vaughn et al., 2016). Within this form of attachment, the individual is comfortable openly asking for the help they need and being available to support others. Secure attachment styles enable individuals to feel confident and thrive in healthy, close relationships. The secure attachment style indicates greater happiness and experience within intimate relationships.

A secure attachment style is ideal for PMDD partners as they navigate the caretaker role in their relationship with the PMDD sufferer (Righetti et al., 2020). These individuals confidently rely on others for assistance when needed and do not hesitate to reach out for help while maintaining boundaries (Fraley & Roisman, 2019). As the PMDD partner tends to the sufferer's emotional, physical, and mental needs, the desire for closeness and boundaries with personal space are solidified with a secure attachment style. As the needs, desires, and behavioral patterns of the PMDD sufferer shift with the presence of PMDD, the PMDD partner can feel secure in the validity of their intimate relationship despite the fluctuations (Salzman et al., 2013).

The caregiver's sensitivity to another's needs is vital for well-being and emotional health (Roisman, 2009). Knowing that the changes experienced within PMDD do not define the emotional connectedness of their relationship may enhance the sense of emotional security and the attachment style of the PMDD partner. The healthy balance of being emotionally connected during the luteal and follicular phases may contribute to the relationship fulfillment of the PMDD partner.

## **Related Literature**

### **Premenstrual Dysphoric Disorder**

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), PMDD is an incapacitating disorder with symptoms that occur on a cyclic basis, which stem from the natural fluctuations of hormones during the luteal phase of menstruation and subside during the onset of menstruation (American Psychiatric Association [APA], 2022). Once PMDD is present during the luteal phase of menstruation, the sufferer experiences many symptoms, such as anxiety, depression, anger, mood fluctuations, fatigue, feelings of increased stress, insomnia, or hypersomnia (Pearlstein, 2014). PMDD affects 1.8% to 5% of women of childbearing age for one-third of every month and is classified as a depressive disorder with no cure and no identifiable cause for its existence to date (Kugathas & Kulkarni, 2022). This disorder exudes mental, emotional, and physical symptoms that last approximately 14 days out of the month. The quality of life of a PMDD sufferer decreases due to the vast amount of time spent afflicted with the symptoms associated with the disorder (Victor et al., 2019).

Maintaining intimate relationships while having the diagnosis of PMDD comes with many barriers to the foundational aspects of a relationship, such as intimacy, trust, compassion, communication, emotional regulation, and the ability to navigate conflict (Wikman et al., 2019).

PMDD partners face the vigorous tasks of enduring the emotionally abusive treatment associated with being intimately connected to a PMDD sufferer and processing the vicarious symptoms they develop. Breaux et al. (2000) noted the evidence that PMDD sufferers might develop Major Depressive Disorder, which leads to distress for PMDD sufferers because, within this phenomenon, there is no cure for PMDD. The treatment options for PMDD sufferers include Cognitive Behavioral Therapy, exercise, anti-depressants, and an oophorectomy, which removes one or more ovaries (Ciccone et al., 2022). The treatment options vary as each PMDD sufferer reacts to the treatments differently when the symptoms are present; thus, the effects are fleeting. The goal of treatment is to reduce the suffering associated with having PMDD and cope with the fluctuations of symptoms for half of every month, yet it does not eliminate the disorder.

PMDD is not widely known, yet it impacts approximately one in 20 women of childbearing age worldwide, with 1.8% to 5% of women within their child-bearing years being impacted by PMDD (Comasco et al., 2021). PMDD was integrated into the *International Classification of Diseases 11th Revision* on January 1, 2022 (Schroll et al., 2022). This addition brought much controversy as PMDD is commonly mistaken for other mental disorders, such as bipolar disorder, anxiety, and depression. The gateway to defining the presence of PMDD is the timeline in which the symptoms present themselves in the luteal phase of menstruation in conjunction with the timeframe in which the symptoms subside during the follicular phase of menstruation (Pearlstein, 2004). This timeline of the monthly rise and fall of distressing symptoms within the menstrual cycle distinguishes PMDD and other mental disorders within the *DSM-5-TR* (2022).

Premenstrual Dysphoric Disorder has recently been introduced within the *DSM-5* (APA, 2022). Over the years, there has been much debate regarding the relevance and placement of

PMDD within the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Classification of Diseases*. The process by which a disorder can be added to the *DSM* is by defining its characteristics with documented data within peer reviews in conjunction with collaboration with the APA. PMDD was added to the *DSM-5* in 2013 and identified as a depressive disorder; however, its addition did not come without speculation and suspicion regarding its validity. According to the APA (2000), adding a mental disorder to the *DSM* includes the following steps: peer reviews, conferences and workshops, semiannual newsletters, and communication with the APA and non-APA affiliated organizations.

The overall symptoms of PMDD and the timeframe in which they occur vary with each individual. Hamidovich et al. (2023) noted that PMDD sufferers' hormone levels are unrelated to the condition's causation. Although commonly miscategorized as PMS, PMDD is far more severe and has debilitating effects on the individual's quality of life with normal functioning, work, and relationships. PMDD is vastly different from PMS in severity and its effect on one's mortality (Petersen et al., 2019). The timing of the PMDD symptoms and their specific pairing differentiates it from PMS. According to the *DSM-5*, women must have five mental, physical, and emotional symptoms that alter functional impairment, such as mood changes, anger, and irritability (APA, 2022). This criterion is imperative as it is the primary distinguishing factor between PMDD and other disorders.

Self-reporting through the tracking of symptoms is the basis for diagnosing PMDD (Slyepchenko et al., 2021). The diagnosis of PMDD is made primarily by self-reporting, where the individual tracks their symptoms and records when they arrive and when they are no longer present. Petersen et al. (2017) noted that PMDD sufferers often present with low pre or postcentral gyrus activation, and low dorsolateral prefrontal cortical activity was observed when

the PMDD sufferer completed emotion regulation task within the symptomatic phase of the menstrual cycle. Because PMDD is not a hormonal imbalance, assessing an individual's hormones will not be an effective way of identifying the diagnosis of PMDD. It is important to note that the diagnosis of PMDD does not indicate the individual's hormone levels are unbalanced; instead, the abnormal response to the natural fluctuations of hormones during their menstrual cycle produces the symptoms (Rubinow, 2021). An individual's hormone levels can be considered normal with a diagnosis of PMDD. PMDD's origin is unknown, and it remains an area of research that is borderline untouched (Hardy & Hardie, 2017).

The exact cause of PMDD is not fully understood, but it is believed to be a complex interplay of biological, genetic, hormonal, and environmental factors. Some potential causes and contributing factors are hormone fluctuations, particularly estrogen and progesterone, which are believed to play a significant role in PMDD. These hormonal changes can affect neurotransmitters in the brain, such as serotonin, which regulate mood. Serotonin is a neurotransmitter that plays a crucial role in mood regulation. Kaminsky et al. (2023) examined the biomarkers for PMDD related to the selective serotonin reuptake inhibitor response. Lower serotonin levels during the premenstrual phase may contribute to the emotional and physical symptoms experienced in PMDD. There appears to be a genetic component to PMDD. If one has a family history of PMDD or mood disorders, like depression and anxiety, they may have an increased risk of developing PMDD (Kamat et al., 2019). Some women with PMDD may have increased sensitivity to the regular hormonal changes during the menstrual cycle, leading to more pronounced symptoms. High-stress levels and lifestyle factors, such as poor diet and lack of exercise, can exacerbate PMDD symptoms. A serotonin dysfunction, resulting in impulsivity, may be a possible mechanism of PMDD (Walderhaug et al., 2002). Aside from serotonin, other

neurotransmitters, like dopamine and gamma-aminobutyric acid, are also thought to be involved in PMDD.

## **Menstrual Cycle**

Every month between puberty and menopause, a woman experiences phases in preparation for an impending pregnancy. These phases encompass the menstrual cycle, including four stages: menstruation, follicular phase, ovulation phase, and the luteal phase (Draper et al., 2018). Menstruation is an expected and healthy event in fertile women, yet it is not absent of debilitating physical, mental, and emotional symptoms throughout the weeks leading up to menstruation (Slavin et al., 2017). These symptoms are experienced in numerous ways depending on the individual experiencing them monthly, as each body reacts differently to the rise and fall of hormones throughout a regular menstrual cycle.

The menstrual cycle has four phases (Baker & Lee, 2022). During the menstrual phase, days one through seven, an egg develops and is released through the ovaries. In the follicular phase, days eight to 13, the lining of the uterus begins to build up. During the ovulation phase, day 14, the egg is released. Within the luteal phase, days 15-28, the egg is preparing to implant in the event of pregnancy. These days can fluctuate because some women have longer or irregular menstruation. PMDD indicates that the normal fluctuation of hormones during the menstrual cycle causes alterations in the central neurotransmitters, which change the women's mood and behaviors (Hantsoo & Epperson, 2015). These monthly cyclic changes in moods and behaviors contribute to a decreased quality of life for PMDD sufferers.

### ***Menstruation Phase***

The menstruation phase is the first phase of the menstrual cycle when the woman's period commences and is an indication that the egg from the previous menstrual cycle was not

fertilized, and the cycle continues (Critchley et al., 2020). Menstruation propels the progesterone and estrogen levels to drop. Progesterone is responsible for the regulation of menstruation and aids the body in the case that a pregnancy occurs. Progesterone is created within the corpus luteum of the ovaries and is a transitory gland formed once the egg is discharged from the ovary. Estrogen is a hormone that supports the lining of the women's uterus in the event of pregnancy. Once these hormone levels drop, the uterus lining that was previously thickened and is no longer necessary now that pregnancy has not occurred is shed through the vagina. Fertile women have a four-staged menstrual cycle as part of fertilization and implantation (Omorogiuwa & Egbeluya, 2015). This menstrual process releases mucus, blood, and tissue from the women's uterus.

### ***Follicular Phase***

The follicular phase, also known as the pre-ovulatory phase, is when menstruation has started; thus, it exists in conjunction with the menstrual phase during days one to 13 of the menstrual cycle before the ovulation phase. With the initiation of this phase, the hypothalamus directs a signal to the women's pituitary gland to deliver the follicle-stimulating hormone (Montero-Lopez et al., 2018). The hypothalamus is a part of the brain that balances the nervous system by receiving messages that regulate the body and keep it in homeostasis. The hypothalamus signals the pituitary gland to create the follicle-stimulating hormone, which stimulates a woman's ovaries to create tiny sacs called follicles (Petrofsky, 2015). Within each follicle, there is an immature egg. Over time, one egg will mature, and the remainder will be absorbed within the body. The egg that does mature ignites an increase in estrogen, which thickens the uterus lining. This process is intended to enable an environment for an embryo to grow, resulting in pregnancy. The standard duration for the follicular phase is 16 days and can last from 11 to 27 days (Wang et al., 2019).

Once a woman enters the follicular phase, the PMDD symptoms will fade away until they are non-existent for the duration of this phase (Reed et al., 2008). During the follicular phase, the nature of the intimate relationship is primarily founded on a secure attachment, as there are no symptoms of PMDD. Without the PMDD symptoms, the PMDD partner and sufferer can resume the normality of an intimate relationship, increasing the relationship experience.

### ***Luteal Phase***

The luteal phase occurs at the end of ovulation and continues until the onset of menstruation, with fluctuations in behaviors, moods, and physical symptoms (Petersen et al., 2019). The luteal phase is when the PMDD symptoms arise, and PMDD partners inadvertently experience the most distress. The PMDD sufferer's difficulty is managing the PMDD symptoms and navigating an intimate relationship. The PMDD sufferers' inability to regulate the intense emotions associated with PMDD causes severe conflict within the relationship (Dawson et al., 2018). During this time, the PMDD sufferer shifts into either an avoidant or an anxious attachment style that differs from their attachment level when the PMDD symptoms are absent. In response to this shifting of attachment styles, the PMDD partner may alter their attachment once they encounter negative cognitive behaviors during the luteal phase (Abril-Parreño et al., 2022).

The symptoms of PMDD during the luteal phase that affect relationship experience are emotional changes, such as anger, depressed mood, disinterest in everyday activities, fatigue, irritability, forgetfulness, and lethargy. There is a cyclical pattern of cognitive and physical symptoms, including fatigue, insomnia, and inattention (Lin et al., 2021). The physical symptoms that affect intimate relationships are weight gain, muscle aches, and tension. To

effectively diagnose an individual, at least five of the above symptoms must occur during the luteal phase and subside during the onset of menstruation (Reid & Soares, 2018). The PMDD sufferer is often extremely limited by these symptoms (Yamada & Kamagata, 2020). Much of life is based on diminishing hopes for an intimate relationship.

### ***Ovulation Phase***

Ovulation takes place on the fourteenth day of a woman's menstrual cycle. Initially, this phase occurs when the hypothalamus releases the gonadotropin-releasing hormone. Once this hormone is released, the woman's brain's pituitary gland produces the follicle-stimulating and luteinizing hormones (Reid & Soares, 2018). During ovulation, a woman's ovary releases an egg that travels down the fallopian tube in anticipation of being fertilized by sperm. After the egg's release, the hormone progesterone increases in preparation for pregnancy.

Once ovulation has occurred, the beginning of the PMDD symptoms is triggered. This sudden shift in hormones causes PMDD sufferers to experience an array of symptoms, such as depression, anxiety, insomnia or hypersomnia, anger, increased stress, and overall negative changes in their mood (Bougain, 2001). During this time, the shift into PMDD begins to impact the intimate relationship because the PMDD partner experiences a change in the overall nature of their partner. The timeframe in which the PMDD symptoms arise after ovulation is the determining nature of the presence of this disorder (Rubinow, 2021). The negative changes within the intimate relationship vary because each woman reacts differently to their PMDD symptoms within the relationship.

### **Premenstrual Dysphoric Disorder Partner**

A PMDD partner is categorized as an individual in an intimate relationship with a PMDD sufferer. Although the partners do not have the PMDD symptoms themselves, they suffer an

array of mental and emotional anguish as they attempt to navigate an intimate relationship with an individual suffering from PMDD (Bond et al., 2003). Managing an intimate relationship with a PMDD sufferer includes months of frustration, stress, and confusion in navigating the relationship in the best way possible. The relationship's survival can be placed on the PMDD partner's ability to react perfectly to the symptoms of the PMDD sufferers. Accepting flaws and mistakes may be met with emotional disappointment, criticism, contempt, and resentment for adding to the stress of the PMDD sufferer (Kappen et al., 2018).

Within the population of PMDD sufferers, PMDD partners are often not recognized for the mental and emotional turmoil they endure monthly to have an intimate relationship. It is often speculated that the cure for this period would be to avoid an intimate relationship with PMDD sufferers altogether (Gao et al., 2022). However, is this a reasonable solution when the PMDD sufferer is often exactly whom the PMDD partner desires for half of the month? An individual who bears the burden of caretaking for a partner who suffers from PMDD results in losing intimate relationships, difficulty concentrating at work, and overall declining mental health (Pearlstein & Steiner, 2008). The idealization of ending a relationship for what one must endure for half of the month causes the bulk of the mental anguish. PMDD is often identified within the aftermaths of a relationship commencing, and thus a great deal of these relationships involves family and commitments tied to one's sense of security. To abandon these things because of the presence of PMDD is not a viable option because it would lead to an even more significant manner of despair, such as divorce, single-parent families, childhood trauma for any offspring involved, and the potential guilt and regret that a termination of the relationship would cause (Esmaeili et al., 2011). Due to all these reasons, PMDD partners make the conscious choice each month to endure mental and emotional abuse in hopes that one day they can navigate

an intimate relationship with their PMDD sufferer without continuously suffering.

The helplessness involved with the PMDD partner's suffering is often one of the hardest things to bear (Akbari et al., 2022). They sit on the sidelines every month for approximately two weeks and watch their partner suffer from a disorder with no cure, medicine, or hope of leaving until the PMDD sufferer reaches menopause. This disorder is often diagnosed in young patients because PMDD can occur as soon as a female menstruates, which could be as young as nine years old (Bixo et al., 2018). PMDD takes approximately 70% of a woman's adulthood during the time in which an intimate relationship occurs (Delara et al., 2012). If the couple decides to initiate the route of an oophorectomy which removes the ovaries and is the critical factor in producing the PMDD symptoms, the PMDD sufferers are then subjected to giving up the hopes of having children. The emotional trauma the PMDD partner would have to live with because of that decision is another type of distress.

### **The Four Horsemen of the Apocalypse**

The four horsemen of the apocalypse, a concept by Dr. John Gottman (1999), is illustrated as a predictor of relationship experience and is inclusive of the four destructive behaviors of criticism, contempt, defensiveness, and stonewalling (Beeney et al., 2019). The four horseman of the apocalypse encompasses the four main characteristics a PMDD sufferer can display to the PMDD partner monthly during the luteal phase of menstruation when PMDD symptoms are present, impacting their relationship experience. All four of these behaviors are central factors in the relationship experience of PMDD partners, primarily when PMDD symptoms are present (Holman & Jarvis, 2003). When in an intimate relationship, a partner feeling as if they are being attacked may resort to becoming dismissive and defensive as a coping mechanism. Although these behaviors are detrimental to an intimate relationship, they are often

used to gain a sense of control during conflict.

### ***Stonewalling***

Stonewalling is synonymous with an avoidant attachment style when PMDD symptoms are present (Belo et al., 2017). The tactic is used as a means of disassociating from the PMDD symptoms. When a PMDD sufferer reflects the stonewalling technique, it may appear in neglect, avoiding interaction with the other partner, or remaining engulfed in activities that deter their attention away from their partner (Beeney et al., 2019). Dissociation is a common coping mechanism for PMDD sufferers and partners as they tend to avoid the presence of PMDD in hopes that it will go away. Emotionally disengaging in communication or interaction with others damages the relationship (Kwan, 2020). Simultaneously, the PMDD partner may perceive their partner's avoidant demeanor and begin to develop an anxious attachment style and cling to their partner to gain a sense of a secure attachment. The combination of these cyclic avoidant and anxious attachment styles that the PMDD sufferer and partner develop during the luteal phase creates an elevated level of trauma, anxiety, and fear within the relationship.

### ***Criticism***

Criticism identifies flaws in an individual's character and focuses on them as a reflection of their true nature (Beeney et al., 2019). Criticism within an intimate relationship is considered damaging because it catalyzes intimacy and closeness (Song et al., 2022). Ideally, both partners are inclined to please the other within an intimate relationship, and criticism of the actions towards doing so causes strife within the relationship. Criticism is most frustrating as they are forced to interact with the persona of an individual to which they are not accustomed. PMDD sufferers' behaviors are often spontaneous, erratic, and unpredictable (Barker-Smith, 2020). The criticism stems from the PMDD sufferers' inability to manage their symptoms, so they lash out

with harmful words to the closest individual, often their partner.

### *Contempt*

Contempt often arises within the relationship once PMDD is present in the luteal phase, and the ego ascends. During this time, PMDD sufferers are engulfed in their symptoms and means of survival that they are no longer worried about their partner's emotional and mental needs compared to their own. The disrespectful gestures of contempt may be name-calling, blaming, or abrasive body language (Beeney et al., 2019). Actions that exhibit rage are often associated with this destructive behavior, such as the PMDD sufferer lashing out in uncontrollable anger while simultaneously saying hurtful and demeaning comments to their partner, often without cause or reason. Anger and rage are some of the primary symptoms that most damage relationships involving PMDD (Soyda et al., 2013).

Once the PMDD partners are subjected to continuous effects of contempt against them, they often react uncharacteristically in response to this form of abuse, which creates a cycle of damaging behavioral patterns within the relationship by both the PMDD sufferer and partner (Halpern-Meehin et al., 2013). In these cases, the PMDD partner often deals with a great deal of internal shame and regrets their behavior and inability to control their own emotions while being subjected to contempt, which leads to feelings of insecurity and criticism within themselves. The PMDD partner often feels that there is no solution to ending the emotional turmoil, and they may begin to entertain the notion of ending the relationship altogether (Dailey et al., 2020). Breaking up with the PMDD sufferer tends to be the most common solution in relationships involving PMDD because the PMDD partner's relationship experience continues to decrease and become unbearable (Olfiffe et al., 2022).

### *Defensiveness*

Defensiveness is typical for a PMDD partner who has developed an anxious attachment style because they need to continuously ensure that the PMDD sufferer knows their true intentions as they experience a great deal of discomfort by not being in emotional alignment and feeling accepted (Byrow et al., 2016). When a partner gets defensive during a disagreement, they often shift the blame to the other partner and neglect to take responsibility for their actions (Beeney et al., 2019). Often amid the frustration of dealing with their symptoms, the PMDD sufferer will blame their partner for various things to exonerate themselves from thinking that the fact that they have PMDD is all their fault. In these cases, the PMDD partner gets defensive and feels the need to protect themselves from their partner's allegations that their actions and behaviors directly correlate to their PMDD symptoms.

Overall, the four horseman of the apocalypse is an integral part of the overall relationship experience of PMDD partners (Mardani et al., 2021). The inability to manage conflict while PMDD symptoms are present is the root cause of how criticism, contempt, defensiveness, and stonewalling damage intimate relationships (Rueda et al., 2021). Without adequate emotional regulation, while enduring the stress caused by PMDD, the partners are inadvertently subjected to mental and emotional trauma induced by utilizing the four horsemen of the apocalypse behaviors, which include criticism, contempt, defensiveness, and stonewalling. Emotional regulation is severely lacking in women with PMDD, making the presence of the four horsemen of the apocalypse prevalent. Gottman (1999) remarked that criticism towards one's partner could predict divorce (Leggett et al., 2019). While examining the direct impact these behaviors have on PMDD partners, it is critical to note that over time this can become detrimental to their mental and emotional well-being.

## **Vicarious Trauma**

PMDD inadvertently causes the sufferer's attachment level to shift as the symptoms arise. Vicarious trauma results from secondhand trauma exposure and involves cognitive and affective changes (Pearlman et al., 2007). The PMDD partners' attachment styles experienced in a relationship with a PMDD sufferer are cyclic. Specifically, many partners experience a secure attachment style when PMDD is absent during the follicular phase; once PMDD arises, the PMDD partners' attachment styles can change to avoidant, anxious, or insecure. The reasoning behind the PMDD partners' attachment style fluctuations is explained by how the PMDD sufferers treat them during the onset and continuation of PMDD during the luteal phase (Marthur et al., 2020). During this time, the behavioral patterns of emotional and mental abuse trigger the PMDD partner to come out of their secure attachment within the relationship and retreat to one of avoidant, anxious, or insecure, and sometimes a compilation thereof. When stress and conflict arise in the relationship in conjunction with PMDD, the PMDD partner suffers primarily because of their capacity to deal with stress and conflict decreases during the luteal phase when PMDD is present (Girdler & Klatzkin, 2007). How the PMDD sufferer manages stress directly correlates to where she is in her menstrual cycle. During the luteal phase, increases in stress will exacerbate her PMDD symptoms, causing more damage to the PMDD partner (Beddig et al., 2019). In contrast, during the follicular phase, the individual's ability to manage stress increases, and the impact on the PMDD partner and the relationship is minimal.

## **Compassion Fatigue**

Compassion fatigue is the emotional and physical destruction that occurs when an individual cannot replenish themselves while caring for another (Najjar et al., 2009). The stress that is involved with compassion fatigue leaves the individual feeling depleted. The physical

symptoms include anxiety, irritability, digestion issues, fatigue, and headaches (Finzi-Dottan & Berckovitch Kormosh, 2018). These symptoms are synonymous with the overall decline in experience within the relationship as both partners develop a negative outlook on the other within the framework of them being blamed for their suffering.

The primary source of the overwhelming stress described within compassion fatigue is the lack of self-care exuded by the caretaker of the suffering individual. Without the time to restore what is being lost in their efforts to care for another, they are left empty, and their emotional and physical symptoms arise to reflect this notion (Kohli & Padmakumari, 2020). Irritability and anger often coincide with the deprivation that occurs with compassion fatigue because the individual feels like they cannot bear the burden of suffering anymore. This frustration often leads to isolation and disinterest in performing activities that were once enjoyed (Ordway et al., 2020).

PMDD lasts 10-14 days out of every month; thus, compassion fatigue is due to the cyclic nature of the disorder (Balik et al., 2014). The timeframe it takes to recover from one PMDD episode is often met with the frequent occurrence of another. With no end in sight, the PMDD partner exudes symptoms of compassion fatigue as the recovery time is inadequate, and the frequency of the monthly PMDD occurrences often leads to the weakening of the immune symptoms of the PMDD partner, leaving them susceptible to various physical illnesses and mental anguish (Shi et al., 2022). In conjunction with similar symptoms within PMDD, the fatigue, anger, and irritability associated with compassion fatigue ignites relationship conflict as the PMDD partner and sufferer experience intense emotional and physical suffering (Bissett, 2021).

## **Relationship Burnout**

Burnout is the emotional, mental, and physical enervation from prolonged exposure to emotionally demanding environments (Plieger et al., 2015). The symptoms associated with this state are depression, avoidance, emotional fatigue, and negative perceptions of one's partner and relationship. These individuals are likely to disassociate within their relationship due to a lack of interest in continuing with the suffering that they are experiencing. Conflict in conjunction with burnout is expected due to intense irritability from being stressed and overwhelmed with emotions (Hung, 2021). Intimacy tends to decrease during this time due to a lack of interest in getting close to one's partner, primarily due to the partner experiencing burnout during the luteal phase of menstruation when PMDD symptoms are present, which creates an environment where the PMDD partner could potentially believe the worst about their partner and their actions may follow suit (Zardini et al., 2021). The disassociation that occurs during a burnout is prevalent by enabling the partner to become less interested in their partner's well-being, leaving the other partner feeling abandoned and neglected (Sagalowsky et al., 2019).

Throughout durations longer than a couple of months, the cycle of conflict that arises in the relationship between the PMDD partner and the sufferer becomes strenuous on their mental and emotional health. Burnout is common and, in some cases, inevitable as the duration of the presence of PMDD will last for over 30 years of a PMDD sufferer's lifetime (Trejo, 2023). Depending on the timeframe in which a PMDD partner initiates an intimate relationship with the sufferer, they may spend much of their lifetime experiencing the ramifications of their partner's PMDD symptoms and the accumulation of burnout symptoms (Fairweather, 2012).

## **Relationship Experience**

Relationship experience is relevant to the partners' mental health within an intimate

relationship. A lack of overall relationship experience has been linked to suicidal ideations (Bagge et al., 2013). Partner separation is a leading factor in the suicidal ideations that occur. When the PMDD partner begins to feel that they are contributing more to the relationship or enduring more suffering, the imbalance of efforts becomes an issue, and the relationship experience decreases. Discord, discontentment, and hopelessness are often linked to the notion that life is not worth living (Batterham et al., 2014). When a partner dedicates their livelihood to the success of their intimate relationship, and it begins to deteriorate, suicidal ideations can potentially begin to surface because they cannot see themselves existing outside of the realms of their partners' existence in their life. Relationships and PMDD partners suffer when the PMDD symptoms are increased due to stress (Foran, 2015). A lack of relationship experience is linked to mental health symptoms. Relationship stress alters physical and mental health (Robles et al., 2014). In contrast, an individual who contributes positively to a partner's mental health has been proven to influence their partner's mental health (Carr et al., 2014). When there is an element of positive reinforcement within an intimate relationship, the level of self-confidence in the relationship and overall experience increases.

### **Post-Traumatic Stress Disorder**

Post-traumatic stress disorder (PTSD) is a condition that affects the mental health of those who have an adverse reaction to experiencing or witnessing a traumatic event. Wittchen et al. (2002) noted increased PTSD among women with PMDD, which may indicate that trauma can be a factor in PMDD. An individual diagnosed with PTSD will exhibit flashbacks, anxiety, sensitivity to noise or smells reminiscent of the event, intrusive thoughts, and insomnia. These symptoms impact the quality of life of these individuals as they navigate through work, school, and relationships (DiMauro & Renshaw, 2021).

There are many variances within the interaction with PMDD sufferers that could potentially lead to a PMDD partner developing PTSD (Pilver et al., 2011). Most relatable is the presence of PMDD rage, the anger, and irritability enveloped in the symptoms. This level of anger creates an environment where intense traumatic events can occur. A PMDD partner witnessing this PMDD rage and interacting with the PMDD sufferer in response to it can create an atmosphere where PTSD is inevitable over time (Nillni et al., 2014). The triggers with PTSD can show up in flashbacks of previous conflicts with the presence of PMDD symptoms, which can entail verbal, emotional, or physical abuse. In addition, the monthly presence of PMDD symptoms in the PMDD sufferer can inadvertently trigger the PMDD partner to anticipate a traumatic response based on previous unhealthy altercations (Miller et al., 2013). The PMDD symptoms themselves indicate the possibility of a traumatic event because they cause the shifts in moods and behavioral patterns of the PMDD sufferer. Without any indicator that the PMDD symptoms will dissipate, their presence has the propensity to be an ongoing PTSD trigger within the PMDD partner.

PTSD in an intimate relationship can be a barrier to relationship experience and secure attachment (Petersen & Elklit, 2013). Women tend to be more sensitive to traumatic events than men (Wittchen et al., 2003). Intimacy, closeness, and security are all at risk with PTSD in a relationship (Monson et al., 2009). It is imperative that PMDD partners feel safe within their intimate relationship throughout the fluctuations in attachment styles and mood shifts that are inevitable with the presence of PMDD symptoms.

### **Summary**

This research explored the relationship experiences of the PMDD partners, how PMDD partners describe their potential cyclic attachment styles within their relationship, and how

PMDD partners discover that their relationship experience with a PMDD sufferer can place them at risk for suicide. Much of the prior research on PMDD has been primarily dedicated to the menstrual and biological aspects of the disorder rather than the impacts of the PMDD partners' lived experiences of suffering while navigating intimate relationships with PMDD sufferers.

What differentiates PMDD from other mood disorders is the glimpse of hope that appears every month within the follicular phase of the menstrual cycle when the PMDD symptoms are absent (Caplan., 2004). During this time, PMDD sufferers can enable a secure attachment with their partners in a way that solidifies their desire to be with one another. This secure attachment is then torn away within weeks or even days once PMDD symptoms arise within the PMDD sufferer. This cyclic means of attachment can cause immense emotional and mental trauma for the PMDD partner because nothing within their biology has changed, yet they are subjected to their partners' fluctuating moods and actions (Osborn et al., 2020). The partners of PMDD sufferers are just as connected to their partner and longing for the continuation and stability of a secure attachment when PMDD arises every month. However, instead of that secure attachment that they once had days prior in the follicular phase, they are exposed to emotional and mental trauma from their partner, who is now suffering from this devastating disorder for weeks. It is a very isolating and depressing state that the partners of the PMDD sufferers face every month as they are inadvertently placed in a holding pattern for the approximate two weeks that PMDD is present while watching the core of their loving partner disappear (Schmalenberger et al., 2017).

The likelihood of individuals maintaining an intimate relationship while suffering from the ramifications of PMDD is exceptionally negative when the PMDD sufferer and partner are unaware of the effects that the disorder is having monthly. A predictor of relationship experience lies in managing emotions and behavioral responses during conflict and inevitable disagreements

(Ogurlu, 2015). The inability of PMDD sufferers to exude these qualities with the presence of the symptoms associated with the disorder impacts the experience level of the relationship (Garthus-Niegel et al., 2018). The emotional and mental damage that the partners of PMDD sufferers experience leads to an overall decline in relationship experience because they are subjected to continuous trauma in the form of abuse.

## Chapter Three: Methods

### Overview

Individuals who suffer from PMDD incur severe despair for approximately two weeks out of every month, and their partners are the direct recipients of this suffering. Most women in their reproductive years suffer from some PMS symptoms; therefore, care must be taken to diagnose PMDD (Young, 2001). PMDD partners are often present for every outburst, frustration, and moment of discontent that the PMDD sufferers experience. The PMDD partner is expected to endure the emotional and mental pain and suffering they experience in silence as they attempt to navigate an intimate relationship with a PMDD sufferer for love, dedication, and commitment. Nevertheless, amid their loyalty, they are faced with despair at attempting to survive mentally, physically, and emotionally within a relationship with a PMDD sufferer. However, without an understanding of the rationale behind their pain, along with tools to combat it, they may continue to suffer in their relationship and be potentially at risk for suicide.

The cause of the PMDD partners' suffering can be the cyclic attachment style that occurs when PMDD symptoms are present during the PMDD sufferer's luteal phase (Jonsdottir & Coyne, 2016). When these symptoms dissipate during the follicular phase of menstruation, PMDD symptoms are absent, and the PMDD sufferer is in a mental and physical state that supports a secure attachment with their partner.

The purpose of this transcendental phenomenological qualitative study was to explore the PMDD partners' relationship experience. Additionally, this study explored the potential cyclic attachment styles that exist once PMDD symptoms are absent and when symptoms are present. Finally, this study explored the potential suicidal ideations and behaviors that may exist because of the PMDD partners' pain and suffering within the relationship. This chapter describes the

research design, research questions, study setting, participants, procedures, researcher's role, data collection, and analysis.

## **Design**

This study utilized a transcendental qualitative research methodology with a phenomenological approach. This methodology required the rigor of quality over quantity regarding the investment of time in establishing the interview questions and observing the interviews to allow the participants to give the most organic data (Hamilton, 2020). The phenomenological approach explored the relationship experiences of PMDD partners, their cyclic attachment styles, and the potential risk of suicide. Neubauer et al. (2019) suggested that qualitative research focuses primarily on the participants' lived experiences. The qualitative method was ideal for this study because it required an in-depth exploration of the PMDD partners' relationship experiences. This study primarily produced an understanding of the potential cyclic attachment styles that PMDD partners develop and its impact on their relationship experiences. The phenomenological approach of the qualitative design was appropriate because it illuminated the essence of PMDD and its impact on the partners in an intimate relationship with a PMDD sufferer. The goal of this study was to identify the commonality that exists between PMDD partners and their intimate relationship experiences.

## **Research Questions**

The focus of this study was to explore the PMDD partners' relationship experiences, their cyclic attachment styles, and their potential risk of suicide. To identify the perceptions of PMDD partners' relationship experiences, the researcher explored the following questions:

**RQ1:** What are the relationship experiences of the PMDD partners?

**SQ1:** How do PMDD partners describe their potential cyclic attachment styles within their relationship with PMDD sufferers?

**SQ2:** How do PMDD partners discover that their relationship experience with a PMDD sufferer can potentially place them at risk for suicide?

### **Setting**

The setting for this study was virtual. Upon receipt of the Institutional Review Board's (IRB) approval (see Appendix A), flyers will be posted on social media on various PMDD community forums via Facebook and Instagram to recruit participants who meet the criteria (see Appendix B). Participants for this study will go through a vetting process inclusive of a questionnaire stating their eligibility to participate. The pseudonym for the setting will be the PMDD Partners Institute.

The presence of PMDD equates to 14.5 million disability-adjusted life years lost annually for the 1.8% to 5% of women affected by this disorder (Rubinow, 2021). During the luteal phase of the menstruation cycle, PMDD sufferers experience an array of symptoms, including fatigue, depression, anxiety, and a heightened desire to isolate themselves from socialization. It is imperative that the setting used for the interviews would be a safe place for participants to express themselves in an unfiltered and unaltered manner. The capability to be within one's own home with an established sense of comfort was ideal for accurate data to be received.

A virtual setting was designed to obtain a broad audience of PMDD partners internationally from various regions to address any notions that the PMDD partners' region or environment had any impact on the relationship experiences that they were having. All interviews were conducted via Zoom Video Conferencing and recorded with the participants' permission. Another benefit of utilizing this setting was the privacy of the PMDD partners and

sufferers to have the interviews within their homes. In addition, for the PMDD partners, the virtual setting contributed to the ease of expressing their raw experiences within the environment that the relationship experiences with the PMDD sufferer occurred. With a virtual setting, the PMDD partners can actively engage in how they felt differently with their partner during the luteal and the follicular phase of menstruation and its effects on their relationship experience.

### **Participants**

The participants for this study were six individuals: three PMDD partners and three sufferers, making up three couples who have been in an intimate relationship for six months or longer. Three PMDD partners were selected to adequately display a pattern in their relationship experience with a PMDD sufferer and develop a common theme that might exist. Moser and Korstjens (2018) suggested that the research concentrate on fewer than ten participants. The participants shared their relationship experience in-depth and were recorded individually. Creswell and Poth (2018) emphasized that the qualitative sample size aims to study a small group of individuals while collecting extensive data regarding their experiences. Sim et al. (2018) indicated that the sample size within a phenomenological study should be based on the inquiries and responses received during the interviews. In this study, the questions were focused on an in-depth understanding of the PMDD partners' relationship experience; therefore, the sample size of six participants reflected the appropriate data to be presented to the audience.

### **Procedures**

The initial procedures were to gain IRB approval, elicit participants for the study, gather the data, and record procedures. Once the IRB approval was granted, the researcher's primary course of action was to begin the recruitment phase of the study to obtain participants. Recruitment was completed by posting virtual flyers on social media forums within the PMDD

community. A copy of the flyer can be found in Appendix B. The initial recruitment process included answering a questionnaire to deem the participants eligible for the study.

The instruments used to prescreen the participants were Google Forms. The ethnicity and gender of the participants were not a deciding factor within the research. However, age was a deciding factor in eligibility because the basis of the research was on the PMDD partner's adult attachment styles. The timeframe that a participant was in an intimate relationship was vital to capture the experiences of the PMDD partners over at least three menstrual cycles to articulate a pattern in their experience with the PMDD sufferer during the luteal and follicular phases of the menstrual cycle. A participant was selected as a candidate for this study once they answered the screening questions. The contact information in the Google Form was utilized to notify the participant of their selection for this study.

Once the participants were selected, they signed a formal consent form (see Appendix C), which included their rights, privacy, the overall nature of the study, and its risks. The researcher utilized interviews to collect data within this study. Each participant was interviewed individually to glean their relationship experience during the luteal and follicular phases of the menstrual cycle. The duration of the interviews was about 30-45 minutes. All interviews will be audio and video recorded utilizing the videoconferencing software Zoom and will be transcribed upon completion of the interview. Researchers can take notes as observers when they review recordings of interviews (Creswell & Poth, 2018).

### **The Role of the Researcher**

As the human instrument in this study, the researcher was to be a facilitator, observer, and guide. The researcher assumed the role of an observer when reviewing the interview recordings and taking copious notes. To eliminate bias, the researcher assumed the role of

facilitator and did not disclose any information about their personal experience with PMDD and intimate partner relationships.

### **Data Collection**

To gain in-depth experiences from PMDD partners, the researcher conducted interviews. Using this mechanism, the researcher understood the PMDD partners' experiences during the luteal and follicular phases of the PMDD sufferers' menstrual cycle. The data must be collected through both the follicular and luteal phases to determine the differentiation in the attachment style that exists once PMDD is present and once it dissipates.

### **Pre-Screening Questions**

1. What is your full name?
2. What is your age?
3. Have you been in an intimate relationship with an individual who suffers from PMDD for six months or longer?
4. Are you a PMDD sufferer?
5. Does your partner have PMDD?
6. Are you and your partner both willing to participate in this study?

### **Semi-Structured Interviews**

During this study, semi-structured interviews were conducted within a single month with the PMDD sufferer and partner on separate days. (Thomas, 2020) emphasized the importance of interviews within the phenomenological research process as a means to openly listen to the participants without any bias as a means to delve deep into their overall experience. The participants were interviewed once during the luteal phase and could recall their relationship experiences throughout all menstrual cycle phases. The semi-structured interviews served as a

means of exploration of what the PMDD sufferer and PMDD partner experienced individually (Tanwir & Habib, 2021). The PMDD partner and PMDD sufferer were asked a separate set of interview questions to allow the relationship experience to be explained in ways that were most authentic and unique to their perception. All interviews were conducted virtually and recorded within the home of the PMDD partners and sufferers to support vulnerability, authenticity, consistency, and accuracy in the data collected.

***PMDD sufferer Interview Questions***

Thank you for being here and participating in this study; please start by introducing yourself to me. Now, we will talk about your journey with PMDD and how it has impacted your intimate relationship.

***Questions related to their diagnosis of PMDD***

1. When did you get diagnosed with PMDD?
2. How did you find out that you had PMDD?
3. What PMDD symptoms do you struggle with monthly?
4. When do your PMDD symptoms start?
5. When do your PMDD symptoms end?

***Questions related to their relationship experience with the diagnosis of PMDD***

6. Which of your PMDD symptoms affect your intimate relationship with your partner?
7. Before being diagnosed, do you believe PMDD caused issues with your past and present intimate relationships?

***Questions related to their attachment styles towards their partner while experiencing PMDD symptoms***

8. What are your feelings about your partner and intimate relationship during the luteal phase when PMDD symptoms are present?
9. How do you feel about your partner and intimate relationship during the follicular phase when PMDD symptoms are gone?
10. When PMDD symptoms are present during the luteal phase, do you need more attention or more space from your partner?
11. Do you often feel insecure about your relationship or partner during the luteal phase when PMDD symptoms are present?
12. Do you want to avoid your partner when your PMDD symptoms arise?
13. When PMDD symptoms are present during your luteal phase, would you rather be single?
14. Do you fear that you are losing your independence in your relationship when PMDD symptoms arise?
15. Do you think your partner would be better off without you when PMDD symptoms arise?
16. Do you start to question your partner's intentions or love for you when PMDD symptoms arise?

***Questions related to their relationship issues with the presence of PMDD symptoms***

17. What is one of your most damaging disagreements with your partner during PMDD?
18. Have you ever been asked to break up with your partner because of PMDD?
19. What brought you to the decision of desiring to end the relationship with your PMDD partner?

20. What happened after the breakup that caused you and your partner to reconcile?
21. Do you experience guilt from your behavior towards your partner while having PMDD symptoms?
22. Looking into the future of your life with your partner and managing PMDD, what are your hopes for your intimate relationship?
23. Now, I want to ask you a question summarizing our conversation. Reflecting on your experience as a PMDD sufferer, what advice would you give to other PMDD sufferers struggling to navigate intimate relationships?
24. We have gone in-depth with your experience as a PMDD Sufferer, and I appreciate your willingness and openness in sharing your experience. I have one last question, what is one thing you wish your partner understood about your suffering with PMDD?

The semi-structured interview questions were formulated based on the three research questions within this research study (Henriksen, 2021). Each research question aligned with a set of interview questions that supported the exploration of the PMDD partner and PMDD sufferer's relationship experience. The manner and order in which the interview questions were asked allowed the couples to give their perception of the way in which PMDD affected their relationship (Oerther, 2021). The interviews were conducted separately and in a safe place without fear of repercussion from the other partner within the relationship.

Questions one through seven allowed the PMDD sufferers to validate their diagnosis, explain their early journeys, and how they perceive it has impacted their intimate relationships.

Questions eight and nine deal with the cyclic attachment style during the luteal and follicular phases and how it influenced the PMDD sufferers' view of their partners. Question 10 identified the insecure or secure attachment style of PMDD sufferers during the luteal phase.

Question 11 was an indication of an anxious attachment style with the presence of PMDD symptoms. Question 12 was an indicator of an avoidant attachment style with PMDD symptoms.

Questions 13 and 14 were indicators of a dismissive avoidance attachment style with the presence of PMDD symptoms. Questions 15 and 16 were indicators of a fearful avoidance attachment style with the presence of PMDD symptoms. Questions 17 through 21 gave insight into the monthly fluctuations encompassed being in a relationship with a PMDD sufferer, summarized their PMDD journey, and allowed the PMDD sufferers to offer more insight that may not have been captured throughout the interview. Questions 22 to 24 enlightened the reader on the true intentions and hopes of the PMDD sufferers within an intimate relationship.

#### ***Interview Questions for PMDD Partners***

Thank you for being here and participating in this study; please start by introducing yourself to me. Now, we will discuss the background of your relationship with your partner and the presence of PMDD in the luteal phase.

#### ***Questions related to their knowledge of PMDD***

1. How did you find out that your partner had PMDD?

#### ***Questions related to their relationship experience with their partner with the presence of PMDD symptoms***

2. How would you explain your struggles with an intimate relationship with a PMDD sufferer?
3. How do you feel about your partner and relationship during the luteal phase when

PMDD is present?

4. When your partner experiences PMDD symptoms, what is your initial reaction?
5. How does the presence of PMDD symptoms change your relationship with your partner?

***Questions related to their attachment styles to their partner with and without the presence of PMDD symptoms***

6. When your partner is in PMDD, do you need more attention from them?
7. Do you feel clingy or needy once your partner has PMDD symptoms?
8. Do you feel like you lack affection and attention from your partner when they are in PMDD?
9. Do you want to avoid your partner when you know that PMDD symptoms are present?
10. Do you feel you cannot get enough space from your partner when PMDD is present?

***Questions related to the mental and emotional impact of being in a relationship with a PMDD sufferer***

11. Do you question whether your partner loves or cares about you when they are in PMDD?
12. Do you question if you would be better off single when your partner is in PMDD?
13. Do you feel like you are a burden to your partner when they are in PMDD?
14. Do you keep your wants and needs to yourself when your partner is in PMDD?
15. Is it hard for you to connect with your partner during PMDD?
16. Does monthly PMDD with your partner make you feel emotional pain?

***Questions related to the risk of suicidal ideations and behaviors from being in the relationship with the PMDD sufferer***

17. How do you deal with the pain of your partner having PMDD every month?
18. Have there ever been times when you felt like the stress and pain of being with your PMDD partner was too much for you?
19. What is one of your most damaging disagreements with your partner during PMDD?
20. Have you ever been asked to break up with your partner because of PMDD?
21. What brought you to the decision of desiring to end the relationship with your partner?
22. What happened after the breakup that caused you and your partner to reconcile?

***Questions related to their relationship experience with and without the presence of PMDD symptoms***

23. What is the hardest part about being in an intimate relationship with a partner having PMDD?
24. During the luteal phase, when PMDD is present, what do you feel is missing from your partner?
25. What are your fears about intimate relationships with a PMDD sufferer?
26. How do you feel about your partner and relationship during the follicular phase when PMDD is gone?
27. What do you appreciate most about your partner when PMDD is not present?
28. What is your relationship with your partner like during the follicular phase?
29. What are your feelings once PMDD is gone, and you think of everything that was

said and done during the luteal phase with your partner?

30. Looking into the future of your life with your partner, what are your hopes for your intimate relationship?

31. We have gone in-depth with your experience as a PMDD partner, and I appreciate your willingness and openness in sharing your experience. I have one last question.

Imagine that your best friend came to you and told you that they were about to enter an intimate relationship with a PMDD sufferer; what advice would you give them?

Questions one and two created the framework of knowledge within the PMDD partner, giving a baseline on their vision and experiences with intimate relationships and providing guidelines of what they could potentially expect within their own intimate relationship.

Questions three through five gave insight into how the PMDD partner experiences the shift in their relationship with PMDD. Question six identified the attachment style of the PMDD partner during PMDD. Questions seven and eight indicated an anxious attachment style.

Questions nine and 10 indicated a dismissive avoidant attachment style. Questions 11 and 12 indicated a fearful avoidant attachment style. Questions 13 and 14 indicated the presence of burdensomeness from the interpersonal theory of suicide. Question 15 indicated the presence of thwarted belongingness from the interpersonal theory of suicide. Questions 17 through 22 indicate the acquired ability to be at risk for suicide according to the interpersonal theory of suicide. Questions 23 through 30 let the PMDD partners describe their cyclic attachment styles.

With the participants' permission via a consent form, the researcher recorded all interviews via video and audio utilizing Zoom for transcription and analysis. All questions were tailored to the PMDD partners' relationship experiences, cyclic attachment styles, and potential risk for suicide based on being in a relationship with the PMDD sufferer based off of the

research questions (Thomas, 2020). During the interview process, all couples were asked the same questions to contribute to the data analysis phase of the study. The interview guides utilized for this study are in Appendix D.

### **Data Analysis**

The researcher's chosen data analysis method for this study was Interpretative Phenomenological Analysis (IPA) analysis, a qualitative research approach used in psychology and other social sciences to explore and understand the lived experiences of individuals (Smith & Fieldsend, 2021). IPA was initially developed by Jonathan A. Smith, Paul Flowers, and Michael Larkin in the late 20th century and has become a popular method for investigating various psychological phenomena, such as mental health issues, coping strategies, identity development, and interpersonal relationships. It primarily concerns how people make sense of or give meaning to their experiences and their world. The goal of IPA is to gain insight into the subjective perspectives of participants and explore the complexities and nuances of their experiences.

IPA involves in-depth, semi-structured interviews or other data collection methods that allow participants to provide detailed accounts of their experiences. Researchers aim to understand rich, contextualized information about how individuals interpret and make sense of their experiences. The approach is phenomenological, which means it focuses on the participants' perceived subjective experiences. Researchers aim to bracket their preconceived notions and avoid imposing external interpretations on the data. IPA is interpretative because the researchers actively interpret the data, analyzing the interview transcripts or other textual data to identify themes, patterns, and meanings within participants' accounts. The analysis in IPA is idiographic, meaning it seeks to understand the unique aspects of individuals' experiences rather than seeking generalizations across a larger population. In IPA, there is a double hermeneutic

process. The researchers interpret the participants' accounts, and the participants, in turn, interpret their own experiences during the interview. These two levels of interpretation are considered in the analysis. Researchers using IPA are encouraged to be transparent about their biases and preconceptions and to engage in reflexivity throughout the research process, ensuring that the researcher's interpretations are as unbiased as possible.

Overall, IPA is a valuable qualitative research method, allowing researchers to explore the complexity of individuals' subjective experiences and gain deeper insights into various psychological phenomena. By capturing participants' unique perspectives, IPA can provide a rich understanding of human experiences and contribute to developing theory and practice in psychology and related disciplines.

The researcher's reason for using the IPA method was that it is designed to allow the reader to deeply understand the relationship experiences of PMDD partners and how it is viewed from their perspective. According to Smith (2018), IPA is a tool that enables the audience to leave the reading feeling as if they have gained insight and knowledge and ensures that they have an overall enlightened view of the PMDD phenomenon from the partner's lens. IPA is not merely about gaining the details of the PMDD partners' experience but also about gaining insight into the emotions involved in their relationship experience with the PMDD sufferer. Therefore, this data analysis must be performed in a manner that reveals the detriment and suffering that PMDD partners silently face every single day.

The steps of the IPA process include gathering the transcripts from the interviews, reading the transcripts, identifying significant phrases and common themes, analyzing connections between the common themes, and identifying if additional theories support the common themes. To gather the data, the researcher transcribed the interviews. Memoing was

utilized as a primary strategy to identify the themes within the interviews as the researcher wrote memos inclusive of details about the code formation and the existing similarities (Creswell & Poth, 2018). Once all the data was collected and organized, the researcher disassembled it into groups using bracketing.

The researcher coded each emerging theme to analyze if it was an individualized relationship experience of the PMDD partner. If it was a collective theme, it was recognized and evaluated as one of the proposed relationship experiences of the PMDD partner. Once the codes were established, the researcher began reassembling the data in groups, identifying the themes within the coded data. At this stage, the researcher examined the texts' context and the group they were placed. Definitions were utilized to identify the nature of the codes. The reassembling stage involved combining themes to form a complete thought, idea, or experience. There were various themes that the codes fit into, and this was the process in which the common themes were identified and placed into sub-themes. The researcher viewed the connections between the themes extracted from the interviews to establish a deep understanding of the commonalities of the PMDD partners' relationship experiences. To conclude, the researcher identified the commonalities amongst the PMDD partners' cyclic attachment styles from the data extracted during the PMDD sufferers' luteal and follicular phases of menstruation.

### **Document Analysis**

Document analysis occurred with the notes the researcher took during the observation of the interviews. The document analysis of the notes from observation of the interviews was to validate that the documented experiences were done thoroughly and authentically. By analyzing the interview notes, the research supported the themes within the relationship experiences of all three PMDD partners.

## **Trustworthiness**

Peer reviews were utilized within this research study to enhance trustworthiness. The four most widely established criteria to enhance trustworthiness are confirmability, transferability, dependability, and credibility (Lincoln & Guba, 1985). This process inspects the authentic nature and accuracy of the research.

### **Credibility**

The credibility of this research study was contained in the participants' authentic data collected in various forms to contribute to common themes and consistency over the month timeframe during the luteal and follicular phase of the menstrual cycle. All data collected and analyzed was exclusively from the participants' input.

### **Dependability and Confirmability**

The dependability of the research study was solidified as the researcher enabled the entire study to be investigated by a fellow researcher with no prior knowledge of the study or context, which enabled greater confidence in the research conducted. Additionally, the consistency of the study remained intact because all interviews occurred within a one-month observation and data collection period.

### **Transferability**

Throughout this study, the researcher provided the reader with a detailed illustration of the PMDD partners' relationship experiences, the nature of their subsequent cyclic attachment styles, and the potential risk for suicide. The researcher provided the reader with context inclusive within the luteal and follicular phases to enable identification in both echelons of the relationship with the PMDD sufferer, thus enhancing the transferability of the study.

### **Ethical Considerations**

Prior to data collection or research involving participants, IRB approval was obtained. Pseudonyms were utilized for the participants to remain anonymous. All interviews conducted were maintained in confidential, password-protected digital folders. Participants were recruited on a strictly volunteer basis and compensated with a \$25 gift card. Each participant reviewed, agreed to, and signed a consent form indicating that their participation in this study could be terminated at will with no questions asked. The consent forms were kept in a password-protected digital folder. Once the research study was completed, all data was kept in a password-protected file and will be preserved for five years. Once the five years have passed, the collected data will be permanently deleted.

### **Summary**

The transcendental phenomenological qualitative research design was utilized within this study (Moerer-Urdahl & Creswell, 2004). This study explored the relationship experiences of PMDD partners, their cyclic attachment styles, and their potential risk for suicide. Interviews were the method utilized to collect the data. The data collected was analyzed by utilizing the IPA method. This method was employed to gain knowledge in response to research questions (Adams–Harmon & Greer–Williams, 2020). The trustworthiness of the data was maintained through the interviews with the PMDD sufferers. All ethical considerations were observed as the participants reviewed and signed an informed consent form. With this added information in this study, PMDD partners were equipped with the knowledge of the themes within their experience with PMDD sufferers and the reasoning behind their cyclic attachment styles. The researcher’s goal was that once PMDD partners have this knowledge, the hopelessness that was once present

will be replaced with enlightenment and restored hope that they can have a healthy, secure relationship with a PMDD sufferer without engaging in mental, physical, and emotional harm.

## **Chapter Four: Findings**

### **Overview**

The purpose of this transcendental phenomenological study was to describe the relationship experiences of PMDD partners. This study involved six individuals, including three couples who have been in an intimate relationship for six months or longer. The research was conducted via semi-structured interviews. All participants were interviewed individually. The interviews ranged from 30-60 minutes each. The three emerging themes were developed through the data collection and transcription of the interviews. The three themes developed were linked to the research questions.

**RQ1:** What are the relationship experiences of the PMDD partners?

**SQ1:** How do PMDD partners describe their potential cyclic attachment styles within their relationship with PMDD sufferers?

**SQ2:** How do PMDD partners discover that their relationship experience with a PMDD sufferer can potentially place them at risk for suicide?

### **Participants**

The demographics of the research participants were three males and three females, within heterosexual relationships, and the median age of the participants was 26 years old. The average length of their relationship was three years. Four participants were Caucasian, one participant was African American, and one participant was Indian. One couple is married, and two couples are in a committed relationship and cohabitating. The locations of the participants were the United States, Canada, and the United Kingdom. The participants within the study exemplified an ideal level of diversity within the realms of age, race, locality, and the timeframe of the relationship.

**Daniel**

Daniel was 27 years old at the time of the research study. He is an African American male who lived in the state of Washington, USA, in a relationship with a PMDD sufferer for 13 months. He described his relationship experience with a PMDD sufferer as unpredictable, concerning his secure and stable demeanor. According to Daniel:

It is difficult just being with someone who on its face goes through these cyclical changes. You know I am normal and level-headed and do not have anything like that myself so my, you know on Monday, today and on Monday two weeks from now are going to work the same, for me, nothing will work that differently. But, for her, that is not the case.

In addition to the lack of predictability, he also faced difficulty with his mental health because he was in a relationship with the PMDD sufferer. He stated, “it is difficult psychologically because it is really hard being with someone who is not, as you know, just happy as you day to day.” A significant part of his experience as a PMDD partner was the fear of losing independence because of being in a relationship with a PMDD sufferer. He expressed:

Just all the negative feelings around PMDD and being with someone with PMDD...the way I felt was that I was an adult living my best life, and then overnight, I was thrust into this long never end in sight kind of babysitting role.

**Pearl**

Pearl was 25 years old at the time of the research study. She is Daniel’s partner; they have been together for 13 months. Her experience as a PMDD sufferer is that she was formally diagnosed with PMDD in 2020, yet she feels that she had it for many years before her diagnosis. She describes her PMDD symptoms as: “really intense mood swings, crying spells, intrusive

thoughts, ramped-up depression, anxiety, a lot of obsessive thoughts...a lot of random bursts of rage or anger like a lot more difficulty communicating, clumsy, gut issues, breast pain, and migraines.” She expressed that her PMDD symptoms begin at ovulation and end once she gets her period, which is approximately 14 days of experiencing the PMDD symptoms. This period of PMDD symptoms is followed by period symptoms, which are alleviated on day seven.

Therefore, she has 10 good days within her follicular phase monthly. Within her relationship with her PMDD partner, she expressed that the most challenging part was wanting her partner to break up with her monthly when she experiences PMDD symptoms. She stated:

I just feel bad for him, and...I have read a lot of things about PMDD that talk about people wanting to break up with their partners, and, for me, it is more the opposite, that I want my partner to break up with me because I do not want you to have to experience this. I do not want you to have to be around this. I do not want you to see me like this.

There was also an apparent sense of guilt towards her behavior with her PMDD partner and a decline in self-worth associated with having PMDD. She expressed, “I sometimes feel like I am the worst version of myself with the people I am most intimate with.”

### **Samuel**

Samuel was a 36-year-old male. He is a Caucasian male who lived in Canada and has been married to a PMDD sufferer for five years at the time of this study. Samuel’s relationship experience with a PMDD sufferer is explained as a journey he consistently tries to navigate. He outwardly admitted to being in a codependent relationship with his partner, which makes it difficult when she is suffering from PMDD symptoms. He shared, “I immediately feel like I did something, and I need to help.” The burden of being in the caretaker role appears evident in his relationship experience with a PMDD sufferer. In addition, he expressed a deep sense of hurt

regarding her mentioning breaking up when his partner was suffering from PMDD symptoms. He explained his emotional response to her, mentioning breaking up as “it was like a big freezing moment like I just did not even know what to say or what to do. I thought she was serious. And then, as it went on, it still hurt to hear it” Along with the emotional pain from proposing monthly breakups, he also expressed a fear of the future with his partner as he stated:

Sometimes, I question some things about the future, like we want to have a child, and I am a little scared at times of...if we are planning to start having a child, how are we going to have a little child with these types of episodes; alternatively, what is having a child going to do to her hormones?

### **Ashley**

Ashley was a 33-year-old female at the time of the research study. She is Caucasian, lives in Canada, and has been with her partner for five years, which consisted of dating for three years and married for two years. She discovered she had PMDD by tracking her symptoms monthly and noticing the emotional and physiological shifts that occurred. She stated:

It was the emotional response and the heightened emotionality that I had leading up to my cycle that was showing up in a pattern that was undeniable. It was much more extreme than regular PMS, especially to the point where it was affecting my relationships and my intrusive thoughts and my depression and anxiety.

She expressed that her relationship with her partner caused her to discover that she had PMDD because of the damage it was causing in a cyclic manner. The monthly PMDD symptoms that she experienced were “low mood, heightened anxiety, paranoia, ruminating thoughts, and then I have physical symptoms too, like headaches, I cannot sleep, [and] elevated body temperature.” She concurred that she mentioned breaking up with her partner while she was experiencing

PMDD symptoms, and her reasoning was based on the idea that they would be better off without each other. She expressed, “he would be better off with someone who was not in an emotional spiral. And then those were the times when I would desire that independence.”

### **Aaron**

Aaron was a 20-year-old college student at the time of this study. He is a Caucasian male who lives in the United Kingdom. He has been with his partner, who suffers from PMDD, for three years. He describes his relationship experience with a PMDD sufferer as being in the role of the caretaker. He envisions it as his role to take care of his partner when she is suffering from PMDD, which often includes his own needs and desires being put on hold for her well-being. He expressed, “what I do think maybe lacks attention wise is if I have got a problem or I need to like talk to her about something, the PMDD stuff is the priority.” In addition, he is going through a mental struggle between operating within the caretaker role and maintaining a sense of independence within his own life. He explained, “I have got...two contrasting, you know, angel and devil sort of voices in my head, and I am like ah, listen, I will always, always, always look after you.” He emphasized his commitment to his partner because it is evident in her suffering that she needs him; he seemingly takes pride in that fact. He said, “I like that she needs me in those kinds of times more than ever.” He finds purpose in being the caretaker of the PMDD sufferer.

### **Emily**

Emily was a 22-year-old at the time of this research study. She is Indian, lives in the United Kingdom, and has been with her partner for three years. She was officially diagnosed with PMDD a year ago, although she can recall suffering from her symptoms earlier but not knowing what was wrong. Her symptoms include:

Really intense hunger. It is a sort of a complete avoidant attachment to my partner. Anger directed towards my partner, unfortunately, and other people in my life, really intense anger turning to normal life and then really intense anger again. I also have really low self-esteem, body dysmorphia, and I have depressed thoughts and really intense mood swings. And some months, I struggle with anxiety.

These symptoms affect her relationship; specifically, her cyclic attachment style towards her partner is affected. She explained:

There were phases where my brain was trying to convince me that I should leave my partner, that he is not the right person for me, that I should break up with him, [and] that I would be so much happier single, and I thought oh, I feel like an awful person for feeling all these things. And then, some days, I feel completely fine.

Recognizing her cyclic attachment style, she expressed that how she behaved with her partner affected his mood, yet he maintained his demeanor of being supportive and committed to the relationship.

## **Results**

Data collection was completed via semi-structured interviews and observations. Upon analysis of the data, three distinct themes were developed in alignment with exploring the relationship experience of partners of individuals who suffer from PMDD. The three themes were hopelessness, cyclic attachment style, and lack of support and understanding.

### **Theme Development**

The themes for this study were developed utilizing the IPA method. The three themes and subthemes include hopelessness, cyclic attachment styles, and lack of support and understanding. This information is detailed in Table 1.

**Table 1***Identified Themes and Related Codes*

Theme	Theme Codes	Subthemes	Total Subthemes Codes
Hopelessness	46	The Burden of a Caregiver Role	38
Cyclic Attachment Styles	52	Internalization of Emotions	21
Lack of Support/Understanding	40	Questioning the Relationship	26

*Hopelessness*

The hopelessness within PMDD partners was directly correlated with their inability to ease their partners' suffering during the luteal phase of menstruation when PMDD symptoms were present. "Well, by the time we got into a relationship she has already tried a million things whether that is anti-depressant, birth control, like she has already tried the big the heavy hitters and most of those do not work." Samuel stated:

Well, it is difficult just being with someone who on goes through these cyclical changes. You know I am pretty normal and level-headed and do not have anything like that myself so on Monday, today and on Monday two weeks from now are going to work pretty much the same, for me, nothing will work that differently. But for her, that is not the case. And so just knowing that in itself is difficult because yeah, just you want to be able to expect someone to be happy and healthy in the future even the short-term future of a few weeks and knowing that is not the case is a difficult thing to deal with. And then within her cycles themselves like when she is in her luteal phase it is difficult. It is hard emotionally, psychologically even physically because you know I have to just pick up the slack a little more you know I have to do more house tasks or just you know be with her in times like that of doing something else and yeah, it is just it is a much greater

emotional ask just to be there and be supportive during those times. And it is difficult psychologically because it is really hard being with someone who is not as you know just happy as you day to day because I mean it is not fault obviously that is why we here but it is you know when I have a good day or a normal day or even a bad day I am still pretty much fine but you know coming home from work kind of sunny Friday and her being you know like a ball on the bed you know just crying it is hard because you feel like you have to be sad with them. You know I am like I do not want to be sad I do not want that for myself. So, it is difficult.

Hopelessness has been described as having undesired thoughts, expectations, or feelings about the future (Parpa et al., 2019). Aaron expressed “Just my feelings of kind of helplessness of wanting it to be over. I mean I have all sorts of negative thoughts towards the end of do I want to do this anymore, why am I doing this is this what I want but I still love her blah, blah, blah and I do not know it just it is hard for me to unthink all of those thoughts just with a snap of my fingers.” The participants expressed a deep sense of frustration and fatigue in knowing that there is no cure for PMDD, and every month it was impacting them and their relationship with their partner. PMDD partners expressed the stress of knowing there is no cure for PMDD, and they expressed fear and concern about the long-term impact of the disorder on their relationship. These thoughts and concerns contributed to a feeling of hopelessness or a sense of uncertainty about the future.

Additionally, feelings of hopelessness arose in the PMDD partners’ struggle to find effective methods to navigate their partners’ PMDD symptoms. Daniel stated:

Just my feelings of kind of helplessness of wanting it to be over. I mean I have all sorts of negative thoughts towards the end of do I want to do this anymore, why am I doing this is

this what I want but I still love her blah, blah, blah and I do not know it just it is hard for me to unthink all of those thoughts just with a snap of my fingers. It takes a few days for me to wash those thoughts off and come back to where she is. I mean she is happy, giddy and I am like okay.

Conflict often arose within the relationship as the PMDD partner proposed methods to alleviate their partner's PMDD symptoms that were ineffective, which led to further feelings of inadequacy and a loss of hope. "I do not like feeling like I have to say no to plans or yes to this or just I do not like feeling that I am not in control, and I am just not PMDD is the driver." At times when PMDD symptoms were debilitating, observing their partner's suffering with no indication of what they could do to ease it was almost unbearable. In some cases, the PMDD partners were also observed as the source of suffering and frustration of the PMDD sufferer, which impacted the PMDD partner's mental health as they struggled to maintain a level of support while simultaneously emotionally depleted.

### *Cyclic Attachment Styles*

The most common theme identified within the data gathered from PMDD partners was the cyclic attachment styles. "She makes quirks about it jokes about it how eventually everyone gets tired of dealing with it and they leave her." Aaron recalled a time where he and the PMDD sufferer were apart during PMDD:

I mean everything was easier and part of that was just because we were in two separate locations and partly because I did not have to deal with PMDD. I mean it is just it is obvious it is way easier if you are one person than two, I can exercise when I want I can you know go out when I want I just did not have to worry about any of the things that just come with a relationship in general. But then skipping out on the PMDD I mean it just, it

was a breath of fresh air I just did not have to deal with much at all. And, of course, we would still talk every day but when she was in her luteal phases you know we would just talk a lot less and she would just stay in bed and watch TV and hang out with her friends and I would say okay, I am sorry you are feeling that way you know you have got this.

And I would just go about my life for the day.

The PMDD partners' attachment style was most commonly avoided or insecure, which was evident as they sought to avoid the PMDD symptoms accompanying their partner during the luteal phase of menstruation. "I mean everything was easier and part of that was just because we were in two separate locations and partly because I did not have to deal with PMDD." In Aaron's case he displayed an avoidant attachment style when the PMDD sufferer was experiencing symptoms as a way to cope. Avoiding the PMDD symptoms seemed to relieve the PMDD partners because they were constantly frustrated while attempting to understand and exist effectively alongside PMDD.

The PMDD partners expressed fear of abandonment during the luteal phase as they viewed the constant emotional fluctuations as an indication that their partners may leave them, primarily due to the avoidant nature of some of the PMDD sufferers once they experienced PMDD symptoms. The reason for the avoidant attachment style of the PMDD sufferer was to prevent their partner from enduring the same turmoil that they faced. It did not appear to be evident to the PMDD sufferer that, inadvertently, their avoidance was causing more harm rather than relief from navigating PMDD symptoms within the relationship. In contrast, during the follicular phase of menstruation, when the PMDD symptoms subsided, the partners adopted a secure attachment style with the PMDD sufferers.

### ***Lack of Support***

One of the most prevalent sources of suffering for PMDD partners was the lack of support available to ease their suffering while navigating a relationship with a PMDD sufferer. “Just all the negative feelings around PMDD and being with someone with PMDD I just I kind of the way I felt was that I was an adult living my best life and then overnight I was thrust into this long never end in sight kind of babysitting role.” Aaron stated:

It is the stress of knowing that she is in pain the stress of knowing there is no cure for it. The stress of knowing that it puts a strain on our relationship. The stress of knowing that we can only learn how to deal with that, but we cannot fix that. You know it is like if someone brought you a deal and it is like here is the deal you get two positives but no matter how you do it you have got one negative do you still want to take the deal? I mean it would be a tough call at the time but especially if you, I do not know once you are in it, it is just difficult.

The lack of knowledge and accommodation for tools to manage the relationship was daunting for the PMDD partners. They did not feel like they could talk to anyone about their relationship and mental health struggles. A lack of support was inevitable since PMDD is rare, often misdiagnosed, and underrated. The PMDD partners stated that they outwardly searched for resources to learn more about PMDD and help their partners manage their lifestyles and relationships without sustenance.

The lack of awareness of PMDD within the professional realm directly affected PMDD partners as they were sent to find someone who has established tools and strategies to address PMDD and not be directed to resources outside the diagnosis. PMDD partners stated that the PMDD sufferers were misdiagnosed with medical conditions similar but not specific to PMDD, such as bipolar disorder, borderline personality disorder, PMS, anxiety, or depression. PMDD

significantly impacts the sufferers more than PMS (Marfuah, 2018). This false diagnosis only gave resources to disorders that the PMDD sufferer did not have, thus causing further turmoil in finding support for the condition of PMDD that they were experiencing.

### **Research Question Responses**

The purpose of this transcendental phenomenological study was to describe the relationship experiences of PMDD partners. The interview questions that were answered by the PMDD partners and the PMDD sufferers were directly correlated with the research questions and provided insight onto the relationship experiences of PMDD partners. There were a variety of responses that were given and yet there were common themes that existed to connect them all together.

### ***Central Research Question***

The central research question: **What are the relationship experiences of the PMDD partners?** The relationship experiences of PMDD partners had many similarities in feeling anxious, fearful of the future, and confused about how to best support the PMDD sufferer and their emotional well-being. Aaron stated, “I would hate to...refer to her as a mood killer or so to speak, but it is something that I have to kind of mentally sort of prepare myself before I go in...[to] kind of interaction.” This directly expressed his need to protect himself from his partner suffering from PMDD and led to the fear of the unknown that existed with all the PMDD partners within this study. Since every month with a PMDD sufferer is different because the symptoms experienced fluctuate, there was little sense of security or comfort in preparedness for the PMDD partner. Aaron said” Well, it is scary because I care about her a lot, but I also do not know if I want to subject myself to being with someone with PMDD for the next thirty years you

know.” Another common experience is the lack of control experienced by PMDD partners.

Samuel stated:

Just having to regiment my life in a way that I am not used to, where we can do whatever we want but only half the time. I do not like feeling limited in that way. I do not like feeling like I have to say no to plans or yes to this, or I do not like feeling that I am not in control, and I am just not PMDD is the driver.

Because PMDD had control over the sufferer’s life, the partner’s life was also affected, which was a significant struggle.

### ***Sub-Question One***

The first sub-question: **How do PMDD partners describe their potential cyclic attachment styles within their relationship with PMDD sufferers?** Within the interviews with PMDD partners, the attachment styles seemed to shift into the avoidant state once the PMDD symptoms arose for the PMDD sufferer. Aaron revealed “Knowing that she is at you know twenty percent of her full capacity and can barely eat, shower, call her mom back, do any work I feel like my needs, for her sake, I put them on the back burner” The reasoning behind this avoidance was a coping mechanism to avoid potential conflict. Samuel stated:

I would rather have the space; it also creates potential for conflict. For me, to say something wrong or trigger something when she is already in a state where those triggers are going to happen fast or are more likely to come up.

During the times that the PMDD sufferer is experiencing PMDD symptoms, the partner feels the need to give her space to avoid the harm associated with conflict within the relationship. Daniel stated, “I prefer to have space for my own sake because, again, it just kind of saps you of your own spirit.” This quotation indicates his shift into the avoidant attachment style to protect his

own emotional well-being. Aaron confessed “Towards the end of her cycles, I am just kind of over it I am sick of it you know and so it is not that I check out but there is that undercurrent in my head going I will be there for you once this is over you know come and find me when this is done.” Despite the differences in the reasoning behind the shift into the avoidant attachment style, it was evident that it was solely when the PMDD sufferer experienced the presence of PMDD symptoms. Once the PMDD symptoms subsided, the partner resumed having a secure attachment style during the PMDD sufferer’s follicular days.

### ***Sub-Question Two***

The second sub-question: **How do PMDD partners discover that their relationship experience with a PMDD sufferer can potentially place them at risk for suicide?** Aaron revealed “Well, I question it a lot more when she is in her luteal phases I wonder if it is all worth it and what we are doing all of this for.” One of the prominent elements of suicide, according to the interpersonal theory of suicide, was the indication of the individual having a sense of hopelessness, which was apparent within the interview process. “So, to say that for half of our relationship, she has been simply really affected by this disorder I mean that is the scary part and then to say that pretty much however long we are going to be together half of that time is taken by this disorder.” Aaron, a PMDD partner, stated:

Just my feelings of kind of helplessness of wanting it to be over. I mean, I have all sorts of negative thoughts towards the end: do I want to do this anymore? Why am I doing this? Is this what I want? But, I still love her, and I do not know; it just is hard for me to unthink all those thoughts just with a snap of my fingers.

The feeling of being helpless and hopeless as a PMDD partner stemmed from the lack of resources and support available for the partners of PMDD sufferers. “But I do not know it gave

me a scary glimpse into what my life could be like if we were not together.” Ashley, a PMDD sufferer, stated this regarding her observation of her partner’s experience:

I feel like they would be suffering with this potential feeling of helplessness, not being able to solve the situation with the tools and resources that they have. Potentially, like a little bit of doom and gloom because it is a life-long thing.

This additional acknowledgment of helplessness indicated that the PMDD sufferer observed the notion of feeling hopeless as a PMDD partner. Aaron expressed “It is the stress of knowing that she is in pain the stress of knowing there is no cure for it.” Overall, the theme of hopelessness was prevalent within this research study regarding PMDD partners.

### **Summary**

This chapter included descriptions of the research study participants and the developed themes. The developed themes were cyclic avoidant attachment styles, anxiety within PMDD partners, and a lack of support and understanding for PMDD partners. Aaron relayed “And so it starts off slow, giving extra, trying to be as you know supportive as possible but by the end of it I am pretty drained and I am like no I do not want to do all the dishes four days in a row anymore.” The relationship of PMDD partners was explained as tumultuous on a monthly basis. They expressed their deep emotional pain in attempting to navigate an intimate relationship with a PMDD sufferer without the effective tools that could lead to the cyclic nature of this disorder. Eventually, the follicular days which were once considered the good days within the relationship were overshadowed by conflict, bitterness and resentment from the negative relational experiences monthly. The potential risk for suicide is directly linked to the PMDD partner’s ability to manage their emotional responses to the PMDD sufferer’s episodes. The chapter

addressed the responses to the central research question and the sub-research questions. This chapter concluded with an overview of the relationship experiences of PMDD partners.

## **Chapter Five: Conclusion**

### **Overview**

This transcendental phenomenological research intended to explore the relationship experiences of partners of individuals suffering from PMDD. This chapter includes a summary of the findings and a discussion regarding the literature and theories utilized within this study: the adult attachment theory and the interpersonal theory of suicide. Additionally, it elaborates on the delimitations and limitations of the research study, provides recommendations for future research, and concludes with a summary.

### **Summary of Findings**

Through the data collection and analysis process, the researcher discovered three themes regarding the relationship experience of PMDD partners: hopelessness, cyclic attachment styles, and a lack of support and understanding of PMDD. The three themes identified directly correlated to the research questions.

### **Research Question One**

**What are the relationship experiences of the PMDD partners?** The response to this research question was that PMDD partners were operating in their relationships with much caution and confusion, primarily because they lacked the knowledge of what to do when their partner was suffering from PMDD. When the PMDD partners expressed their failed attempts to support the sufferer, they explained how they were verbally abused for their failures, which they internalized. The lack of support stems from not having an outlet to openly express how they feel in a forum that would provide potential solutions to the PMDD disorder. Traditional forms of therapy that PMDD partners had utilized were ineffective because it did not provide them with tools to take back to their relationship with the PMDD sufferer to help them navigate the intimate

relationship in a way that did not cause them to suffer.

### **Sub-Question One**

**How do PMDD partners describe their potential cyclic attachment styles within their relationship with PMDD sufferers?** The response to this research question was that the avoidant attachment style was developed within PMDD partners due to their avoidance of PMDD. They disliked the traits that PMDD caused in their partners, so they avoided the PMDD sufferer altogether. Initially, this was a subconscious process as they genuinely love and care for their partner, yet as time progressed, they found themselves avoiding spending time interacting with the PMDD sufferer until they knew that the PMDD symptoms were gone. The cyclic nature arises when the PMDD sufferer is in her follicular days without PMDD symptoms, and the PMDD partner desires to relate to the sufferer again. This cycle happens monthly and has reached a point where both individuals within the relationship accept the cyclic avoidant attachment style as normality.

### **Sub-Question Two**

**How do PMDD partners discover that their relationship experience with a PMDD sufferer can potentially place them at risk for suicide?** The overarching theme of hopelessness was prevalent amongst the PMDD partners, primarily due to their inability to solve their partner's suffering. The PMDD partners explained that it hurt them to see their partner suffering from PMDD symptoms for weeks and be unable to do anything about it. In addition, the hopelessness was further solidified by the fact that there is no cure for PMDD. Many PMDD partners spoke of their hopes and dreams of a family with the PMDD sufferer, which was accompanied by an overwhelming sense of fear and anxiety on how they would manage to have a family alongside the suffering of the PMDD symptoms. Finally, a sense of isolation reinforced

the hopelessness as they believed that no one understood what they were experiencing as PMDD partners, and seeking help was not a viable option because of the rarity of the knowledge of the PMDD disorder.

### **Discussion**

This section reviews the literature examined in Chapter Two. The theoretical framework identified within this study consisted of the interpersonal theory of suicide and the adult attachment theory. Gaps within the research were discovered within PMDD, specifically regarding the partner's relationship experience. Overall, the research surrounding this study authenticated the discussion of the lived experiences of partners of individuals who suffer from PMDD.

The symptoms of PMDD are far more intense and debilitating compared to regular Premenstrual Syndrome (PMS) and can significantly interfere with an individual's daily life and activities (Heinemann et al., 2010). Common symptoms of PMDD include emotional symptoms of mood swings, irritability, anxiety, depression, feelings of hopelessness, and a sense of being overwhelmed. Physical symptoms of fatigue, bloating, breast tenderness, headaches, joint or muscle pain. Behavioral symptoms of changes in sleep patterns, difficulty concentrating, changes in appetite or food cravings, and social withdrawal. The exact cause of PMDD is not fully understood, but it is believed to be related to the normal hormonal changes during the menstrual cycle, particularly fluctuations in estrogen and progesterone levels (Eisenlohr-Moul et al., 2022). Additionally, neurotransmitter imbalances in the brain, such as serotonin, may also play a role in the development of PMDD (Lin & Thompson, 2001).

PMDD partners experienced an array of difficulties within an intimate relationship with a PMDD sufferer. PMDD partners witnessed the PMDD Sufferer going through intense emotional

changes, such as mood swings, irritability, and feelings of hopelessness and it caused them immense emotional strain. Dealing with these emotional fluctuations was emotionally draining for PMDD partners every single month. During the luteal phase when PMDD symptoms were at their peak, PMDD sufferers had difficulty expressing themselves clearly and were more sensitive to perceived criticism and rejection sensitivity and this greatly impacted the intimate relationship. PMDD partners found it challenging to communicate effectively during this time, which led to misunderstandings and conflicts within the intimate relationship.

The severity and cyclic nature of the PMDD symptoms led to disruptions in the intimate relationship. PMDD partners felt overwhelmed and frustrated by the unpredictable nature of the symptoms and the impact they had on daily life, intimacy, and social plans. When PMDD symptoms were severe, partners needed to take on additional responsibilities to support the PMDD sufferer during that time. This shift in roles was stressful for the PMDD partner, particularly if they were unprepared for such changes. PMDD partners struggled with knowing how best to support the PMDD sufferer during PMDD episodes. They felt helpless, unsure of what to do or say, and feared inadvertently saying or doing things that triggered an emotional PMDD response. PMDD partners found themselves dedicating significant time and energy to support the PMDD sufferers and this often led to bitterness and resentment over time. Additionally, it created feelings of exhaustion and neglect if they don't prioritize their own self-care and social lives. PMDD symptoms are unpredictable, making it challenging for PMDD partners to anticipate how the PMDD sufferer will feel or behave during the luteal phase within their relationship. This uncertainty added to the emotional strain and stress on the relationship.

## **Theoretical Literature**

PMDD is a cyclical, hormone-based mood disorder with symptoms arising during the premenstrual or luteal phase of the menstrual cycle and subsiding within a few days of menstruation (Sharma & Pathak, 2022). It affects an estimated one in 20 women of reproductive age. PMDD can lead to significant mood changes, emotional sensitivity, and physical symptoms in the days leading up to menstruation, which can affect an intimate relationship. There are 11 symptoms of PMDD: anxiety, mood swings, depression, irritability or anger, decreased interest in regular activities, problems concentrating, appetite changes, fatigue, problems sleeping, feelings of being out of control or overwhelmed, and feeling overwhelmed or out of control (Berger, 1996). While PMDD primarily affects the person experiencing it, it also has an impact on their partners and relationships. PMDD symptoms can fluctuate cyclically, causing significant mood, behavior, and emotional regulation changes. These fluctuations can create challenges in the dynamics and attachment styles within the relationship. The interpersonal theory of suicide and the adult attachment theory guided the theoretical literature examined in this research study. Throughout this study, these two theories were extended as they identified a gap in research within the context of the relationship experiences of partners of individuals who are suffering from PMDD.

### ***Interpersonal Theory of Suicide***

Van Orden et al.'s (2005) interpersonal theory of suicide provided insights into the relationship experience of PMDD partners by highlighting the potential risk factors and dynamics that may contribute to the vulnerability of individuals affected by PMDD. This theory directly correlates to the experiences of PMDD partners as they withheld the three main characteristics of the predictors of suicide, which are thwarted belongingness, perceived

burdensomeness, and the acquired ability for suicide. This theory indicates that suicidal behavior can be challenging because of the emotions surrounding it (Ribeiro, 2014). The PMDD partner's emotional well-being was often neglected because their suffering was not directly correlated with a disorder, yet they also suffered because of it (Huang et al., 2018). The desire for suicide directly correlates to the intense emotions regarding this experience. The PMDD partners need to minimize their suffering stemming from their perceptions that their emotional well-being was far inferior to the suffering they witnessed from the PMDD sufferer.

**Thwarted Belongingness.** A predictor of suicide risk within the interpersonal theory of suicide was thwarted belongingness. The PMDD partners felt a deep sense of isolation within the relationship during the luteal menstruation phase when PMDD symptoms were present. According to Morpeth (2018), if one is not connected, one may begin to desire death. In this study, thwarted belongingness occurred primarily because some PMDD sufferers isolate themselves as they attempt to cope with their symptoms. Additionally, the PMDD partners perceived themselves as a burden and felt that their emotional and physical needs were less important than their partners' needs.

During the luteal phase, PMDD partners continuously minimized sharing their struggles because they did not believe that the PMDD sufferer could manage any additional challenges. PMDD patients have severe symptoms during the late luteal phase (Kask et al., 2008). The feelings of isolation also stemmed from others' lack of understanding of their struggle with navigating a relationship inclusive of PMDD. The lack of support for navigating a relationship with PMDD caused the PMDD partners to develop a sense of abandonment and a loss of their sense of self.

PMDD significantly impacts the emotional well-being and social functioning of PMDD sufferers. The intense mood swings, irritability, and depressive symptoms associated with PMDD strained intimate relationships, leading to feelings of disconnection and isolation. PMDD partners struggled to understand and empathize with the PMDD symptoms, resulting in a sense of thwarted belongingness. The PMDD sufferer felt misunderstood and unsupported, while the partner felt helpless and disconnected from their loved one.

**Perceived Burdensomeness.** PMDD symptoms, such as emotional volatility, anxiety, and irritability, can contribute to a perception of burdensomeness in the PMDD partner. The PMDD partners described feeling guilty or responsible for the distress they cause their partner, leading to a sense of being a burden. Being unable to provide any sense of relief from the PMDD sufferers' symptoms was a daunting burden to carry. Additionally, during the luteal phase, high rates of conflict arose, including the four horsemen of the apocalypse, which are blaming, shaming, defensiveness, and contempt. These factors supported the notion that the PMDD partner was a burden to the sufferer because they failed to provide adequate support that would allude to their intimate relationship being helpful instead of hopeless. The simultaneous presence of hopelessness and thwarted belongingness are statistically proven to be predictors of suicidal ideations (Mantachie et al., 2021). This perceived burdensomeness amplified the PMDD partners' distress and contributed to the risk of suicidal ideations.

**Acquired Capability for Suicide.** The acquired capability component of this theory is applied to PMDD partners and their relationship experiences with PMDD sufferers. While a PMDD relationship itself does not directly increase the acquired capability for suicide, the emotional distress and challenges associated with being in an intimate relationship with a PMDD sufferer did become a factor. When combined with other risk factors, such as past traumatic

events within the relationship, PMDD contributed to the development of acquired capability. One of the most significant risk factors was the monthly breakup suggestions made by the PMDD partners and sufferers. These decisions to terminate the relationship were claimed to have occurred during the precipice of the conflict during the luteal phase when PMDD symptoms were present.

The ability to manage a heightened level of conflict and stress was significantly decreased for the PMDD partner and sufferer during the luteal phase, which contributed to the desire to terminate the relationship to ease the emotional distress that was experienced. The thoughts of breaking up led to a sense of hopelessness within the PMDD partner. PMDD partners are faced with the notion that their partners' suffering is not curable, and thus the feeling of hopelessness resides in the inability to affect any positive change in their relationship. This hopelessness is a crucial factor in the acquired capability of suicide for the PMDD partner.

Hopelessness was a pivotal contributor to the acquired capability for suicide for PMDD partners. The sense of hopelessness was derived from the PMDD partners' challenges of supporting a partner with PMDD, primarily during the luteal phase of the menstrual cycle when PMDD symptoms were present. With no cure for PMDD, the partners progressively lost hope throughout their relationship. Initially, PMDD partners were hopeful that they could navigate their relationship with the presence of the PMDD symptoms, yet over time, the monthly arguments and fights diminished their sense of hope. Hopelessness has the propensity to cause the PMDD partner to develop a depressive mood and thus encounter intense suicidal ideations (Ribeiro et al., 2018).

A critical factor in the hopelessness within the PMDD partners is the cyclic nature of the disorder. They experienced a challenging event within the month and had little to no time to

recover from the negative experience before the PMDD symptoms arose again within the sufferer and caused additional emotional damage to the PMDD partner. The effects of the hopelessness on PMDD partners in conjunction with the acquired capability for suicide is that there is no cure for PMDD and, thus, no end to their suffering if they remain within the relationship.

According to the ideation-to-action framework regarding the interpersonal theory of suicide, the continuous nature of an individual getting triggered by a painful experience creates a guiding path towards the pain and fear associated with attempting suicide, which was prevalent in the PMDD partners' experiences as they are on a monthly cyclic journey of being triggered and experiencing the fear of what each month of PMDD symptoms will bring out of their partner. In addition, there is the pain of observing their partner suffer with an inability to relieve them of their debilitating symptoms for more than half of the month.

This research study illuminated the interpersonal theory of suicide by exploring the relationship experiences of PMDD partners and their potential risk for suicide. There is a comorbid relationship between PTSD and PMDD, but scholars have not determined if the relationship begins with trauma leading to PTSD or if PTSD is directly associated with PMDD (Pilver et al., 2011). It could be perceived that PMDD sufferers would be the only potential risk for suicide; however, this study examined the partners' experiences. The characteristics of hopelessness and thwarted belongingness that are present and thoroughly researched within this theory directly align with the relationship experience of PMDD partners. The partners of individuals suffering from PMDD have a far greater propensity to attempt suicide than previously acknowledged.

### ***Adult Attachment Theory***

The adult attachment theory is a psychological framework that explores the dynamics of emotional bonds and attachment patterns between adults in romantic relationships. The theory was initially developed by John Bowlby, a British psychologist, to understand the parent-child relationship, but later researchers, including Mary Ainsworth and Mary Main, extended it to study adult relationships. The core premise of adult attachment theory is that humans have an innate need to form strong emotional bonds and attachments with others, starting from infancy and continuing throughout adulthood. These emotional bonds influence an individual's emotional regulation, interpersonal relationships, and well-being. The theory suggests that individuals develop internal working models based on their early caregiving experiences, which shape their expectations about how relationships work and how others will respond to their needs. These internal working models are thought to guide behavior and emotional responses in future relationships, including romantic partnerships.

The adult attachment theory primarily focuses on the emotional connections made in intimate relationships. This theory has been widely studied and has provided valuable insights into understanding relationship dynamics, communication patterns, and emotional needs. The PMDD partners in this study exhibited a cyclic attachment style during the luteal phase of menstruation and the follicular, ovulation, and menstrual phases. Adults have four main attachment styles based on their early attachment experiences: secure attachment style, anxious-preoccupied attachment, dismissive avoidant attachment, and fearful-avoidant attachment style.

**Secure Attachment.** Individuals with a secure attachment style typically had caregivers who were consistently responsive, sensitive, and available during childhood. As adults, these individuals tend to have trusting, balanced, and satisfying relationships. They feel comfortable with emotional intimacy and can rely on their partners and be relied upon in return. During the

follicular phase of menstruation, when PMDD symptoms were absent, it was revealed that there was a secure attachment between the PMDD sufferer and partner. Partners in happy relationships see constructive actions from significant others as consistent and characteristic of both partners (Lute, 2015). The follicular phase served as a secure baseline for the foundation of the intimate relationship and solidified the reasoning that the PMDD partners desire to be in an intimate relationship with the PMDD sufferers.

Without the PMDD symptoms, the PMDD partners relished all the qualities they desired to have in a partner, such as love, affection, attention, and validation. Within the same month, once the luteal phase began, it was recounted that the secure attachment style diminished and was replaced by the other phases identified within the adult attachment style. Within the relationship with the PMDD sufferer, the PMDD partner had an interference with attachment needs. Humans have a fundamental need for secure attachment and connection. When conflict disrupts or damages these attachments during the luteal phase when PMDD symptoms are present, it results in emotional pain, feelings of abandonment, and a sense of being fundamentally unlovable, profoundly impacting the PMDD partners' self-esteem and security.

**Anxious-Preoccupied Attachment.** Those with an anxious attachment style often experienced inconsistent caregiving during childhood. As adults, they may worry about being abandoned or unloved, leading to a high need for reassurance and emotional closeness from their partners. They may also be prone to jealousy and fear of rejection. The anxious-preoccupied attachment style has been posited for PMDD sufferers once their symptoms arise. There was a distinct decrease in their self-image and security within the intimate relationship. The premise of managing the PMDD symptoms that displayed negative qualities, such as depression, fatigue, intrusive thoughts, and rage, contributed to the ideation that they were of less value in the

relationship to their partner while suffering the symptoms. It was identified that there was an increased need for external validation from the PMDD partner to self-soothe the lack of self-worth that developed while they were suffering within the luteal phase. Additionally, the need for attention was prevalent from the PMDD sufferers as they sought assurance that their partner desired to be within the relationship once the insecurities associated with this attachment style surfaced, which in turn created a great deal of pressure and burden on the PMDD partner to accommodate this cyclic need for additional validation on a cyclic basis.

PMDD partners also experienced an anxious-preoccupied attachment style during the luteal phase. The intense mood swings, emotional sensitivity, and irritability associated with PMDD lead to uncertainty and a need for constant reassurance and validation from the PMDD sufferer. They consistently worried about their partners' well-being and felt the need to accommodate or tiptoe around potential triggers or conflicts during this time. During this time, they consciously decided not to disclose any issues that involved themselves as they assumed the PMDD sufferer could not manage it.

**Dismissive-Avoidant Attachment.** Individuals with the dismissive-avoidant attachment style may have had caregivers who were emotionally distant or unresponsive during childhood. As adults, they tend to be uncomfortable with emotional intimacy and may have difficulty trusting others. They might value independence and self-reliance in relationships, sometimes leading to emotional distance from their partners. The dismissive-avoidant attachment style was confirmed to be most prevalent within the PMDD partners. It was postulated that they developed a dismissive-avoidant attachment style as a coping mechanism during the luteal phase of their partner's PMDD. The sudden changes in mood and emotional volatility proved overwhelming and led to a desire to distance themselves emotionally. They recounted suppressing their

emotional needs and becoming emotionally self-reliant to protect themselves from potential conflict or distress. The need to dissociate from the intimate relationship during the luteal phase is the cause for this shift in the attachment style, which was indicative of the loss of their social life that was commented on once the PMDD sufferer exhibited their symptoms. PMDD partners articulated that although they tried their best to understand their partner's suffering, they desired to avoid it as much as possible for their own emotional and mental health. It was contended that the avoidance of intimacy did not result from a lack of desire to be close to the PMDD sufferer, yet it was a fear of the outcome because of the fluctuating moods associated with their PMDD symptoms.

**Fearful-Avoidant Attachment.** The fearful-avoidant attachment style is a combination of anxious and avoidant tendencies. Individuals with a fearful avoidant attachment style may have experienced traumatic or abusive caregiving during childhood, leading to internal conflicts and confusion in adult relationships. They may struggle with the desire for closeness and the fear of rejection. It was revealed that PMDD partners experience a fearful-avoidant attachment style during the luteal phase of their partners' cycles. They desired closeness and connection with the PMDD sufferer while fearing rejection, abandonment, or being negatively affected by their mood swings or emotional instability. This conflict created a push-pull dynamic in the relationship because PMDD partners struggled with the need for intimacy while guarding themselves against potential emotional harm.

Individuals with a fearful-avoidant attachment style have negative views of themselves and others. They often desire close relationships but are simultaneously fearful of rejection or being hurt. The fearful-avoidant attachment style was the most common attachment style amongst PMDD partners during their partners' luteal phase. The main reason for adopting this

attachment style is the innate desire not to be hurt within the intimate relationship because of the past trauma associated with conflict involving PMDD. Relationship conflict can create trauma when it involves repeated or severe experiences of emotional, psychological, or physical harm within the context of close relationships. Trauma is the emotional and psychological distress resulting from an overwhelming or distressing event or series of events. The series of events is the cyclic nature of the PMDD sufferer experiencing PMDD symptoms monthly and their reactions to it within the relationship.

Trauma produced within the relationship between the PMDD partner and the sufferer ranged from betrayal and emotional harm due to the monthly intense conflicts characterized by betrayal, emotional manipulation, gaslighting, and psychological abuse, which deeply wounded the PMDD partners. These experiences erode trust, destabilize one's sense of self, and create emotional distress that can be long-lasting.

In addition, the PMDD partners experienced fear and threats during the luteal phase. Conflict that involves threats or intimidation can evoke intense fear and a sense of personal safety being compromised. Living in constant fear and uncertainty can lead to traumatic stress reactions, such as hypervigilance, anxiety, and a heightened startle response. It was contended that there was a presence of power imbalances and control within the relationships. Relationships characterized by power imbalances, control, or coercive tactics can be traumatizing. When one person consistently dominates or suppresses the other's autonomy and agency, it can lead to a sense of helplessness, learned helplessness, and a loss of self-worth.

The PMDD partners expressed that within the relationship with the PMDD sufferers, there was a cumulative impact of suffering for the PMDD partner. The cumulative effect of ongoing conflict, especially when unresolved or escalating over time, can wear down an

individual's resilience and coping mechanisms. This chronic exposure to conflict can lead to chronic stress, emotional dysregulation, and a compromised ability to form healthy relationships in the future.

The adult attachment theory posited the discovery of the cyclic attachment style that exists within a relationship with the PMDD sufferer and the effects that it can have on the PMDD partner. It is important to note that these attachment style fluctuations were specific to the luteal phase and not reflective of the overall attachment style in the relationship. Outside of the luteal phase, PMDD partners experienced a secure attachment style.

### **Empirical Literature**

This study extended previous research by revealing the relationship experiences of partners of individuals with PMDD and closed the research gap between what the PMDD sufferer was experiencing and its impact on the PMDD partner. For example, existing research clearly stated the physical, emotional, psychological, and functional impairment of PMDD sufferers, but it lacked insight into how that would affect another individual who would relate to the PMDD sufferer in an intimate relationship.

What differentiates PMDD is a list of 11 groups of symptoms that, according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), are used to make the diagnosis. The list includes feelings of hopelessness and sadness, persistent irritability, feeling anxious or tense, mood swings, losing interest in daily activities and withdrawing from social situations, fatigue and lethargy, feeling overwhelmed, sleeping too much or not sleeping at all (insomnia), inability to concentrate, food cravings and changes in appetite, bloating, breast tenderness, headache, or other cyclic physical changes. (Bosarge, 2003, p. 14)

PMDD's cyclic nature makes this insight unique because the suffering, conflicts, and negative impacts on the relationship lasted only half a month.

This study gave new insight into the adult attachment theory by incorporating the impacts of PMDD and its correlation to the cyclic attachment styles in an adult intimate relationship. The adult attachment theory addresses the impacts of childhood experiences in adult intimate relationships, and this translates to the PMDD sufferers' and partners' experiences in the follicular phase of the menstrual cycle when no PMDD symptoms are present. In contrast, this research identified that PMDD symptoms in the luteal phase of the menstrual cycle affected the attachment style of the PMDD partner based on how the PMDD sufferer shifted their behaviors and perceptions of the intimate relationship, which extended to in-depth analysis and understanding that the cyclic aspect of PMDD affects the attachments styles of the PMDD partner without the inclusivity of childhood experiences, which revealed that although attachment styles are founded in early childhood experiences, they can adversely be altered when the presence of PMDD is integrated within the relationship.

This study confirmed previous research regarding the interpersonal theory of suicide concerning the experience of PMDD partners. This theory identified that the desire for suicidal actions emerges when an individual experiences perceived burdensomeness, thwarted belongingness, and the capability for suicide. For PMDD partners, it was uncovered that the relationship experiences that connected them to this theory were linked to the anguish of the PMDD sufferers. PMDD can have a significant impact on PMDD partners due to the emotional and behavioral symptoms it presents. The cyclic attachment styles extrapolated by the intense mood swings, irritability, and emotional instability associated with PMDD impacted the well-

being of the PMDD partners and aligned with the feelings of thwarted belongingness. PMDD partners struggled to cope with the cyclic shifts in mood and behavior.

### **Implications**

This section intended to provide empirical, theoretical, and practical implications for this research. Recommendations were provided for the psychologist, counselors, therapist, and students who desire to advance this research through further exploration.

#### **Empirical Implications**

This study aimed to address the gaps in the current studies that failed to examine the relationship experiences and impact assumed by partners of individuals suffering from PMDD. PMDD is an under-researched and controversial disorder recently added to the *Diagnostic and Statistical Manual of Mental Disorders 5* in 2013. The article “How a Bake Off Winner Shed Light on the Monthly Torture of PMDD” (2019) stated, “The International Association for Premenstrual Disorders (IAPMD) estimates that 30% of PMDD sufferers will attempt suicide in their lifetime yet, despite the severity of the condition, many women struggle to receive a correct diagnosis” (para. 18). Since PMDD has been added to the DSM, the focus has been on the PMDD sufferer and not the impacts that pertain to the PMDD partner. Furthermore, research failed to address the implications of the emotional, mental, and suicidal risks of the PMDD partner as they navigate an intimate relationship with a PMDD sufferer who experiences an array of debilitating symptoms that last half of every month. The themes and subthemes identified within this research study enhance the awareness of the PMDD partners’ relationship experience and can open the pathway toward more support and resources for the areas where they suffer.

The symptoms of PMDD are far more intense and debilitating compared to regular PMS and significantly interfere with the PMDD sufferer’s and partner’s daily lives and relationships.

Common PMDD symptoms reported within this study included emotional, physical, and behavioral changes during the luteal phase of menstruation. The emotional symptoms included mood swings, irritability, anxiety, depression, feelings of hopelessness, and a sense of being overwhelmed. The physical symptoms were fatigue, bloating, breast tenderness, headaches, and joint or muscle pain. The behavioral symptoms included changes in sleep patterns, difficulty concentrating, changes in appetite or food cravings, and social withdrawal.

PMDD partners in this study struggled with knowing how best to support their loved ones during PMDD episodes. PMDD symptoms are unpredictable, making it challenging for partners to anticipate how their loved one will feel or behave during the luteal phase, which can add to the emotional strain and stress on the relationship. The PMDD partners felt helpless, unsure of what to do or say, and inadvertently feared saying or doing things that triggered emotional responses while there were PMDD symptoms. The PMDD sufferer often berated PMDD partners for not knowing how to support them, and the messaging was inclusive of anger, rage, hostility, and a lack of remorse for the emotional well-being of the PMDD partner. During these times, the PMDD partners developed a sense of fear and anxiety within the relationship due to the unpredictability of the mood and behavioral shifts of the PMDD sufferer.

Additionally, PMDD partners found themselves dedicating significant time and energy to supporting their loved ones with PMDD, which led to their own feelings of burnout, fatigue, and neglect. The PMDD partners often kept their emotional and physical needs to themselves because of the ideation that their struggles were inferior to the PMDD sufferer. The internalization of their suffering created a lack of intimacy and connectedness. In addition, isolation was a factor as PMDD partners failed to share their burden with anyone else because they feared that no one would understand due to the limited visibility and awareness of PMDD.

The related literature revealed within chapter two recognized some of the sufferings that PMDD partners could potentially endure in an intimate relationship with a PMDD sufferer. However, the cyclic attachment styles and suicidal risks that were identified within this research study for PMDD partners were not explored in prior research. For example, Rückert-Eheberg et al. (2019) stated that individuals with insecure attachment styles are approximately three times more likely to experience suicidal ideation than their counterparts with other attachment styles. This research provided insight into how PMDD partners would be a vital indicator of these risks due to their relationship experiences. This research provided much-needed information to develop coping strategies customized to PMDD partners' needs.

### **Theoretical Implications**

This research study included theoretical implications that coincide with Joiner's interpersonal theory of suicide. Research indicated that the menstrual cycle can produce thoughts and behaviors of self-injury, which may indicate that neurobiological hormonal sensitivities, such as those encountered in PMDD, may increase suicidal risk in females (Eisenlohr-Moul et al., 2022). This research study supported the notion that PMDD is an identified risk for suicide, yet not primarily for the sufferer but also for the partner. Joiner's theory accurately revealed the suicidal risk in conjunction with PMDD, and this research study expounded on that exploration by including the potential risk for the PMDD partners.

### **Practical Implications**

The practical implications for this research study are that PMDD can impact the partner's social life in several ways, depending on the severity of symptoms and the coping strategies employed by both partners. PMDD is characterized by various physical, emotional, and behavioral symptoms that occur in the luteal phase of the menstrual cycle, which is the time

between ovulation and the start of menstruation. PMDD significantly impacts the partners of individuals who experience the disorder. “Among men who had attempted suicide, the main precipitating reason offered was distressed intimate partner relationships, which manifested participants’ ‘tainted masculine honor” (Oliffe et al., 2022, pg. 366) PMDD partners often navigate various challenges and emotions when supporting someone with PMDD. PMDD partners endured emotional strain monthly as they witnessed their loved one going through intense emotional changes, such as mood swings, irritability, and feelings of hopelessness. Dealing with these emotional fluctuations was draining for PMDD partners.

Some of the most common relationship difficulties were with communication and conflict resolution. During the luteal phase, when PMDD symptoms were at their peak, PMDD sufferers had difficulty expressing themselves clearly and were more sensitive to perceived criticism. PMDD partners found communicating effectively during this time challenging, leading to misunderstandings or conflicts. The severity and cyclic nature of the PMDD symptoms lead to monthly disruptions in the relationship, primarily during the luteal phase of menstruation, and the conflicts seemingly subsided as the PMDD symptoms dissipated. PMDD partners felt overwhelmed and frustrated by the unpredictable symptoms and their impact on daily life, intimacy, and plans for the future, such as having children and maintaining a healthy home. When PMDD symptoms were severe, PMDD partners needed to take on additional responsibilities to support their loved ones. This role shift was stressful for PMDD partners as they took on the caregiver’s burden.

This study discovered that the PMDD partners’ social lives were significantly impacted as they believed they were limited in their social interactions and that PMDD controlled how they lived and interacted with others. Over time, this formulated bitterness and resentment within

the PMDD partners. These negative emotions were harmful to the relationship with the PMDD sufferer and led to either an anxious or avoidant attachment style to cope with the impacts of this disorder on the relationship.

Counselors, psychologists, and therapists can develop specialized tools and coping mechanisms for PMDD partners as they navigate an intimate relationship with PMDD sufferers. Researchers have expanded the distinction between physiological symptoms and pathology for PMDD patients, pharmaceutical companies, and physicians (Kleinplatz & Offman, 2004). The ideal coping mechanism for the therapist would be support and understanding because PMDD partners often have a crucial role in providing support and understanding for someone with PMDD. Support may involve educating themselves about the condition, accompanying their partner to medical appointments, and providing emotional support during symptomatic periods. While this can be challenging, it can also foster a more profound sense of empathy and resilience in the relationship.

Counselors can address the limitations on future planning within the relationship because the cyclical nature of PMDD, with regular symptoms, can affect the ability to make long-term plans or commitments. The unpredictability of symptom severity or the need to accommodate the partner's needs during symptomatic periods may impact the partner's ability to engage in future social or personal endeavors. Counselors should also address the reduced level of social activities in the relationship during the luteal phase of menstruation relationship. The PMDD sufferer felt less inclined or able to participate in social activities during the luteal phase, leading to decreased shared social engagements and dissatisfaction with the partner within the intimate relationship.

Psychologists can emphasize the increased stress and emotional burdens that must be addressed. PMDD partners may experience increased stress and emotional burden. They may

have to navigate the fluctuations in their partner's mood, provide support during challenging times, and handle conflicts that arise due to PMDD symptoms, which can impact their well-being and lead to feelings of helplessness, isolation, and suicidal ideations. Many patients find visiting different physicians, medication trials, and insurance hurdles cumbersome (Bettendorf, 2022).

### **Delimitations and Limitations**

The delimitations within this study were the minimum number of months that the PMDD partners have been in a relationship with a PMDD sufferer. Because PMDD is a cyclic disorder, it was imperative to create a minimum timeline of six months within the relationship to allow the PMDD partners to accurately express their relationship experience through the luteal phase of menstruation when PMDD symptoms were present as well as the follicular days when PMDD symptoms were absent (Michiko et al., 2021). Through this delimitation, the researcher captured the PMDD partner's whole relationship experience during multiple months as symptoms fluctuated.

The limitation of this study is that it only included heterosexual couples, which was not a disclaimer in the recruitment process, yet the participants who volunteered were all heterosexual; thus, this study was not inclusive of the relationship of PMDD partners with other sexual orientations.

### **Recommendations for Future Research**

Considering this study's findings, limitations, and delimitations, future research could examine the cause and cure for PMDD. The exact cause of PMDD is not fully understood, but it is believed to be related to hormonal changes during the menstrual cycle, particularly fluctuations in estrogen and progesterone levels. Additionally, neurotransmitter imbalances in the brain, such as serotonin, may play a role in the development of PMDD.

As discovered in this research study, much of the suffering imposed on PMDD partners was rooted in the fear of the unknown. The partner suffers as they try to navigate the PMDD symptoms in a way that does not cause further damage to their relationship. Research could expand on developing coping mechanisms and tools for PMDD partners specifically because the mechanisms currently in place do not address the cyclic nature of their partner in conjunction with the effects on their own mental health and attachment style within the relationship. The lack of research regarding PMDD leads to the experience of a loss of hope. With further research, the hope of PMDD partners may be restored along with an increase in their mental health stability.

Future research could explore the PMDD sufferers' desire to end their relationship with their partners once the symptoms arise. Many of the participants in this study who suffer from PMDD stated that their brain is specifically telling them to break up with their partner and creating a narrative that portrays the PMDD partner and their relationship negatively. However, these negative perceptions of their partner and relationship dissipate once the PMDD symptoms are absent during the onset of menstruation. Consequently, this facet needs further research to implement mechanisms to cope with these intrusive thoughts, identify the cause, and determine a cure for them to preserve the relationships between PMDD partners and sufferers.

Understanding the suicidal risk factors included within PMDD relationships can help provide support strategies for PMDD partners. Creating an environment of empathy, open communication, and validation can address the feelings of thwarted belongingness, perceived burdensomeness, and acquired capability for suicide. Encouraging mental health professionals to create, identify, and provide tools for managing PMDD partners can decrease suffering and potentially save lives. By understanding and addressing these factors, mental health professionals can develop effective strategies for suicide prevention and support PMDD partners.

Additionally, future research could examine the divorce rates of couples in a relationship who are navigating PMDD. This research study emphasized the PMDD partner's and sufferer's desire to end the relationship, exclusively during the luteal phase of menstruation with the presence of PMDD symptoms. The ability to maintain a relationship with a PMDD sufferer may be directly correlated to the divorce rates for these couples (Wlodarski et al., 2013). With additional research, the divorce rates of couples navigating PMDD could be lowered, and specific resources aligned with the cyclic nature of this disorder could be provided.

### **Summary**

PMDD is a cyclical mood disorder, meaning symptoms recur each month during the luteal phase of a female's menstrual cycle (Pearlstein, 2004). PMDD partners felt a sense of hopelessness when they saw their loved ones going through the same distressing experiences repeatedly for approximately half of every month with limited ability to prevent or alleviate the symptoms. PMDD symptoms strain the relationship between the PMDD partner and the sufferer. The emotional intensity and irritability during PMDD episodes led to conflicts, lack of intimacy, and emotional distance. PMDD partners felt hopeless about their relationship's future and plans, such as having children, due to the impact of PMDD. When conflicts from each month during the luteal phase remained unresolved, they struggled to communicate effectively. PMDD partners experienced feelings of hopelessness due to the challenging and unpredictable nature of the disorder.

PMDD significantly impacted the emotional well-being and dynamics within the relationship, leading to feelings of hopelessness in various ways. PMDD partners felt helpless and frustrated when they witnessed their loved ones experiencing intense emotional and physical symptoms during the luteal phase of the menstrual cycle (Johnson & Johnson, 2015). Despite

their best efforts at being supportive when their partner was experiencing PMDD symptoms, they struggled to provide adequate support or relief, leading to a sense of hopelessness within the relationship. PMDD symptoms were unpredictable, and PMDD partners found it challenging to anticipate when their partner experienced severe symptoms and feared how they would react emotionally during the luteal phase, which contributed to feelings of hopelessness because they did not know how to support or respond to their partners effectively. While the PMDD partners in this study attempted to offer emotional support and understanding, they felt powerless in addressing the underlying hormonal and physiological factors that contribute to PMDD symptoms, which can lead to hopelessness about the ability to improve their loved one's well-being. PMDD symptoms, such as mood swings and emotional withdrawal, disrupted the emotional and physical intimacy within the relationship, and it devastated the PMDD partners with having to come to terms with the notion that they may only feel connected to their partner for half of the month. This devastation led to feelings of abandonment, isolation, and emotional neglect, creating hopelessness about maintaining a close and fulfilling emotional bond during PMDD episodes. Additionally, PMDD partners felt hopeless because they could not control or fix their loved ones' PMDD. This lack of control was challenging for the PMDD partners who desired to support their partners throughout their suffering.

Partners of individuals with PMDD have experienced a cyclic attachment style due to the cyclical nature of the disorder and its impact on the emotional dynamics within the relationship. A cyclic attachment style refers to fluctuations in how a partner perceives and engages in the attachment relationship, influenced by the monthly cycles of PMDD symptoms. The PMDD partners within this study noted a secure attachment during the follicular phase when the PMDD sufferer was not experiencing severe PMDD symptoms; therefore, PMDD partners felt secure in

the relationship. They felt emotionally connected, trusting, and able to rely on their partner for support and closeness for their needs and well-being. During this phase, the relationship with the PMDD sufferer felt stable, healthy, and satisfying. As PMDD symptoms emerge during the luteal phase, PMDD partners experience anxiety and uncertainty about the relationship resulting in an anxious attachment. During the luteal phase, they observed and felt the PMDD sufferer becoming emotionally distant, irritable, or overwhelmed, leading to feelings of insecurity and fear of rejection or abandonment. In response to the PMDD sufferer's emotional fluctuations and distress during the luteal phase, PMDD partners adopted an avoidant attachment style, described as withdrawing emotionally to protect themselves from the heightened emotional intensity of the effects of the PMDD symptoms on the PMDD sufferer. PMDD partners also exhibited caretaking behavior during the luteal phase with PMDD symptoms, trying to alleviate their loved one's distress and provide support. PMDD partners experienced guilt and emotional conflicts related to their reactions during the luteal phase. They struggled with balancing their need for emotional support and understanding with the frustration or emotional exhaustion they experienced during the luteal phase.

This transcendental phenomenological study was intended to describe the lived experience of partners of individuals suffering from PMDD. The data was collected through semi-structured interviews and document analysis of the researcher's observations. Once the data collection process was completed, three major themes were developed: cyclic avoidant attachment styles, anxiety within PMDD partners, and a lack of support and understanding for PMDD partners. Upon completing the analysis of the PMDD partner's relationship experiences, it was discovered that PMDD partners are not adequately equipped with the knowledge or tools to navigate an intimate relationship with a PMDD sufferer without it causing harm to their

mental health. This harm is not based on their lack of effort but on the lack of support provided to the PMDD sufferer in managing their symptoms. The cyclic attachment style is linked to avoiding their partner suffering from PMDD symptoms so that they will not damage the relationship or themselves more. The anxiety comes from the fear of the unknown of how much longer they can survive the mental anguish they endure monthly, and then a sense of hopelessness comes from the knowledge that there is no cure for PMDD. To mitigate these issues, psychologists, counselors, and therapists need to learn about the intricacies of PMDD to provide some relief and coping mechanisms to PMDD partners and sufferers.

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## Appendix A

### IRB Approval

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# LIBERTY UNIVERSITY.

## INSTITUTIONAL REVIEW BOARD

April 12, 2023,

Rose Alkattan  
Mollie Boyd

Re: IRB Exemption - IRB-FY22-23-1051 A PHENOMENOLOGICAL STUDY OF THE RELATIONSHIP EXPERIENCES OF PARTNERS OF INDIVIDUALS WHO SUFFER WITH PREMENSTRAUL DYSPHORIC DISORDER (PMDD).

Dear Rose Alkattan, Mollie Boyd,

The Liberty University Institutional Review Board (IRB). has reviewed your application in accordance with the Office for Human Research Protections (OHRP). and Food and Drug Administration (FDA). regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2. (iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording). if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a).(7).

**Your stamped consent form(s). and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB.** Your stamped consent form(s). should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s). should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at [irb@liberty.edu](mailto:irb@liberty.edu).

Sincerely,

**G. Michele Baker, Ph.D., CIP**

*Administrative Chair*

**Research Ethics Office**

## **Appendix B**

### **Recruitment Flyers**

ATTENTION PMDD PARTNERS: I am conducting research as part of the requirements for a Doctor of Education with a concentration in Traumatology at Liberty University. The purpose of my research is to provide PMDD partners with an understanding of their cyclic attachment styles and tools to navigate their intimate relationship with a PMDD sufferer. To participate, you must be 18 years or older and be a couple in a relationship with a PMDD sufferer for six months or longer. Participants will be interviewed (30-45 minutes). If you want to participate and meet the study criteria, please click the link at the end of this post. A consent document will be provided on the first page of the survey. Please review this page, and if you agree to participate, click the Proceed to Survey button at the end. Participants will be given a \$25 Visa gift card as compensation for their participation and time.

To take the survey, click here:

# Research Participants Needed

## A PHENOMENOLOGICAL STUDY OF THE RELATIONSHIP EXPERIENCES OF PARTNERS OF INDIVIDUALS WHO SUFFER WITH PREMENSTRUAL DYSPHORIC DISORDER (PMDD).

- Are you 18 years of age or older?
- Have you been in an intimate relationship with an individual who suffers from Premenstrual Dysphoric Disorder (PMDD). for six months or longer?
- Are you the Partner with PMDD, or do you have a Partner with PMDD?
  - Are you and your partner both willing to participate in this study?

If you answered **YES** to these questions, you may be eligible to participate in a PMDD Partners Research Study.

The purpose of my research is to provide PMDD Partners with an understanding of their potential cyclic attachment styles and tools to navigate their intimate relationship with a PMDD Sufferer. Participants will be asked to individually participate in a one-on-one recorded interview that should take 30 to 45 minutes to complete. Names and other identifying information will be requested for this study, but participants' identities will not be disclosed. If you meet the study criteria, a consent document will be emailed to you. Participants will also receive a \$25 gift card for their time and participation. No medications will be given.

The study is being conducted virtually, and a Zoom link will be provided.

Rose Alkattan, a doctoral candidate in Community Care and Counseling with a concentration in Traumatology at Liberty University, is conducting this study.

**Please contact Rose Alkattan at [xxxxxxxxx@liberty.edu](mailto:xxxxxxxxx@liberty.edu) for more information.**

## **Appendix C**

### **Consent Form**

**Title of the Project:** A Phenomenological Study of the Relationship Experiences of Partners of Individuals Who Suffer with Premenstrual Dysphoric Disorder (PMDD).

**Principal Investigator:** Rose Anna Alkattan, Doctoral Candidate, School of Behavioral Sciences, Liberty University

#### **Invitation to be Part of a Research Study**

You are invited to participate in a research study. To participate, you must be 18 years old and have been in an intimate relationship for six months or longer with an individual diagnosed with PMDD or have PMDD. Taking part in this research project is voluntary.

Please read this entire form and ask questions before deciding to participate in this research.

#### **What is the study about, and why is it being done?**

The purpose of the study is to explore the relationship experiences of partners of individuals suffering from PMDD. This study aims to gain insight into the cyclic attachment styles of PMDD partners. The results of this survey will be utilized to enhance the relationship quality of PMDD partners and provide them with tools for navigating an intimate relationship with PMDD sufferers.

#### **What will happen if you take part in this study?**

If you agree to be in this study, I will ask you to do the following:

1. Each couple will be individually recorded in an audio and video interview that will take no more than 45 minutes.

#### **How could you or others benefit from this study?**

When participating in this study, you should not expect to receive a direct benefit from participating.

However, there may be benefits to the PMDD Community as they gain insight and awareness of the struggles and experiences of partners of PMDD sufferers, which will enhance the relationship quality of couples in intimate relationships while navigating PMDD.

#### **What risks might you experience from being in this study?**

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of psychological stress due to recalling traumatic events from your past. To reduce risk, I will monitor the interviews, and you can discontinue the recording at any time.

#### **How will personal information be protected?**

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer. After five years, all electronic records will be deleted.
- Recordings will be stored on a password-locked computer for five years until participants review and confirm the transcripts' accuracy and then be deleted. The researcher and members of her doctoral committee will have access to these recordings.

#### **How will you be compensated for being part of the study?**

Participants will be compensated for participating in this study. After the interview, participants will receive a \$25 Visa Gift Card.

#### **Is study participation voluntary?**

Participation in this study is voluntary. Your participation will not affect your current or future relations with Liberty University. If you decide to participate, you are free not to answer any questions or withdraw at any time.

#### **What should you do if you decide to withdraw from the study?**

If you choose to withdraw from the study, please notify me via email of your decision, exit the interview, and close your internet browser. Your responses will not be recorded or included in the study.

#### **Whom do you contact if you have questions or concerns about the study?**

The researcher conducting this study is Rose Alkattan. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at xxxxxxxx@liberty.edu.

You may also contact the researcher's faculty sponsor, Dr. Mollie Boyd  
at xxxxxx@liberty.edu

### Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and want to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

*Disclaimer: The Institutional Review Board (IRB) ensures that human subjects research is conducted ethically as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.*

### Your Consent

By signing this document, you agree to be in this study. Make sure you understand what the study is about before you sign. You were given a copy of this document for your records. The researcher will keep a copy of the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

*I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.*

The researcher has my permission to audio/video-record me as part of my participation in this study.

---

Printed Subject Name

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Signature & Date

## Appendix D

### Interview Guides

#### PMDD Sufferer Interview Questions

Thank you for being here and participating in this study; please start by introducing yourself to me. Now, we will talk about your journey with PMDD and how it has impacted your intimate relationship.

1. When did you get diagnosed with PMDD?
2. How did you find out that you had PMDD?
3. What PMDD symptoms do you struggle with monthly?
4. When do your PMDD symptoms start?
5. When do your PMDD symptoms end?
6. Which of your PMDD symptoms affect your intimate relationship with your partner?
7. Before being diagnosed, do you believe PMDD caused issues with your past and present intimate relationships?
8. What are your feelings about your partner and intimate relationship during the luteal phase when PMDD symptoms are present?
9. How do you feel about your partner and intimate relationship during the follicular phase when PMDD symptoms are gone?
10. When PMDD symptoms are present during the luteal phase, do you need more attention or more space from your partner?
11. Do you often feel insecure about your relationship or partner during the luteal phase when PMDD symptoms are present?
12. Do you want to avoid your partner when your PMDD symptoms arise?

13. When PMDD symptoms are present during your luteal phase, would you rather be single?
14. Do you fear that you are losing your independence in your relationship when PMDD symptoms arise?
15. Do you think your partner would be better off without you when PMDD symptoms arise?
16. Do you start to question your partner's intentions or love for you when PMDD symptoms arise?
17. What is one of your most damaging disagreements with your partner during PMDD?
18. Have you ever been asked to break up with your partner because of PMDD?
19. What brought you to the decision of desiring to end the relationship with your PMDD partner?
20. What happened after the breakup that caused you and your partner to reconcile?
21. Do you experience guilt from your behavior towards your partner while having PMDD symptoms?
22. Looking into the future of your life with your partner and managing PMDD, what are your hopes for your intimate relationship?
23. Now, I want to ask you a question summarizing our conversation. Reflecting on your experience as a PMDD sufferer, what advice would you give to other PMDD sufferers struggling to navigate intimate relationships?
24. We have gone in-depth with your experience as a PMDD Sufferer, and I appreciate your willingness and openness in sharing your experience. I have one last question, What is one thing you wish your partner understood about your suffering with PMDD?

Questions one through seven allowed the PMDD sufferers to validate their diagnosis, explain their early journeys, and how they perceive it has impacted their intimate relationships.

Questions eight and nine deal with the cyclic attachment style during the luteal and follicular phases and how it influenced the PMDD sufferers' view of their partners.

Question 10 identified the insecure or secure attachment style of PMDD sufferers during the luteal phase.

Question 11 was an indication of an anxious attachment style with the presence of PMDD symptoms.

Question 12 was an indicator of an avoidant attachment style with PMDD symptoms.

Questions 13 and 14 were indicators of a dismissive avoidance attachment style with the presence of PMDD symptoms.

Questions 15 and 16 were indicators of a fearful avoidance attachment style with the presence of PMDD symptoms.

Questions 17 through 21 gave insight into the monthly fluctuations encompassed being in a relationship with a PMDD sufferer, summarized their PMDD journey, and allowed the PMDD sufferers to offer more insight that may not have been captured throughout the interview.

Questions 22 to 24 enlightened the reader on the true intentions and hopes of the PMDD sufferers within an intimate relationship.

### **Interview Questions for PMDD Partners**

Thank you for being here and participating in this study; please start by introducing yourself to me. Now, we will discuss the background of your relationship with your partner and the presence of PMDD in the luteal phase.

1. How did you find out that your partner had PMDD?

2. How would you explain your struggles with an intimate relationship with a PMDD sufferer?
3. How do you feel about your partner and relationship during the luteal phase when PMDD is present?
4. When your partner experiences PMDD symptoms, what is your initial reaction?
5. How does the presence of PMDD symptoms change your relationship with your partner?
6. When your partner is in PMDD, do you need more attention from them?
7. Do you feel clingy or needy once your partner has PMDD symptoms?
8. Do you feel like you lack affection and attention from your partner when they are in PMDD?
9. Do you want to avoid your partner when you know that PMDD symptoms are present?
10. Do you feel you cannot get enough space from your partner when PMDD is present?
11. Do you question whether your partner loves or cares about you when they are in PMDD?
12. Do you question if you would be better off single when your partner is in PMDD?
13. Do you feel like you are a burden to your partner when they are in PMDD?
14. Do you keep your wants and needs to yourself when your partner is in PMDD?
15. Is it hard for you to connect with your partner during PMDD?
16. Does monthly PMDD with your partner make you feel emotional pain?
17. How do you deal with the pain of your partner having PMDD every month?
18. Have there ever been times when you felt like the stress and pain of being with your PMDD partner was too much for you?
19. What is one of your most damaging disagreements with your partner during PMDD?
20. Have you ever been asked to break up with your partner because of PMDD?

21. What brought you to the decision of desiring to end the relationship with your partner?
22. What happened after the breakup that caused you and your partner to reconcile?
23. What is the hardest part about being in an intimate relationship with a partner having PMDD?
24. During the luteal phase, when PMDD is present, what do you feel is missing from your partner?
25. What are your fears about intimate relationships with a PMDD sufferer?
26. How do you feel about your partner and relationship during the follicular phase when PMDD is gone?
27. What do you appreciate most about your partner when PMDD is not present?
28. What is your relationship with your partner like during the follicular phase?
29. What are your feelings once PMDD is gone, and you think of everything that was said and done during the luteal phase with your partner?
30. Looking into the future of your life with your partner, what are your hopes for your intimate relationship?
31. We have gone in-depth with your experience as a PMDD partner, and I appreciate your willingness and openness in sharing your experience. I have one last question. Imagine that your best friend came to you and told you that they were about to enter an intimate relationship with a PMDD sufferer; what advice would you give them?

Questions one and two created the framework of knowledge within the PMDD partner, giving a baseline on their vision and experiences with intimate relationships and providing guidelines of what they could potentially expect within their own intimate relationship.

Questions three through five gave insight into how the PMDD partner experiences the shift in their relationship with PMDD.

Question six identified the attachment style of the PMDD partner during PMDD.

Questions seven and eight indicated an anxious attachment style.

Questions nine and 10 indicated a dismissive avoidant attachment style.

Questions 11 and 12 indicated a fearful avoidant attachment style.

Questions 13 and 14 indicated the presence of burdensomeness from the interpersonal theory of suicide.

Question 15 indicated the presence of thwarted belongingness from the interpersonal theory of suicide.

Questions 17 through 22 indicate the acquired ability to be at risk for suicide according to the interpersonal theory of suicide.

Questions 23 through 30 let the PMDD partners describe their cyclic attachment styles.