

## PREMENSTRUAL SYNDROME IN WOMEN WITH MENTAL HANDICAP: A PILOT STUDY

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### Introduction

In recent years, there has been a marked increase of interest in menstruation-related behavioural disorder (Osofky *et al.*, 1988). More commonly known as premenstrual syndrome, this disorder refers to a constellation of symptoms, usually consisting of depression and irritability, which often start the week before, and continue a few days after, the onset of menses. Other symptoms often include decreased concentration, feelings of tension and anxiety, and changes in sleep and appetite. Rates of prevalence vary according to the criteria used. A recent study estimated that as many as 70% of women report mild to moderate premenstrual changes, although only 2-3% regard their symptoms as being severe and distressing (Andersch, 1980).

Although people with mental handicap are known to be predisposed to psychiatric and behavioural disorders (Eaton and Menolascino, 1982), it is surprising that little systematic research has been done on the prevalence of premenstrual syndrome in this population. Thus, information about its presentation and management is limited to a few scattered case reports (Kaminer *et al.*, 1988). In this pilot study, the authors comment on the presentation and outcome of a group of women with mental handicap referred with the complaint of premenstrual syndrome.

### Method

The study was conducted at the University of Michigan Medical Center.

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The sample was drawn from a group of patients consecutively referred to a gynaecologic clinic for women with mental handicap. This is a tertiary referral centre, meant specifically for women with mental retardation. It is run by a multidisciplinary team consisting, among others, of gynaecologists, social workers and specialist nurses. During the period under study, 1986-87, there was no psychiatric input to the clinic. Details about the organization and function of the clinic are more fully described elsewhere (Elkins *et al.*, 1986). The referrals came mostly from group homes and the patients were labelled as suffering from premenstrual syndrome by the staff. The symptoms consisted of one or more of the following: increased aggressivity, screaming, self-injurious behaviour, lability of mood, and reluctance to follow directions. These were reported by staff to be exacerbated around the menses, supplemented by daily charting of mood and behaviour in most cases. After a general physical examination, patient management consisted of a stepwise approach, starting with vitamin B<sub>6</sub> and non-steroidal anti-inflammatory agents. If response was not seen, cyclic modulation with low dose oral contraceptives was then considered. For those with severe symptoms, consideration was finally given to total cyclic hormonal suppression with Depo-provera, or continuous oral progestins. Outcome was assessed 3 to 6 months after referral based on clinicians' global assessment. Whenever possible, an attempt was made to obtain information directly from the patients and additional information was

collected from the case notes and the caregivers.

## Results

Twenty four patients were referred during the index period as suffering from premenstrual syndrome. The age range was 14 to 52 years and the mean was 28 years. Twenty two patients were living in group homes at the time of the referral and the remaining with their families. All the patients were either moderately or severely retarded. Six patients were classified as moderately retarded and the rest as severely retarded. Six patients had seizure disorder, one had a diagnosis of schizophrenia, one of autism and one of attention deficit hyperactivity disorder. As many as ten patients were on psychotropic medication. At follow-up appointment at 3 months, improvement was recorded in 7 patients; however, this persisted in only 5 (20%) patients at 6 months. Two patients appeared to have deteriorated, while in the remaining 15, no improvement was recorded. Occasionally efforts were rewarded with dramatic success, as in two patients who stopped self-injurious behaviour when Depo-provera was started, but these situations were rather uncommon.

## Discussion

Only 5 patients out of 24 (20%) showed sustained improvement at 6 months. This suggests that very few patients labelled by caregivers as suffering from premenstrual syndrome improve after being referred to a

gynaecological clinic. This could be due to one or more of the following reasons. First, the possibility of over-diagnosis should be considered. Any exacerbation of behavioural symptoms around menses may be misinterpreted as premenstrual syndrome by staff. This is perhaps more likely to occur in those who are either moderately or severely retarded as in the present sample. As behavioural symptoms usually occur in an environmental and social context, the first step should be to look for any environmental precipitants or life events (Ghaziuddin, 1988). A properly kept behavioural chart may also be helpful.

Secondly, other psychiatric disorders may mimic premenstrual syndrome. This is particularly likely to occur when cognitive deficits are severe and when communication skills are grossly impaired, as in the present sample. It is important to note that a substantial number of patients were on psychotropic medication which should alert the clinician to the possibility of an underlying psychiatric illness. Six patients also had a history of seizure disorder which by itself, or in combination with the side effects of anticonvulsants, may contribute to behavioural disturbance. Although this study did not look for the prevalence of physical disorders and sensory deficits, it is well-known that these conditions may also account for disturbed behaviour in people with mental retardation (Gunsett *et al.*, 1989).

Thirdly, a relative lack of psychiatric services for people with mental handicap may also contribute to their being labelled as suffering from

premenstrual syndrome and referred to the gynaecologists. Diagnosis of mental illness in mental retardation presents with particular difficulties. This problem is confounded by the fact that few psychiatrists tend to have a special interest in this population. At the time and place where this study was undertaken, there was no special clinic catering to the psychiatric needs of the mentally retarded. It is conceivable, therefore, that under such circumstances, caregivers may use the label of premenstrual syndrome in a desperate attempt to seek help for their clients.

At the same time, the fact that about 20% of our sample responded to treatment supports the view that gynaecologic treatment does have a place in the management of premenstrual syndrome in women with mental retardation. All of our patients were moderately or severely retarded which may account for the modest response to gynaecologic intervention. It is possible that patients who are mildly mentally retarded may respond better to gynaecologic management of premenstrual syndrome than those who suffer from severe forms of mental retardation.

In conclusion, although premenstrual syndrome may occur in the mentally retarded population, other causes of acute behavioural disturbance such as psychiatric disorders and painful physical conditions should first be excluded. Since staff may use the label of premenstrual syndrome as a cry for help, a full physical and psychiatric examination, with a reliable charting of the patient's behaviour, should be considered as the

minimum requirements in all patients. While physicians and caregivers may differ in their understanding of premenstrual syndrome as it occurs in the mentally retarded population, it is clear that in a subgroup of patients, gynaecologic treatment may be successful. Controlled research is, therefore, needed to define the criteria of premenstrual disorder in this population and identify those patients who may benefit from treatment.

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