Female Mood Swings

Understanding Causes, Hormonal Changes, PMS, PMDD, Mental Health, Modern Treatment and the Unani Approach

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Updated: September 2026

Introduction

One of the common concerns women discuss with me is:

"Doctor, my mood changes very quickly. Sometimes I feel perfectly fine and after a short time I become irritated, emotional, anxious or sad. Is this because of hormones?"

Sometimes hormones do play an important role, but **every mood change in a woman should not automatically be blamed on hormones**.

Mood is influenced by a complex interaction between the brain, reproductive hormones, sleep, nutrition, physical health, stress, relationships, medicines, pregnancy, menstruation, menopause and mental-health conditions.

The National Institute of Mental Health recognizes that certain mental-health problems in women may become particularly noticeable during periods of hormonal change, including around menstruation, during pregnancy and postpartum, and during the transition to menopause. At the same time, women can experience depression, anxiety, bipolar disorder and other mental-health conditions completely independently of the reproductive cycle.

Therefore, I prefer to think of **female mood swings as a symptom rather than one single disease**.

For some women, occasional emotional changes are a normal response to stress, lack of sleep or the menstrual cycle. For others, severe recurring mood symptoms may represent **premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD), depression, anxiety, a thyroid disorder, perinatal depression, perimenopausal depression or another medical or psychological condition**.

In Unani medicine, emotional health is not separated completely from physical health. The traditional Unani framework pays particular attention to **Mizaj, Akhlat, sleep, diet, physical activity, psychological activity and rest**, all of which can influence overall well-being. The Ministry of AYUSH describes Unani medicine as emphasizing the psychosomatic relationship between mind and body and the importance of the six essential factors of life.

At **Saira Health Care**, my approach is therefore not simply to prescribe a "mood medicine." I first try to understand **when the mood changes occur, what triggers them, whether they follow the menstrual cycle, whether pregnancy or menopause is involved, and whether an underlying physical or mental-health condition needs treatment**.

What Are Mood Swings?

A mood swing is a noticeable change from one emotional state to another.

A woman may, for example, move from feeling calm to becoming irritable, tearful, anxious, angry or unusually low.

These changes can occur over minutes or hours in ordinary daily life, or they can form predictable patterns lasting several days.

Common experiences include:

- Sudden irritability.
- Becoming emotional or tearful more easily.
- Feeling unusually sensitive.
- Anxiety or nervousness.
- Anger or frustration.
- Temporary sadness.
- Feeling overwhelmed.
- Reduced patience.
- Social withdrawal.
- Changes in motivation.
- Difficulty concentrating.
- Changes in sexual desire.
- Feeling energetic at one time and exhausted at another.

Having some of these symptoms does **not automatically mean that a woman has a psychiatric illness**.

The key questions are:

How severe are the changes? How long do they last? How often do they occur? Is there a clear menstrual or hormonal pattern? And are they interfering with daily life, relationships or safety?

Normal Emotional Variation Versus a Medical Problem

Everyone experiences changes in mood.

A stressful day at work may cause irritability.

Sleep deprivation may make a person emotional.

An argument may produce temporary sadness.

Receiving good news may cause excitement.

These are normal human emotional responses.

Medical evaluation becomes more important when mood changes:

- Become severe or difficult to control.
- Repeatedly disrupt work, study or family life.
- Damage relationships.
- Occur in a very predictable pattern before every menstrual period.
- Are associated with prolonged depression.
- Cause severe anxiety.
- Include extremely elevated or unusually energized periods.
- Involve impulsive or risky behaviour.
- Continue for weeks rather than hours.
- Appear suddenly after childbirth.
- Occur together with hallucinations or severe confusion.
- Include thoughts of death, suicide, self-harm or harming another person.

The distinction is important because different conditions require very different treatments.

Why Can Hormones Affect Mood?

Female reproductive hormones, particularly **estrogen and progesterone**, interact with the brain and nervous system.

Hormone levels naturally change during:

- The menstrual cycle.
- Pregnancy.
- The postpartum period.
- Breastfeeding.
- Perimenopause.
- Menopause.

These fluctuations may influence neurotransmitter and neurosteroid systems involved in emotional regulation.

The latest 2026 synopsis of ACOG guidance on premenstrual disorders describes current thinking that premenstrual symptoms may involve changes in estrogen-related serotonin regulation and heightened sensitivity to changes in **allopregnanolone**, a neuroactive metabolite of progesterone.

An important point is that a woman with PMDD does not necessarily have “abnormally high” or “abnormally low” reproductive hormones.

For many patients, the problem may be **how sensitive the brain is to normal cyclical hormonal changes**, rather than a simple deficiency that can be identified by one hormone test.

Mood Swings Before Menstruation — PMS

Premenstrual syndrome, or **PMS**, is one of the common reasons women notice cyclical mood changes.

PMS symptoms generally occur during the later part of the menstrual cycle and improve when menstruation begins or shortly afterward.

Common emotional symptoms include:

- Irritability.
- Mood swings.
- Anxiety.

- Crying spells.
- Feeling depressed.
- Difficulty concentrating.
- Social withdrawal.
- Changes in sexual desire.
- Sleep disturbance.

Physical symptoms may include:

- Breast tenderness.
- Headache.
- Fatigue.
- Abdominal bloating.
- Fluid retention.
- Food cravings.
- Muscle or joint discomfort.

Mayo Clinic notes that PMS symptoms recur in a predictable pattern and may range from mild to significant. For most women, symptoms improve within several days after menstruation begins.

This timing is extremely useful diagnostically.

If a woman is depressed or irritable **throughout the entire month**, the problem should not automatically be labelled PMS simply because symptoms become slightly worse before menstruation.

PMDD — When Premenstrual Mood Changes Become Severe

Premenstrual Dysphoric Disorder (PMDD) is more severe than ordinary PMS.

The emotional symptoms may be strong enough to interfere with relationships, work, education and normal daily functioning.

Possible symptoms include:

- Severe irritability or anger.
- Marked mood swings.

- Feeling suddenly sad or tearful.
- Depression or hopelessness.
- Severe anxiety or tension.
- Feeling overwhelmed or out of control.
- Reduced interest in normal activities.
- Difficulty concentrating.
- Fatigue.
- Sleep disturbance.
- Appetite changes.

PMDD symptoms usually appear during the one to two weeks before menstruation and improve shortly after menstruation begins. The NHS's current 2026 guidance describes PMDD as producing severe emotional and physical symptoms capable of substantially affecting work, relationships and social functioning.

One particularly important point is that **PMDD can include suicidal thoughts**.

Those symptoms require immediate attention rather than being dismissed as “normal periods.”

Keeping a Menstrual Mood Diary

When I suspect PMS or PMDD, one of the simplest but most informative things a patient can do is maintain a **daily symptom diary**.

For at least two consecutive menstrual cycles, record:

- Mood.
- Irritability.
- Anxiety.
- Sleep.
- Energy.
- Appetite.
- Breast tenderness or bloating.
- Menstrual dates.

- Significant stress.
- Medication use.

Both modern clinical guidance and the 2026 JAMA summary of ACOG recommendations support prospective daily symptom tracking across at least two cycles when diagnosing premenstrual disorders.

A diary often reveals patterns that the patient had never noticed.

For example:

Days 1–15: emotionally stable.
Days 20–27: marked irritability and anxiety.
Day 28: menstruation begins.
Day 2 of period: emotional symptoms disappear.

That pattern is far more informative than simply saying, “I have mood swings.”

Pregnancy and Mood Changes

Pregnancy produces major hormonal, physical and psychological changes.

Some emotional variation is understandable.

A woman may experience excitement about the pregnancy while simultaneously worrying about childbirth, the baby's health, finances, work or family responsibilities.

Sleep disturbance, nausea, fatigue and physical discomfort may further affect emotional resilience.

However, persistent depression or severe anxiety during pregnancy should not be ignored.

ACOG recommends screening women for depression and anxiety during pregnancy and again postpartum using validated tools, with systems in place for further assessment and treatment when needed.

Mental health is part of antenatal care.

Mood Swings After Childbirth — Baby Blues

The period immediately after childbirth deserves special attention.

Within several days of delivery, many mothers experience temporary:

- Mood swings.
- Crying.

- Anxiety.
- Irritability.
- Feeling overwhelmed.
- Sleep difficulty.

This is commonly called the **baby blues**.

It usually improves spontaneously within a few days to approximately two weeks.

The hormonal shift after childbirth is dramatic, but physical exhaustion, interrupted sleep and adapting to care of a newborn also contribute.

The baby blues should improve.

When symptoms become more severe or persist beyond approximately two weeks, we need to consider postpartum depression.

Postpartum Depression Is Different

Postpartum depression is not simply an extended mood swing.

Symptoms may include:

- Persistent sadness.
- Severe irritability.
- Anxiety.
- Hopelessness.
- Excessive crying.
- Loss of enjoyment.
- Withdrawal from family.
- Severe fatigue.
- Difficulty bonding with the baby.
- Difficulty caring for oneself or the baby.
- Thoughts of harming oneself.
- Thoughts of harming the baby.

NIMH distinguishes postpartum depression from the baby blues by its greater intensity and duration; severe mood or anxiety symptoms persisting beyond two weeks after childbirth warrant professional assessment.

ACOG recommends routine depression and anxiety screening during pregnancy and postpartum rather than waiting for patients to volunteer symptoms.

A mother should never be expected simply to “be strong” while experiencing significant postpartum depression.

Effective treatment is available.

Postpartum Psychosis Is an Emergency

A rare but very serious condition called **postpartum psychosis** can develop after childbirth.

Symptoms may include:

- Severe confusion.
- Hallucinations.
- Delusions.
- Paranoia.
- Extremely unusual beliefs.
- Mania.
- Rapid and severe mood changes.
- Severe agitation.
- Thoughts or behaviour that may endanger the mother or baby.

NIMH classifies postpartum psychosis as a **psychiatric emergency**, and ACOG recommends immediate medical attention.

This condition should **never be treated only with counselling, herbs or home remedies**.

Emergency psychiatric treatment is required.

Mood Changes During Perimenopause

The years leading up to menopause are called **perimenopause**.

During this period, estrogen and progesterone production can fluctuate unpredictably.

Women may experience:

- Irregular menstruation.
- Hot flashes.
- Night sweats.
- Sleep disturbance.
- Vaginal dryness.
- Irritability.
- Tearfulness.
- Anxiety.
- Mood changes.
- Changes in sexual desire.

The Menopause Society explains that estrogen receptors are widely distributed in brain regions involved in mood regulation and that hormonal fluctuations, sleep disruption, vasomotor symptoms and life stress may all contribute to emotional symptoms during perimenopause.

Women who have previously experienced depression, postpartum depression or significant menstrual-related mood symptoms may be particularly vulnerable during the menopausal transition.

However:

Perimenopausal mood changes are not automatically the same as major depression.

If persistent sadness, hopelessness or loss of interest develops, depression needs proper assessment and treatment.

Menopause Does Not Mean Emotional Instability Is Inevitable

Some women have almost no significant psychological symptoms during menopause.

Others experience troublesome irritability, anxiety or emotional sensitivity.

Therefore, menopause should not be used as a universal explanation for every behavioural change in a middle-aged woman.

The clinician should still consider:

- Depression.

- Anxiety.
- Thyroid disease.
- Medication effects.
- Sleep apnea.
- Chronic stress.
- Relationship problems.
- Medical illness.

Hormones are one part of the picture—not the entire picture.

Thyroid Disease and Mood Changes

Thyroid disease is an important medical cause that can sometimes resemble psychological or hormonal mood symptoms.

An overactive thyroid may produce:

- Nervousness.
- Anxiety.
- Irritability.
- Palpitations.
- Heat intolerance.
- Weight loss.

An underactive thyroid may contribute to:

- Low mood.
- Fatigue.
- Slowing.
- Weight gain.
- Cold intolerance.
- Menstrual changes.

Mayo Clinic's updated 2025 guidance confirms that both hyperthyroidism and hypothyroidism can affect mood, although mood symptoms are rarely the only manifestation of thyroid disease.

This is why thyroid testing may be appropriate in selected women rather than assuming that every mood change is PMS.

PCOS / PMOS and Mood Health

Women with PCOS—now increasingly referred to internationally as **Polyendocrine Metabolic Ovarian Syndrome (PMOS)**—may also experience anxiety, depressive symptoms and emotional distress more commonly than women without the condition.

The reasons are probably multifactorial.

Menstrual irregularity, infertility concerns, acne, unwanted facial hair, metabolic problems, sleep difficulties and body-image concerns can all contribute.

In such women, managing only menstrual periods while completely ignoring emotional well-being is incomplete care.

This is especially relevant in an infertility clinic, because fertility treatment itself can be emotionally demanding.

Sleep Deprivation: A Very Common but Underestimated Cause

I frequently find that patients search extensively for a hormonal explanation while regularly sleeping only four or five hours.

Sleep affects emotional regulation.

Inadequate sleep can cause:

- Irritability.
- Reduced patience.
- Anxiety.
- Poor concentration.
- Fatigue.
- Increased emotional sensitivity.

The effect can be particularly strong in:

- New mothers.
- Shift workers.
- Women experiencing menopausal night sweats.

- Women under chronic family or occupational stress.

Improving sleep does not cure every mood disorder, but it is one of the first areas I assess.

Stress and Mental Overload

Modern women often carry several responsibilities simultaneously:

Employment.

Children.

Household responsibilities.

Caring for elderly parents.

Financial concerns.

Relationship responsibilities.

Health problems.

Infertility treatment.

Chronic mental overload can result in irritability and emotional exhaustion even when hormone levels are completely normal.

The Unani concept of **Harakat-o-Sukun Nafsani—mental or psychic activity and rest—is particularly relevant here**.

CCRUM's standardized Unani terminology describes mental activity and peace as one of the six essential determinants of health and emphasizes the importance of an appropriate balance between mental activity and rest.

This classical concept has obvious practical relevance today.

Diet and Mood

Nutrition can indirectly influence emotional health.

A highly irregular eating pattern may contribute to fluctuations in energy and concentration.

Iron deficiency can contribute to fatigue.

Vitamin deficiencies may coexist with poor nutrition.

Excess alcohol can worsen sleep and mood.

Very high caffeine intake may worsen anxiety in sensitive individuals.

However, there is no scientifically established single **“mood balancing diet for women.”**

A balanced eating pattern with:

- Adequate protein.
- Vegetables and fruits.
- Whole grains where appropriate.
- Healthy fats.
- Adequate iron and calcium.
- Regular meals.

is more rational than extreme dietary restriction.

The goal should be sustainable health rather than creating another source of stress.

Medicines Can Affect Mood

Whenever a patient's mood changes after starting or changing medication, I take that history seriously.

Medicines and substances can influence sleep, anxiety, energy and emotional state.

This does not mean that a patient should suddenly stop a prescription medicine.

Stopping certain antidepressants, hormonal medicines, steroids, seizure medicines or other treatments abruptly can itself create significant problems.

The prescribing physician should review:

- Why the medicine was prescribed.
- When mood changes began.
- Dose.
- Possible interactions.
- Whether an alternative is appropriate.

Depression Is More Than Mood Swings

Depression should not be reduced to “feeling sad.”

Major depression can involve:

- Persistent depressed mood.

- Loss of interest or pleasure.
- Hopelessness.
- Fatigue.
- Sleep disturbance.
- Appetite changes.
- Poor concentration.
- Feelings of worthlessness.
- Social withdrawal.
- Thoughts about death or suicide.

WHO's 2025 update estimates that depression affects more women than men globally and emphasizes that depression is different from normal short-term changes in mood. Effective treatments exist.

If symptoms persist for most of the day for at least approximately two weeks and interfere with functioning, professional assessment is appropriate.

Anxiety Can Also Look Like Mood Instability

A woman experiencing significant anxiety may appear irritable, restless or emotionally unpredictable.

She may experience:

- Excessive worry.
- Muscle tension.
- Palpitations.
- Poor sleep.
- Difficulty concentrating.
- Restlessness.
- Fear that something bad will happen.

In these situations, repeatedly treating “hormonal mood swings” without addressing anxiety may provide little benefit.

Bipolar Disorder Must Not Be Mistaken for Ordinary Mood Swings

This distinction is extremely important.

The term **"bipolar"** is sometimes casually used to describe someone whose mood changes frequently.

That is medically incorrect.

Bipolar disorder involves defined episodes of depression and **mania or hypomania**, with significant changes in mood, energy, sleep and activity.

Signs suggesting mania can include:

- Extremely elevated or unusually irritable mood.
- Markedly increased energy.
- Racing thoughts.
- Very rapid speech.
- Sleeping much less without feeling tired.
- Unusually inflated confidence.
- Increased impulsivity.
- Reckless spending or sexual behaviour.
- Poor judgment.

NIMH explains that manic or hypomanic episodes last for days or longer rather than representing ordinary moment-to-moment emotional changes.

This distinction also affects treatment.

Antidepressants should not simply be prescribed without considering bipolar disorder when symptoms suggest it, because antidepressant treatment alone can precipitate mania or rapid cycling in susceptible individuals.

ACOG similarly recommends screening for bipolar disorder before initiating medication for depression or anxiety during the perinatal period when this has not already been done.

Symptoms That May Accompany Female Mood Swings

Mood symptoms may occur alone or alongside physical symptoms.

Emotional Symptoms

- Irritability.

- Anger.
- Sadness.
- Crying.
- Anxiety.
- Emotional sensitivity.
- Feeling overwhelmed.
- Loss of enjoyment.
- Feelings of rejection.
- Reduced confidence.

Cognitive Symptoms

- Poor concentration.
- Forgetfulness.
- Difficulty making decisions.
- Racing thoughts in some conditions.
- Feeling mentally slowed in others.

Physical Symptoms

- Headaches.
- Breast tenderness.
- Fatigue.
- Bloating.
- Pelvic discomfort.
- Sleep disturbance.
- Changes in appetite.
- Palpitations.
- Muscle tension.

Behavioural Symptoms

- Social withdrawal.
- Arguments with family members.

- Reduced productivity.
- Changes in eating patterns.
- Changes in sexual desire.
- Increased alcohol or substance use.
- Impulsive behaviour in some psychiatric conditions.

The combination and timing of these symptoms helps determine the diagnosis.

How I Evaluate Female Mood Swings

When a woman comes to me with mood changes, I do not start by asking which medicine she wants.

I first try to understand the **pattern**.

I ask:

When did this begin?

Does it occur every month?

Does it begin one or two weeks before menstruation?

Does it disappear after the period begins?

Are periods regular?

Could pregnancy be present?

Has childbirth occurred recently?

Is the woman breastfeeding?

Is she approaching menopause?

How many hours does she sleep?

Has there been major life stress?

Has sexual desire changed?

Is there painful intercourse?

Is infertility creating emotional stress?

Are there symptoms of thyroid disease?

Which medicines are being used?

Has depression or anxiety occurred previously?

Has the woman ever experienced unusually high energy, reduced need for sleep or risky behaviour?

Are there thoughts of self-harm?

These questions often provide more useful information than ordering a large set of hormonal tests immediately.

There Is No Single "Mood Swing Test"

Mood swings cannot be diagnosed with one blood test.

For PMS or PMDD, the pattern across the menstrual cycle is particularly important.

For depression and anxiety, validated questionnaires may help.

Examples include:

- PHQ-9 for depressive symptoms.
- GAD-7 for anxiety.
- EPDS for perinatal depression.
- MDQ where bipolar disorder needs consideration.

ACOG recommends standardized validated screening during pregnancy and postpartum and specifically emphasizes having a system for further assessment and treatment after a positive screen.

Laboratory investigations should be selected according to clinical indications.

Depending upon symptoms, these may include:

- Thyroid function.
- Complete blood count.
- Iron status.
- Glucose evaluation.
- Pregnancy testing.
- Other hormonal or nutritional assessments where clinically justified.

Every woman does not require every test.

Modern Treatment of Female Mood Swings

Treatment depends upon the diagnosis.

There is **no universal mood-stabilizing tablet for every woman**.

A woman with PMDD requires one approach.

A woman experiencing sleep deprivation after childbirth needs another.

A woman with hypothyroidism needs treatment of thyroid disease.

A woman with major depression needs appropriate mental-health care.

A woman with bipolar disorder requires specialist psychiatric treatment.

The symptom may sound similar, but the underlying conditions are different.

Lifestyle Treatment

For mild symptoms, especially when stress, sleep and premenstrual changes are major contributors, lifestyle measures can be very useful.

These include:

- Regular sleep.
- Regular physical activity.
- Balanced nutrition.
- Limiting excessive alcohol.
- Reducing excessive caffeine if it worsens anxiety or PMS.
- Stress-management techniques.
- Regular time for rest.
- Maintaining social support.

Mayo Clinic and ACOG guidance recognize exercise, stress reduction, patient education and nutritional strategies as useful components of PMS management.

The key word is **regularity**.

Doing one hour of exercise once every three weeks will not compensate for chronic sleep deprivation and daily stress.

Exercise

Exercise has benefits for both physical and emotional health.

It may help:

- Energy.
- Sleep.
- Stress.
- Metabolic health.
- Mild depressive symptoms.
- Premenstrual symptoms.

ACOG includes routine exercise among evidence-based or recommended supportive approaches for premenstrual disorders.

I usually advise choosing an activity that can actually be continued rather than following an extreme temporary plan.

Walking, cycling, swimming, strength exercise and other regular activity can all be useful depending upon the person's health.

Cognitive Behavioural Therapy and Counselling

Psychological therapy is not reserved for “serious mental illness.”

Cognitive behavioural therapy, commonly called **CBT**, can help patients understand how thoughts, behaviours and emotional responses influence one another.

It can be useful for:

- Anxiety.
- Depression.
- Stress.
- Premenstrual mood symptoms.
- Relationship-related distress.

The ACOG guideline includes psychological counselling as part of multimodal treatment of premenstrual disorders, and a guideline summary reports evidence that CBT improves affective PMS symptoms.

Sometimes counselling is more appropriate than adding another medicine.

SSRIs for Severe PMS and PMDD

For moderate-to-severe PMS and particularly PMDD, **selective serotonin reuptake inhibitors, or SSRIs**, are among the best-supported pharmacological treatments.

ACOG gives a strong recommendation for SSRIs for affective premenstrual symptoms, supported by multiple randomized clinical trials.

Unlike their use in major depression, SSRIs for PMDD can sometimes work with intermittent dosing confined to the luteal or premenstrual phase.

Treatment still requires a physician because:

- The appropriate medicine varies.
- Side effects may occur.
- Sexual side effects are possible.
- Pregnancy planning matters.
- Bipolar disorder should not be missed.

A patient should not start an antidepressant simply because an internet article lists it.

Hormonal Contraception

For selected women with premenstrual disorders, **combined hormonal contraception** can reduce overall premenstrual symptoms by modifying ovarian cycling.

ACOG recommends combined oral contraceptives as one pharmacological option for premenstrual symptoms.

However, hormonal contraception is not suitable for every woman.

The choice depends upon:

- Smoking.
- Migraine history.
- Blood pressure.
- Blood-clot risk.
- Age.
- Other health problems.
- Fertility goals.

Treatment of Severe Refractory PMDD

A small proportion of patients have disabling symptoms despite standard treatment.

Specialist options can include medicines that suppress ovarian hormonal cycling, such as **GnRH agonists**, with appropriate hormonal add-back therapy.

ACOG reserves these approaches for more severe refractory disease because of cost, side effects and the consequences of creating a temporary low-estrogen state.

These treatments should be supervised by experienced specialists.

Treatment During Perimenopause

If mood changes occur together with hot flashes, night sweats and sleep disruption during perimenopause, treating the menopausal symptoms may improve overall well-being.

The Office on Women's Health notes that menopausal hormone therapy may help some women with mild menopause-related mood symptoms. However, significant depression or anxiety should be assessed as a distinct mental-health condition and may require psychotherapy, antidepressant medication or both.

Hormone therapy should therefore not be presented as a universal antidepressant.

Treatment During Pregnancy and Postpartum

Pregnancy and breastfeeding require particular care when selecting medicines.

ACOG's current clinical guidance emphasizes balancing the risks of untreated maternal mental illness against the benefits and potential risks of psychological and pharmacological treatments.

Treatment can include:

- Psychological therapy.
- Social and family support.
- Antidepressant or anxiety medication when clinically appropriate.
- Specialist psychiatric care for severe disease.

Postpartum psychosis requires emergency treatment.

Female Mood Swings According to Unani Medicine

Unani medicine has long recognized a close relationship between **mental and physical health**.

The traditional Unani framework does not have a single classical disease corresponding exactly to the modern casual phrase “female mood swings.”

Therefore, I do not believe it is historically accurate to assign every mood swing to one specific Unani diagnosis.

Instead, Unani assessment can consider:

Mizaj — individual temperament.
Akhlat — the traditional humoral framework.
Quwa Nafsaniyya — psychic faculties.
Harakat-o-Sukun Nafsani — mental activity and rest.
Naum-o-Yaqza — sleep and wakefulness.
Ghiza — diet and nutrition.
General physical and reproductive health.

This allows the physician to look at the patient as a complete person.

The Four Humours

Classical Unani medicine recognizes four principal humours:

Dam — blood
Balgham — phlegm
Safra — yellow bile
Sauda — black bile

The Ministry of AYUSH describes balanced humours and individualized Mizaj as central traditional principles of Unani medicine.

Historically, different emotional tendencies have sometimes been interpreted in relation to temperament and humoral patterns.

However, these traditional concepts should **not be described as scientifically identical to serotonin, estrogen, progesterone or modern psychiatric diagnoses**.

For example:

A classical Sauda-related description should not automatically be equated with major depressive disorder.

A Safra-related temperament should not automatically be equated with bipolar mania.

The two medical systems use different explanatory frameworks.

Quwwat Nafsaniyya and Emotional Health

Unani medicine traditionally describes a **psychic faculty, Quwwat Nafsaniyya**, associated with sensation, thought and response.

CCRUM's official description of Unani medicine discusses the mind through the concept of psychic faculties and **Ruh Nafsani**, and also recognizes psychological approaches within traditional treatment.

Again, these are traditional philosophical and physiological concepts rather than modern neurological structures.

Their practical importance lies in the fact that Unani medicine has historically recognized that **mental well-being influences physical health and vice versa**.

Harakat-o-Sukun Nafsani — Mental Activity and Rest

This is one of the Unani principles I consider especially relevant to modern women.

CCRUM defines **Harakat-o-Sukun Nafsani** as mental activity and peace, one of the Asbab-e-Sitta Zarooriya or six essential factors required for health.

Today we might look at a woman who:

- Works throughout the day.
- Manages children.
- Sleeps poorly.
- Worries continuously.
- Has no personal rest.
- Experiences relationship stress.
- Is undergoing infertility treatment.

Simply giving her a medicine without addressing the continuous psychological load would be incomplete treatment.

Unani medicine encourages the physician to ask about this balance.

Asbab-e-Sitta Zarooriya — Six Essential Factors

Unani medicine gives great importance to six essential determinants of health:

1. Air and environment.
2. Food and drink.
3. Physical activity and rest.
4. Mental activity and rest.
5. Sleep and wakefulness.
6. Retention of useful substances and appropriate elimination of waste.

The Ministry of AYUSH recognizes these factors as fundamental to preventive and promotive Unani healthcare.

Many of these areas have obvious relevance to mood.

Sleep influences emotional stability.

Exercise can affect mental well-being.

Nutrition affects energy.

Stress influences anxiety.

The environment and relationships affect psychological health.

This is why the holistic aspect of Unani medicine can be valuable.

Ilaj Nafsani — Psychological Treatment in Unani Medicine

Classical and institutional Unani descriptions recognize **Ilaj Nafsani**, or psychological treatment.

CCRUM describes the use of modification of sleep, mental processes and verbal psychological approaches in treating psychological and psychosomatic disorders.

In contemporary practice, this can reasonably complement evidence-based psychological counselling.

However, I would not claim that classical Ilaj Nafsani alone should replace psychiatric treatment in severe major depression, bipolar disorder or postpartum psychosis.

The severity of the condition determines the level of care required.

Ilaj-bil-Ghiza — Dietary Treatment

An individualized Unani treatment programme may include **Ilaj-bil-Ghiza**, or dietotherapy.

The aim is to support health according to:

- Mizaj.
- Body composition.
- Digestive health.
- Reproductive status.
- Menstrual symptoms.
- Pregnancy or breastfeeding status.
- Diabetes or PMOS.
- Other medical conditions.

I do not recommend assigning every woman the same list of “hot” or “cold” foods.

Traditional dietary principles should be adapted to the individual's health and contemporary nutritional knowledge.

Ilaj-bil-Tadbir — Lifestyle and Regimental Treatment

Another important component is **Ilaj-bil-Tadbir**, or regimenal/lifestyle management.

Depending upon the patient's condition, this may focus on:

- Sleep correction.
- Physical activity.
- Stress reduction.
- Structured daily routine.
- Appropriate relaxation.
- General health restoration.

Some traditional regimens, including massage or selected therapies, may have a role in relaxation and well-being in appropriate individuals.

But such therapies should not be promoted as a substitute for psychiatric treatment in severe disease.

Herbal Medicines: What About Saffron?

Saffron, or **Zafran (Crocus sativus)**, is often discussed in traditional medicine for emotional and reproductive complaints.

Interestingly, modern research has begun investigating it.

A **2026 systematic review and meta-analysis of randomized clinical trials** reported that saffron supplementation was associated with improvement in overall PMS symptoms and dysmenorrhoea compared with control treatment.

This is encouraging.

However, it does **not** mean that saffron is proven to treat every type of female mood swing, major depression, bipolar disorder or postpartum depression.

Research preparations use defined doses and standardized products. Commercial herbal preparations can vary greatly in purity and concentration.

Women who are pregnant, breastfeeding, taking psychiatric medicines or living with significant medical conditions should therefore not begin concentrated herbal treatment without professional guidance.

What About Rosemary, Fennel and Other Herbs?

Many traditional herbs have historical uses relating to digestion, menstruation, sleep or general well-being.

However, the quality of clinical evidence for **rosemary or fennel specifically treating female mood swings is currently insufficient to justify presenting them as established mood treatments**.

I therefore do not advise patients to take a long list of herbs simply because they are natural.

“Natural” and “appropriate for this patient” are not the same thing.

The medicine should be selected according to the diagnosis, reproductive status and other medications.

Where Unani Medicine Can Be Particularly Useful

I find Unani principles most useful when a woman has **mild-to-moderate mood symptoms connected with lifestyle, sleep, stress, menstrual health or general constitutional health**, provided that serious medical and psychiatric disease has been excluded.

Unani care can contribute through:

- Detailed individualized history.

- Mizaj assessment.
- Sleep correction.
- Dietary regulation.
- Physical activity.
- Stress management.
- Ilaj Nafsani.
- Appropriate Unani pharmacotherapy where indicated.
- Follow-up of associated reproductive or sexual-health problems.

For more serious conditions, I use these measures as **supportive or integrative care**, not as a replacement for necessary psychiatric, gynecological or endocrine treatment.

My Specialized Approach at Saira Health Care

When a woman consults me at **Saira Health Care** because of persistent mood changes, I use a structured approach.

First: I Identify the Pattern

Is the problem present throughout the month or primarily before menstruation?

Did it begin during pregnancy?

Did it start after childbirth?

Is the patient approaching menopause?

Second: I Assess Physical Causes

Where clinically appropriate, I consider:

- Thyroid dysfunction.
- Anemia or nutritional problems.
- PMOS/PCOS.
- Diabetes or metabolic issues.
- Chronic illness.
- Medication effects.
- Sleep disturbance.

Third: I Assess Mental Health

I look for:

- Depression.
- Anxiety.
- Severe stress.
- Trauma.
- Bipolar symptoms.
- Suicidal thoughts.
- Postpartum mental-health disorders.

Fourth: I Assess Sexual and Reproductive Health

I ask whether there is:

- Low sexual desire.
- Pain during intercourse.
- Infertility.
- Menstrual irregularity.
- Vaginal dryness.
- Menopausal symptoms.

Fifth: I Assess the Patient According to Unani Principles

This includes:

- Mizaj.
- Diet.
- Digestion.
- Sleep.
- Physical activity.
- Harakat-o-Sukun Nafsani.
- Overall constitutional and reproductive state.

Sixth: I Create an Individualized Treatment Plan

Depending upon the patient, treatment may include:

- Lifestyle correction.

- Sleep management.
- Ilaj-bil-Ghiza.
- Appropriate physical activity.
- Stress management.
- Ilaj Nafsani or counselling.
- Carefully selected Unani medicines where appropriate.
- Gynecological treatment.
- Endocrine evaluation.
- Psychological therapy.
- Psychiatric referral or medication when indicated.

Seventh: I Follow the Response

For menstrual-related symptoms, I encourage continued cycle and symptom tracking.

Improvement should be measured by:

- Reduced symptom severity.
- Better functioning.
- Better sleep.
- Reduced irritability or anxiety.
- More stable relationships.
- Improved quality of life.

I prefer measurable clinical improvement over giving a patient an unrealistic fixed “success percentage.”

Female Mood Swings, Sexual Desire and Intimate Relationships

Emotional health and sexual health are closely connected.

A woman experiencing depression, anxiety, sleep deprivation or chronic stress may notice a reduction in sexual desire.

Conversely, unresolved sexual difficulties can increase emotional distress.

For example:

Painful intercourse may produce anxiety.

Vaginal dryness may cause avoidance of intimacy.

Infertility may create repeated emotional stress.

Relationship conflict may worsen mood and reduce sexual desire.

Certain antidepressants can also affect libido or orgasm.

This is one reason my focused work in **sexual disorders and infertility** requires attention to mental health rather than treating the reproductive organs alone.

Mood Changes and Infertility

Infertility itself can be psychologically difficult.

Repeated menstrual cycles without pregnancy, fertility testing, family pressure and the financial cost of treatment can produce:

- Anxiety.
- Sadness.
- Irritability.
- Relationship tension.
- Reduced sexual spontaneity.

At the same time, mood swings themselves should not automatically be blamed as the cause of infertility.

If pregnancy is not occurring, the couple requires a proper fertility evaluation.

Underlying medical conditions such as PMOS or thyroid dysfunction can sometimes affect both reproductive function and emotional well-being.

Treating those conditions appropriately may improve several aspects of health simultaneously.

Contribution of Saira Health Care in Sexual Disorders & Infertility

At **Saira Health Care**, our work in sexual disorders and infertility has shown repeatedly that intimate and reproductive-health problems cannot always be separated from emotional health.

Patients may initially consult for:

- Female infertility.

- Male infertility.
- Low sexual desire.
- Painful intercourse.
- Vaginismus.
- Erectile dysfunction.
- Premature ejaculation.
- Menstrual disorders.
- PCOS/PMOS.

But during a detailed consultation, we may also identify:

- Severe stress.
- Depression.
- Anxiety.
- Relationship tension.
- Performance anxiety.
- Sleep disturbance.
- Mood symptoms related to menstruation or menopause.

Our approach therefore emphasizes **confidential consultation, detailed history-taking, individualized Unani assessment, reproductive and sexual-health evaluation, patient education, lifestyle care and appropriate collaboration or referral when specialized mental-health treatment is required**.

I consider knowing **when to refer a patient** just as important as knowing when to prescribe treatment.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi, Founder and Chief Physician of Saira Health Care**, with a focused clinical practice in **Sexual Disorders & Infertility**.

My professional training includes:

BUMS – Hamdard University, Delhi
MD
CGO

Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Through my clinical work, I have learned that sexual and reproductive problems frequently involve more than laboratory results.

A patient's sleep matters.

Her stress matters.

Her emotional well-being matters.

Her relationship matters.

Her fertility goals matter.

And when a genuine psychiatric disorder is present, recognizing and treating it properly matters.

For me, this is what individualized sexual and reproductive healthcare should mean.

When Mood Swings Need Urgent Medical Attention

Certain symptoms should never be treated simply as hormonal changes.

Urgent assessment is particularly important when there are:

- Thoughts of suicide.
- Thoughts of self-harm.
- Thoughts of harming a baby or another person.
- Hallucinations.
- Delusions.
- Severe confusion.
- Extreme agitation.
- Dangerous impulsive behaviour.
- Several days with almost no sleep together with unusually high energy.
- Severe postpartum behavioural change.
- Inability to care for oneself or a newborn.

NIMH and ACOG identify suicidality and postpartum psychosis as conditions requiring urgent assessment and immediate medical attention.

For patients in India, the Government of India's **Tele-MANAS** mental-health service is available through **14416 or 1800-89-14416**, with access to mental-health counselling and referral support.

If there is immediate danger, use local emergency medical services or go to the nearest emergency department.

Common Myths About Female Mood Swings

"Women are naturally emotionally unstable."

Incorrect.

Emotional variation occurs in all people. Some reproductive stages can influence mood, but severe emotional symptoms deserve proper medical understanding rather than stereotypes.

"Every mood swing is caused by hormones."

Incorrect.

Sleep, stress, depression, anxiety, thyroid disease, medicines, relationships and other factors may contribute.

"If hormones are causing the problem, hormone levels must be abnormal."

Not necessarily.

PMDD may involve increased sensitivity to normal hormonal fluctuations rather than simply abnormal hormone concentrations.

"Every woman becomes depressed during menopause."

No.

Some experience mood changes, while many do not develop depression.

"PMDD is just ordinary PMS."

No.

PMDD can cause severe emotional symptoms and marked functional impairment.

"Mood changes after childbirth are always baby blues."

No.

Baby blues are mild and short-lived. Severe or persistent symptoms can indicate postpartum depression, and psychosis is a medical emergency.

“Someone whose mood changes quickly must have bipolar disorder.”

No.

Bipolar disorder involves distinct manic or hypomanic and depressive episodes lasting days or longer, with major changes in energy, sleep and behaviour.

“Herbal medicine is always safer than psychiatric medicine.”

Not necessarily.

Herbal medicines can have side effects, contamination, variable potency and drug interactions. Treatment should be selected according to the patient's actual condition.

Frequently Asked Questions

Are mood swings before periods normal?

Mild emotional changes can occur with PMS. When symptoms become severe, repeatedly interfere with daily life or include significant depression or suicidal thoughts, PMDD or another condition should be assessed.

How can I know whether my mood changes are related to menstruation?

Keep a daily symptom and menstrual diary for at least two cycles. A recurring pattern during the one to two weeks before menstruation followed by clear improvement after the period begins strongly supports a premenstrual relationship.

Can thyroid problems cause irritability or depression?

Yes. Hyperthyroidism may cause anxiety and irritability, while hypothyroidism can contribute to depressed mood and fatigue.

Can lack of sleep cause mood swings?

Yes. Chronic sleep deprivation can worsen irritability, anxiety, concentration and emotional regulation.

Can menopause cause mood changes?

Yes. Hormonal fluctuations, hot flashes, sleep disruption and life stress can contribute during perimenopause, but persistent depression should be treated as a separate medical condition.

Are mood swings common after childbirth?

Temporary baby blues are common and usually improve within one to two weeks. Persistent or severe symptoms may represent postpartum depression.

Can mood swings affect sexual desire?

Yes. Stress, depression, anxiety, sleep problems and relationship difficulties can affect sexual interest and arousal.

Can mood swings cause infertility?

Mood changes alone are generally not a direct cause of infertility. However, underlying conditions such as PMOS, thyroid disease or severe chronic illness may affect both emotional and reproductive health.

Is PMDD treatable?

Yes. Evidence-based options include lifestyle measures, CBT, SSRIs and hormonal treatment in appropriate patients.

Can SSRIs be taken only before the period for PMDD?

For some patients, yes. Certain SSRIs can be used intermittently during the luteal or premenstrual phase under medical supervision.

Does Unani medicine have a role?

Yes, an individualized Unani approach can be useful in comprehensive management through attention to Mizaj, sleep, diet, physical activity, mental activity and rest, Ilaj Nafsani and carefully selected medicines. However, severe depression, bipolar disorder, suicidality and postpartum psychosis require appropriate psychiatric care and should not be managed solely with traditional treatment.

Does saffron help PMS?

A 2026 systematic review and meta-analysis found encouraging evidence that saffron may reduce overall PMS symptoms. More research and standardized preparations are still needed, and it should not be considered a universal treatment for all mood disorders.

A Personal Message From Dr. Nizamuddin Qasmi

When a woman tells me that her mood keeps changing, I do not want her first thought to be:

“Something is wrong with me.”

Instead, I want to understand what her body and mind are experiencing.

If symptoms occur only before menstruation, we examine the possibility of PMS or PMDD.

If she recently delivered a baby, postpartum mental health becomes important.

If she is approaching menopause, we evaluate sleep, vasomotor symptoms, hormones and emotional health.

If she is continuously exhausted, I want to know why she is not sleeping.

If she has irregular periods, weight changes and infertility concerns, we consider PMOS and endocrine factors.

If thyroid symptoms are present, we investigate them.

If she has persistent depression or anxiety, I do not simply label the problem as “hormonal.”

And if there are signs of mania, suicidal thoughts or postpartum psychosis, I consider urgent specialist mental-health treatment essential.

The Unani system gives us a valuable way of looking at **Mizaj, diet, sleep, Harakat-o-Sukun Nafsani and the overall relationship between mind and body**.

I find that philosophy very useful.

But responsible contemporary Unani practice also means recognizing that severe psychiatric illness is a medical condition requiring evidence-based treatment.

At Saira Health Care, my aim is therefore not to give every woman a sedative or a “mood tonic.”

My aim is to identify the pattern, understand the cause and develop an individualized treatment plan.

Good treatment should bring greater emotional stability without ignoring the woman's reproductive health, sexual health, physical health or mental health.

Conclusion

Female mood swings are common, but they are **not one single disease and should not automatically be attributed to hormones**.

Emotional changes may occur with PMS, PMDD, pregnancy, the postpartum period and perimenopause. They may also result from stress, inadequate sleep, thyroid disease, depression, anxiety, medications or other medical conditions.

Severe mood changes can occasionally represent bipolar disorder or another serious psychiatric condition.

Current evidence supports a **multimodal approach** to significant premenstrual mood disorders, including lifestyle measures, exercise, psychological therapy, SSRIs and hormonal treatment when appropriate.

The Unani system offers an important holistic framework through **Mizaj, Akhlat, Asbab-e-Sitta Zarooriya, Harakat-o-Sukun Nafsani, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and Ilaj Nafsani**. Ministry of AYUSH and CCRUM sources confirm the traditional importance Unani medicine gives to the relationship between mental and physical health, appropriate sleep, psychological balance, physical activity and diet.

Emerging evidence for traditional ingredients such as saffron is encouraging for premenstrual symptoms, but herbal treatments should not be exaggerated into universal cures.

At **Saira Health Care**, my approach is to combine individualized Unani assessment with appropriate hormonal, reproductive, medical and psychological evaluation so that treatment addresses the **actual cause of the patient's symptoms rather than simply suppressing her emotions**.

Dr. Nizamuddin Qasmi
Founder & Chief Physician
Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Visit Saira Health Care

Medical Disclaimer: This article is intended for general education and health awareness. Mood symptoms may result from reproductive, hormonal, medical or psychiatric conditions and require individualized assessment. Herbal, hormonal and psychiatric medicines should not be started or stopped solely on the basis of online information. Suicidal thoughts, severe mania, hallucinations, delusions, postpartum psychosis or thoughts of harming oneself or another person require urgent professional medical attention.