



LOVING THE “HORMONE HOSTAGE”

Principles for Couples Coping with
Premenstrual and Menopausal Conditions
Carolyn Sue Childerston & James K. Childerston

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LOVING THE “HORMONE HOSTAGE”

Principles for Couples Coping with Premenstrual and Menopausal Conditions

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

As a couple, we became interested in this topic out of self-defense, when Carolyn began experiencing some fairly significant perimenopausal symptoms. It became imperative to understand more about what was happening to her physiologically, and also the impact emotionally, psychologically, and spiritually. We have discovered it to be not only an experiential process, but an experimental one as well. As we talk with couples who are dealing with hormonal changes and fluctuations, we find that this journey may begin with PMS in the teenage years, move into perimenopausal symptoms as early as age thirty-five, move on through menopause at an average age of fifty-two, and finally reach post-menopause. The hormonal fluctuations occur throughout most of the lifespan, requiring many adjustments and accommodations both personally and relationally.

We have come to believe as we become more familiar with this topic, that God has something significant in store for couples and for the Church. After one workshop we did on this topic, Carolyn had a woman come up to her afterwards and say, “You know, I am just going to pray that the Lord takes this all away from you.” The more Carolyn thought about that, the more she thought about Paul’s words to the Corinthians, which says, “God the Father, who is full of mercy and all comfort. He comforts us every time we have trouble so that when others have trouble we can comfort them with the same comfort God gives us” (2 Corinthians 1:3b-4). We don’t believe God chooses to take away everything that is uncomfortable for us. Rather, He takes us through it so that we can benefit while we are in it and afterwards. It would be great if God wanted to take this all away tomorrow, but that may not be His plan. Suffering is God’s graduate school of life and if you want to move beyond mere Christianity, we believe what you have to look forward to is suffering, which may come in many different forms. Hormonal problems can be that school for some women and perhaps also for their husbands.

Williamson and Sheets (1989) in their delightful parody *Raging Hormones*, defined a “Hormone Hostage” as “any woman who for two to fourteen days each month becomes a prisoner of her own raging hormones and turns her life and the lives of those around her into unholy premenstrual netherworld”. Perhaps the question may be “who is the “hostage” when hormones seem to be out of control? Both partners can be impacted. More than once we have had a husband comment, “I have been a hostage to my wife’s hormones for years.”

To begin, it is important to understand some basics about mood and the menstrual cycle. About 97% of reproductive-age women do report at least a mild degree of mood changes premenstrually. Someone once

suggested that “the other three percent were either lying or in denial.” Sex hormones impact mood in the vast majority of women, but about 20-40% have complaints that can be classified as moderate premenstrual symptoms or Premenstrual Syndrome (PMS) (Lyles, 2000). However, 2-10% of women suffer from severe or disabling symptoms premenstrually, which has been defined as premenstrual dysphoric disorder (PMDD) (Logue & Moos, 1986). PMDD usually begins when a female is in her teens to late twenties. Interestingly though, treatment often is not initiated until she is in her thirties. The physical symptoms associated with PMS include acne, backache, bloating, fatigue, headache, and sore breasts. Emotionally, there can be changes in sexual desire, depression, difficulty concentrating, difficulty handling stress, irritability, and tearfulness.

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

In Appendix B in the back of the DSM-4 (p.715), you’ll find listed the criteria for premenstrual dysphoric disorder (PMDD). These are listed in Figure 1. The unusual aspect of this diagnosis is that the criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive cycles. This is the only DSM diagnosis that requires systematic documentation. The reasoning for prospective versus retrospective ratings is that researchers have discovered that once women begin menstruation, they typically forget how they felt two or three days before. When they begin their period, perspective and perception often changes. Suddenly the things which looked so bleak or out of control have changed—not in reality, of course, only in the perspective with which they are viewed. If women charted their symptoms retrospectively, they may not have the same sort of symptom picture. Once one notes two consecutive cycles of fairly high symptom ratings, it gives us an idea of the severity of the PMS a person may be experiencing or whether it may be PMDD. Sometimes more than two months of ratings are necessary, because many women often experience differences between ovaries. When one ovary drops an egg they experience more severe PMS. The next month on the other ovary, the symptoms are not as bad. You may have an every other month type of situation in terms of the severity of mood changes.

In terms of differential diagnosis, look for the symptoms being worse in the luteal phase (from ovulation to menstruation) and a marked level of impairment. Twenty to twenty-five percent of women also meet the criteria for dysthymia during the first half of the cycle, which means that there are co-morbid conditions taking place (Cohen, et al., 2000). Thirty percent of those with PMDD also have a history of major depressive disorder. This is very significant because 45-70% of women with PMDD develop major depressive disorder over the course of their lifetime vs. 15-20% of women in general (Lyles, 2000). What this indicates is that a woman with PMDD is three times as likely to develop major depression if her condition is not properly recognized and treated. Many women have more suicidal ideation, attempts, and psychiatric hospitalizations during the luteal phase. In fact, it is not unusual for psychiatric hospitals to

note an increased use of sanitary products with many women shortly after they are admitted for suicidal ideation or a suicidal attempt. Within a day or two after they are admitted, they then begin their period.

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

Figure 1

Depressive Disorder Not Otherwise Specified: Premenstrual Dysphoric Disorder

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

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

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

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

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

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

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

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

To emphasize the importance of getting close even when you don’t want to, I’m reminded of an illustration from the 2000 Olympics in Sydney, Australia. The fellow who was voted the most outstanding Olympic male athlete for the United States was Rulon Gardner, a huge dairy farmer from Wyoming who won the gold medal in the Greco-Roman wrestling’s Super Heavyweight Division. He defeated Russia’s Alexandr “The Great” Karelin, a wrestling legend who hadn’t lost in over 250 matches spanning thirteen years. Greco Roman wrestling involves using your upper body to perform a series of holds and throws in an attempt to outscore or pin your opponent. Karelin was considered unbeatable and had a move that was actually named for him in which he was able to put an arm lock around his opponent’s waist, and then because he was double jointed in his knees, he was able to get the leverage necessary to pick the person up over his head, and basically drop over backwards. And as his opponent you had the choice of moving your head and getting pinned or breaking your neck. Rulon Gardner defeated this fellow 1-0 and won a gold medal. Afterwards they were asking him, “How did you do this?” “How did you manage to avoid getting put into that hold?” He said, “Well, the only way I could figure out how to do it was to stay so close to him that he could not get the leverage to get it on me.” As we think about that in the context of what we are discussing here, it is interesting. If I get really close she can’t get a good shot in. No, if I get really close, it is not only what she needs, but it also serves as a protective function for the relationship, and perhaps as a protective function for the husband.

The research in the area of touch can be very instructive to men during this time as an encouragement to get close to your spouse. As you touch your wife, and as you touch in general, you are actually altering your brain cells to make yourself feel calmer. Touch has been shown to reduce tension, elevate moods, enhance self-esteem, and perhaps even strengthen the immune system (Fisher, 1993). This may be because touch can increase serotonin levels to some extent, but more specifically what happens with touch is the neuropeptide hormone oxytocin is released (Crenshaw & Goldberg, 1996. Oxytocin is that chemical

that in women helps induce labor and stimulate lactation. We also see that it peaks in its release during orgasm and helps couples feel more connected (Meston & Frohlich, 2000). When you give or receive touch, your body begins to release oxytocin and will help to produce a much-needed sense of well being for both persons.

2) Collect as much information as possible and be an advocate for your own health care. There is no one answer, pill, exercise, diet, prayer or solution. The more you research this topic, the more likely you will be confused. This does not take into consideration the days you are having difficulty in concentrating. As we read and studied, it seemed like the question was often, “Well, it looks like you can take your choice, either uterine cancer or breast cancer. Which do you want?” Or you will meet people who say, “this is what really worked for me”, “I found this natural remedy, it does this, this, and this”. The difficulty is that a remedy or intervention may not work the same for each person. The whole endocrine system in the body is complex (“we are fearfully and wonderfully made”) and it is also individualized. What that means is what works well for somebody may only be effective for a short period of time. For someone else, however, that remedy may actually exacerbate some symptoms. One must keep in mind that each treatment has to be tailored to that person. This is why collecting as much information as possible is imperative, and it includes information on any medications or herbals that are being taken. One reason for this is during this period of time when one’s hormones are “out of control”, there is a good chance that even the rare side effects of a medication will impact you. As you collect information, it helps to have someone come along side (a physician, a therapist, or spouse) who can help you begin to sort through the symptoms and the options.

3) In seeking Professional Help, find someone you can trust and is ready for the “journey”, not just full of cookbook answers. Be ready for the “past” to resurface during a hormone crisis. There are many areas in which physician supervision may prove useful, including: finding a correct diagnosis, the elimination of other medical problems, for a referral to other professionals (including psychological or nutritional help), to prescribe medication as needed, and to get medical advice on the use of over-the-counter medications. It may be an internist, an OB/GYN, or even an endocrinologist. The main point is that you need someone who is going to work with you through this process, communicate clearly about options, and even sometimes be willing to experiment with you to find the best approach.

In this section on Professional Help, we will briefly summarize various medication options. There are some women who will indicate to you that their PMS drug of choice is a chocolate bar. Although it may briefly satisfy cravings and provide some degree of self-nurturance, it will do little to effectively treat PMS, let alone help one’s waistline.

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

earlier). Younger women respond better than older women, because estrogen is necessary to be able to synthesize the serotonin. Thus, a menopausal woman who is not on some form of estrogen replacement therapy will not respond effectively to SSRI's. Another option for women, which may reduce the impact of adverse side effects, is the finding that half cycle treatment seems to be very effective for many. Some research indicates that it may even be more effective than full cycle treatment (Freeman, et.al., 1999; Wikander, Sundbland, & Andersch, 1998). That is, a woman would take an SSRI about 10-14 days before her period is to begin so that you have the therapeutic effect during the time in which you are most "premenstrual" and then it is discontinued after menstruation begins.

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

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

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

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

4) Diet and Nutrition can help to improve your situation or make it far worse. Weight gain and /or body changes are a natural developmental process during midlife. God is so good to remind us how "stupid" we are about our own bodies. What may have worked at one point in life now may be completely ineffective, as one's hormones have impacted metabolism and body mass. For Carolyn, one of the biggest factors that changed her diet was when she became an experimental guinea pig in the world of testosterone supplementation. For example, she has discovered is that about half of the month she needs to be on a high protein diet and then about half of the month she needs to be on high carbohydrates. She has yet to figure out when in the month that changes. In general, with PMS you need to eat more frequently but not overeat, do not eat less than 1200 calories per day, choose slow-burning foods (lean protein, green veggies), choose whole grains - "look for brown foods", drink more water, and avoid sugars, caffeine, alcohol and salt excesses. A helpful book that is easy to understand and describes well the nutritional component is *PMS-What It Is and What You Can do About It*. (Sneed, 1988). If you have a client who has difficulty concentrating, they could gain help and insight from this book. However, as one moves into perimenopause, the symptom pattern often gets scattered or intensifies, and it becomes much harder to define the dietary rules. Occasionally, a woman may need help trying to avoid particular foods during certain times of the month, or she may be watching her caloric intake because of body weight inconsistencies. But - nothing will make her angrier than if her husband tells her, "I don't think you should have that chocolate." If she craves it, he is going to have to figure out a more empathic way to tell her, because she will not want somebody at that time counting her calories for her. This can be difficult for husbands, because men as a general rule believe if they are asked to help with a problem,

they are going to want to provide a clear answer. Beware, with hormonal conditions those rules don't always work, and husbands need to be prepared for flexible exceptions.

5) **Exercise is important to control weight as well as for other physical, emotional, and psychological benefits.** We know that exercise is useful in treating depression, but it can also increase one's energy and productivity, decrease appetite, and function as a stress reducer. Often, people experience more positive attitudes as a result. In addition, exercise improves the body's ability to metabolize sugars, and is effective in decreasing fat and for improved weight maintenance.

6) **Sleep is impacted by hormonal changes and is necessary to maintain coping skills and cognition.** For about a year and a half before Carolyn went on testosterone therapy, she had panic attacks at some point every night.. Your sleep is impacted by hormonal changes and it is necessary to maintain your coping skills and your cognition. If you don't get sleep, you can't think and you can't cope. You have to figure out how you are going to get sleep and this is often where physician support may be necessary. Neurotransmitters for the most part are produced during sleep. So if you are not getting any sleep you are not getting some of those little natural chemicals, sort of mood regulators, that you need in order to be able to function. Some people find that something as simple as over-the-counter Nytol (it's basically Benadryl) will make all the difference in the world. However, you may move into a situation where you do need a physician to prescribe a sleep aide. Carolyn teaches a women's Bible study, and as these women have aged, many of them are experiencing early morning wakening. What are we doing at 4 o'clock in the morning, except obsessing over the finals the kids have today. It is a frustrating time to be awake because everything seems to be worse in the middle of the night. There are a couple of truths she has discovered. One of them is to get a hold of the Word of God. Consider the verse in Psalms 4:8 that says, "I will lay me down in peace and sleep, for you, O Lord, will cause me to dwell in safety." David probably wrote that when Saul was after him, trying to kill him. Sometimes, in the middle of the night, you feel like someone is out to get you. Safety encompasses more than someone attacking you physically. The other truth about sleep is the profound benefit of awakening her husband and asking him to pray with her. He has wonderful prayers at 4 a.m. in the morning! I'm sure it is good that the Spirit interprets our groanings and utterances because that is mostly what goes on. Sometimes when her insomnia is overwhelming, she will just say to him, "Please read to me from the Word" and it doesn't matter where he reads. Internally, she begins to calm down and can go back to sleep. Husbands, pray with your wives. Not only is it inviting the Lord into our difficulty, it serves to provide a vital sense of security for our wives at a time when they can feel most insecure and unsure.

7) **Many "Natural" Remedies are available which may improve some symptoms. Be aware of individual differences, limited supported research, and quality control problems.** Many people prefer a "natural" approach, but even these products can have significant unpleasant side effects or produce allergic reactions (Bendich, 2000). But, they may be very effective for "some women some of the time." Chasteberry (Vitex Agnus) is an herbal supplement many women are finding to be helpful in the treatment of PMS (Laurizen, et.al., 1997). Some have found Vitamin B6 (pyridoxine) to be useful in improving mental health. Magnesium can help to decrease those chocolate cravings (Walker, et al., 1998). Calcium is very important, not only for PMS treatment, but also as one moves into perimenopause and menopause, it should be increased. Calcium, however, decreases magnesium absorption, so eat foods that have a high magnesium/calcium ratio like millet, corn, wheat, potatoes, and cashews. Evening Primrose Oil (Efamol) reduces prolactin sensitivity and that can be helpful from ovulation until the onset of menstruation. Increasing complex carbohydrate consumption can increase serum tryptophan levels,

which can make more serotonin available (Pearlstein, 1996). We also know that Progesterone does not help in the treatment of PMS for most women. It tends to increase nervous tension, irritability, mood swings, swelling and fatigue. St. John's Wort, while helping some people with depression, is not consistently effective for PMS. With regard to most herbals, there are purity concerns and obviously some drug interaction concerns

8) ***Stress Management is imperative because hormone factors exacerbate an already stressful time of life. Evaluate and maintain some perspective on the "majors" versus the "minors" of life.*** Stress is defined as the body's response to a perceived threat or demand. When a person is particularly premenstrual, or even perimenopausal, everything feels like a threat or demand. Everything seems like a ten on a scale of 1 to 10. Everything is not a ten. Sometimes we need help understanding what the 2's and 3's and 4's are all about so that we don't further exaggerate our stress. There are many things we can do to alter our distorted perception, including how we spend our time. Find some alone time for you, then with your husband, and then with your family. Avoid stress eating, as you will feel worse later, and don't skip your exercise time. Avoid social commitments that are personally demanding, such as dinner parties that require elaborate preparations. Try being more productive during other parts of your cycle so that you can take more time to relax when premenstrual. If you can, schedule vacations for the first 2 weeks after your period. Arrange car pools and other such commitments on a rotation that frees you from responsibility when you're premenstrual. If you have young children at home, arrange occasional babysitting during your premenstrual time.

9) ***Develop a Support Network that may include husband and trusted friends with whom you can be honest and who will listen first, then respond. These people are not in your life to "fix it." Husbands may also consider developing a support group with other men who will encourage him to be consistent in loving his wife.*** Carolyn has a close Christian friend whose goal is not to fix her and that is important. This friend will always listen to whatever Carolyn has to say without reacting even when she says ugly or unkind things. One day Carolyn went on and on, and her friend finally said, "You don't want to do that. It's beneath your dignity." It was a gentle little rebuke – don't go there. Men, it is important for you to develop a support network because if you are finding it quite difficult to love your wife, and yet you know that is what she needs and what you need to do, partner with another husband that you can meet for lunch and say, "You know my wife is really making me crazy." He can help you be accountable and connected back to where you ought to be. When men have close intimate contact with other men, it ultimately results in them developing more intimacy with their wives.

10) ***Find your sense of Humor and the things that encourage it.*** In the book of Proverbs, we see many benefits of humor. "A happy heart will make the face cheerful, but heartache crushes the spirit." (15:13); "... the cheerful heart has a continual feast." (15:15); "A cheerful look brings joy to the heart and good news gives health to the bones. (15:30) Also in 17:22, it says, "A cheerful heart is good medicine but a crushed spirit dries up the bones." Perhaps this is a positive discovery in the prevention of osteoporosis. During this time of life, there are many ways we can learn to laugh at ourselves or our plight. If we don't learn this lesson, we may end up hurting each other instead. Consider an appropriate time to share one of the following greeting card poems with your spouse. This one is called "I Miss You." "I can't forget your gentle touch, I can't forget your smile, so if I can't recall your name, it's only for awhile. I know you think I'm crazy but it's just my monthly phase. So, darling, don't decide we're through, just give me a couple of days." Or how about "Just For You." "If we're to have a romance, there is something you

should know. I want to share it with you because I love you so. You can send me to the moon with just one perfect kiss, but I'll send you to hell and back when I have PMS" (Williamson, 1989). Speaking of that, we find it humorous that the makers of Prozac (one of the SSRIs we referred to earlier) have repackaged this medication under the brand name Serafem and they have received an FDA indication for the treatment of PMDD. The image that comes to our mind is that this company intends to take these "hellish" PMDD creatures and by using this drug, turn them into this sort of divine being- a "seraphim". We're waiting for them to repackage it for children and call it "cherubim." Maintain your sense of humor. It will help to keep you sane during the "crazy times."

11) **Our *Spiritual Development* will greatly impact our ability to cope and maintain a perspective on pain, problems, and reality. Discover the "anchor verses" which fit your symptoms and print them on cards for the times you are having trouble remembering them.** PMS, PMDD, Perimenopause, and Menopause are not "spiritual problems" and yet there can be considerable guilt about the behavior patterns of anger, depression, and irritability. We do know that unresolved spiritual problems can, in fact, make these conditions worse. Ruth Meyer has written an apropos book entitled, *31 Days of Praise*. This is not a happy-go-lucky book of praise. It is a book of praise about the painful things in life and has been helpful on days when things are not going well. In your spiritual walk, don't neglect the book of Psalms. It expresses all of the emotions of the human heart. It is important to claim certain verses, and write them out so you can remember them. She has whole chapters that are memorized but there are times of the month that she cannot remember anything. David wrote Psalm 71:1 in his older age but it applies many times to the hormonal woman. "In you, O Lord, do I put my trust. Let me never be put to confusion." There are days that everything is confusion and on those days, pray that verse back to the Lord. Psalm 34: 4 states "I sought the Lord, and He answered me; He delivered me from all my fears." In the midst of hormonal anguish, these kinds of scriptures can be held onto and offered in prayer to the Lord. When you feel like you're isolated on your own island, your spiritual development is crucial to finding hope for the future.

12). **"*This too shall pass...*" Hormone difficulties may be temporary from the lifespan perspective, but they are not a "quick fix." There is life beyond these phases for couples, provided they don't destroy each other first.** Someone has said, "Marriage is a life long process of trying to correct a mistake." We do not always have the best reasons when we get married but it is lifelong process of making the best out of our situation and of learning to love each other "in sickness and in health." Intimacy, much like spiritual maturity, can be developed out of adversity. As we partner together and commit to move through the inevitable myriad of struggles we will face, the marriage that perseveres to the other side will be blessed.

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References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, D.C.: American Psychiatric Association.
- Bendich, A. (2000) The potential for dietary supplements to reduce premenstrual syndrome (PMS) symptoms. *Journal of the American College of Nutrition, 19*, 3-12.
- Brown, W.A. (1996). PMS: A quiet breakthrough. *Psychiatric Annals, 26*, 569-570.
- Cohen, L., et al., (2000). New trends in treating premenstrual disorders {Audiotape}. *The Journal of Clinical Psychiatry*. Physicians Postgraduate Press.
- Crenshaw, T.L., & Goldberg, J.P. (1996). *Sexual Pharmacology: Drugs That Affect Sexual Functioning*. New York: W.W. Norton.
- Fisher, H.E., (1993). *Anatomy of Love: The Mysteries of Mating, Marriage, and Why We Stray*. New York: Random House.
- Freeman, E.W., Rickels, K., Sondheimer, S.J., Polansky, M. (1999). Differential response to antidepressants in women with premenstrual syndrome/premenstrual dysphoric disorder. *Archives of General Psychiatry, 56*, 932-939.
- Freeman, E.W., Rickels, K., Arredondo, R., et al. (1999). Full- or half-cycle treatment of severe premenstrual syndrome with a serotonergic antidepressant. *Journal of Clinical Psychopharmacology, 19(1)*, 3-8.
- Laurizen, C., et al. (1997). Treatment of premenstrual tension syndrome with Vitex agnus-castus. Controlled, double-blind study versus pyridoxine. *Phytomedicine 4(3)*, 183-189.
- Liebenluft, E. (1999). Why Are So Many Women Depressed? *Scientific American, 6*, 1-7.
- Logue, C.M. & Moos, R.H. (1986). Perimenstrual symptoms and risk factors. *Psychosomatic Medicine, 48(6)*, 388-414.
- Lyles, M.R. (2000). Hormones a' Raging. *Christian Counseling Today, 8(1)*, 54.
- Meyers, R. (1994). *31 Days of Praise*. Sisters, Oregon: Multnomah
- Meston, C.M. & Frohlich, P.F. (2000). The neurobiology of sexual function. *Archives of General Psychiatry, 57*, 1012-1030.
- Nachtigall, L.E. (1998). The symptoms of perimenopause. *Clinical Obstetric Gynecology, 41*, 921-927.
- Pearlstein, T. (1996). Nonpharmacologic treatment of premenstrual syndrome. *Psychiatric Annals, 26*, 590-594.
- Rapkin A.J., Edelmuth E., Chang L.C., et al. (1987). Whole-blood serotonin in premenstrual syndrome. *Obstetrics and Gynecology, 70*, 533-537.
- Smith, S., Rienhart, J., Fuddock, V., Schiff, I. (1987) Treatment of premenstrual syndrome with alprazolam: results of a double-blind placebo-controlled, randomized crossover study. *Obstetrics and Gynecology, 70*, 37-43.
- Sneed, S.M., & McIlhaney, J.S. Jr. (1988). *PMS: What It Is and What You Can Do About It*. Grand Rapids: Baker Books.

Steiner, M., Steinberg, S., Stewart, D., et al. (1995), Fluoxetine in the treatment of premenstrual dysphoria. *New England Journal of Medicine*, 332, 1529-34.

Walker, A.F., De Souza, M.C., Vickers, M.F., et al. (1998) Magnesium supplementation alleviates premenstrual symptoms of fluid retention. *Journal of Women's Health*, 7, 1157-65.

Wikander, I., Sundbland, C., Andersch B., et al., (1998). Citalopram in premenstrual dysphoric disorder. Is intermittent treatment more effective than continuous drug administration? *Journal of Clinical Psychopharmacology*, 18, 390-398.

Williamson, M. & Sheets, R. (1989). *Raging Hormones: The Unofficial PMS Survival Guide*. New York: Doubleday.