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COPING STRATEGIES OF WOMEN SUFFERING FROM PRIMARY DYSMENORRHEA

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Abstract

This article aims to describe the strategies that women suffering from dysmenorrhea (painful menstruation) use to cope with the pain and other physical and psychological difficulties accompanying this disease. Semi-structured interviews were conducted with eighteen women with dysmenorrhea and processed using thematic analysis. The results pointed to a significant connection between psychological and physical aspects and showed several passive and active strategies that women use. Pharmacotherapy in the form of analgesics and thermotherapy was used as first aid. What helped were rest and relaxation, reduction of external stimuli, and withdrawal into oneself, as well as emotional and physical catharsis and authentic pain relief, diversion of attention from pain, and social and emotional support of the immediate environment. Active strategies included various techniques such as yoga and breathing exercises, while passive strategies mainly included drug therapy and rest. Psychological support from family and friends also played a vital role. The study showed that a combination of these strategies can significantly contribute to better pain management and psychological well-being in women suffering from dysmenorrhea.

Keywords: *Chronic pain; Coping strategies; Dysmenorrhea; Emotional catharsis; Social support*

ORIGINAL ARTICLE

INTRODUCTION

Although menstruation is a normal part of every woman's life, it remains a taboo in many societies, including ours. This also applies to diseases related to menstruation, which include dysmenorrhea – painful menstruation. This disorder of the menstrual cycle affects up to 20% of women of reproductive age (Hodická et al., 2015) and represents an important bio-psycho-social topic. In addition to pain of varying intensity, there are several unpleasant physical manifestations, psychological discomfort, disruption of emotional experience (Iacovides et al., 2015) or self-concept and self-confidence (Riva et al., 2011). Female patients are also excluded from many common activities and, depending on the severity of the problems, are unable to work. Their relationship levels and well-being are disturbed (Vlachau et al., 2019).

This paper aims to understand how women suffering from dysmenorrhea deal with the above (and other) difficulties and what coping strategies they use. Our aim was to get the most comprehensive insight into what helps women manage pain, both physically (eliminate pain) and psychologically, i.e., eliminate the negative psychological experiences that accompany and

cause dysmenorrhea, and stabilize psychological well-being.

Theoretical basis

Primary dysmenorrhea

Dysmenorrhea belongs to the system of menstrual cycle disorders. A typical manifestation is pain in the lower abdomen, which, in varying intensity, usually occurs on the day of menstruation or the day before – and lasts one to three days. In addition to spasmodic pains, patients suffer from physical nausea, vomiting, diarrhoea, headaches, hot flushes or chills, dizziness, and even collapse, disturbances in perception, attention, disorientation, sleep disorders, irritability, depressive states, apathy, anxiety, or feelings of exhaustion (Chovanec and Dostálová, 2009; Kolář et al., 2009).

Based on etiopathogenesis, we distinguish between primary and secondary dysmenorrhea. Primary dysmenorrhea occurs in women who have not yet given birth and have functional pelvic anatomy. The etiopathogenesis is not exactly known, but it is related to the increased production of prostaglandins by the endometrium, which leads to an increase in the activity of the myometrium, which causes intrauterine pressure (Rob et al., 2019). Therapy is based on combined hormonal contraception that blocks ovulation and pain medication (Guimarães and Póvoa, 2020). However, relaxation techniques, Lamaze techniques, and autogenic training are also effective (Denney and Gerrard, 1981).

Secondary dysmenorrhea occurs in women over 25 years of age. It is caused by organ anatomical or pelvic abnormality and pathology, or gynaecological diseases such as endometriosis, adenomyosis, myomatosis, etc., and inflammation (Roztočil and Bartoš, 2011).

Coping strategies in managing pain

In individuals experiencing pain, we can encounter several different kinds of reactions and inclinations to manage it. Active coping strategies for managing pain are focused on trying to function normally despite existing pain (adaptation) and strategies to divert attention from pain. Passive coping strategies for managing pain do not arise primarily based on the patient's initiative but are provided to her within her environment. These include helplessness, withdrawal, or surrendering control to an outside force. These strategies and mindsets are directly related to greater levels of pain and depression of the sufferer (Jensen et al., 1991).

Pain catastrophising is a form of cognitive evaluation where there is a terrible and unbearable experience and distortion of pain. Catastrophising is strongly associated with depression and pain. Studies using fMRI imaging have shown that pain catastrophising is significantly associated with increased activity in brain regions related to pain anticipation, attentional focus to pain, and emotional aspects of pain (associated with the amygdala) (Sullivan et al., 1998). The last type of strategy is painful behaviour and social conditioning, or it can also be a secondary gain from illness and learned behaviour (conditioned pain). The care and concern of others can significantly support the sufferer in painful behaviour and experience, which subsequently leads to fixation and an increase in the intensity of the experienced pain. It has been shown that patients who receive a higher level of social support simultaneously increase the level of painful behaviour (grimacing, limping, vocalisation, etc.) (Gracely et al., 2004).

MATERIALS AND METHODS

As part of the qualitative research strategy, semi-structured interviews lasting 30–60 minutes were carried out from August to October 2021. With the consent of the informants, the interviews were recorded on a dictaphone and transcribed verbatim. All informants were free to look into their statements and modify or add new data. The data was revised and supplemented once again for some re-informants based on the need to clarify and supplement information during data collection and analysis. For the analysis and evaluation of the research results, thematic coding and data analysis (Švaříček and Šeďová, 2007) were used in the following steps: (1) Familiarization with the data, (2) Generation of initial codes, (3) Search for topics, (4) Elaboration of topics and their revision, (5) Definition and naming of topics, (6) Preparation of reports.

The main strategy for obtaining female informants was the self-selection method. Women were approached en masse via social networks (Facebook, Instagram) and, based

on their personally expressed interest and fulfilment of the criteria, were subsequently included in the research. Other informants were obtained based on recommendations (snowball technique). Childless women aged 20–30 who had been regularly suffering from dysmenorrhea for at least a year were selected for the research group. The last experience with painful menstruation was usually associated with the last period, i.e., a few days or weeks before the interview. The total number of participants in the study was 18 women. The average age of the informants was 25.5 years, and all women had high school or university education. The most common duration of dysmenorrhea problems was 12 years or more. The first experience with dysmenorrhea most often appeared at the beginning of menstruation, but in some women, it did not start until adulthood (for no known reason). No pathological gynaecological diagnosis was found in any of the informants. The names of the informants were anonymised.

RESULTS

The intensity of dysmenorrhea pain was assessed using a self-assessment six-point scale: minimal, weak, moderate, strong, very strong, extremely strong. The informants then evaluated the pain in the last three intensities. Diarrhoea, vomiting, nausea, feelings of dizziness and fainting, headaches, back pain, weakness (malaise, lack of energy), depression, chills, blurred vision, and cold sweats were the most common associated problems in our group. As a result of dysmenorrhea, women also reported experiencing severe fatigue, impaired concentration/attention, cognitive impairment, and sleep disturbance.

Regarding coping strategies, the informants' statements were very diverse, and we categorised them into active and passive. In all cases, these strategies were aimed at reducing pain and improving psychological well-being. The factors are closely related to each other, or rather interact with each other – in Denisa's words: *"Just reducing the pain gives me so much psychological relief."* We will describe the individual strategies in more detail below.

Analgesics and thermotherapy – "first aid"

The use of analgesics and thermotherapy (hot bath, thermoform, warm drinks), which, in addition to the relaxing effects, leads to improved psychological well-being, were the most intensively used strategies in the informants' statements. These strategies represent the first SOS help, and in most cases helps women to eliminate, at least partially, their pain. Strong analgesics and spasmolytics, such as algifen, flamexin, spasmopan, and analgesic injections have proven to be the most effective because weaker analgesics are ineffective in their case.

Quiet mode and relaxation

"But otherwise, relaxation helps me; I need a feeling of complete relaxation – first of all, that there is no obligation, that I don't have to go anywhere and I don't have to be anywhere, that everyone leaves me alone and doesn't want anything from me. And darkness and sleep and, above all, complete peace, no activities, obligations, demands, stress, performance and no bustle" (Michaela).

The informants used relaxation with music, guided meditation, yoga, and breathing exercises: *"As a relief position, I found the child's position (from yoga), a ball and breathing through my stomach, it relieves me a little from the pain..."* (Marta).

An interesting strategy in this area was the maximum reduction of external stimuli when the informants mentioned the need for silence and darkness, but also the reduction of social stimuli: *"I just have to have silence, darkness, mainly silence and be completely shut off from the environment..."* (Liliana). The reason was the perception of external distracting stimuli as overwhelming. Related to this was withdrawal, including the ability to be alone, away from people, in privacy, and "close" to oneself. *"It's important to be alone at that moment; at that time, I don't want to communicate with anyone... the procedure is to withdraw into myself for some time, disconnect from the surroundings, that helps me"* (Liliana).

Limiting communication leads to a reduction of pain for some informants: *"When I have as little contact with people as possible*

and can be alone..., I feel better psychologically, and at the same time, it also reduces the pain" (Radka).

Emotional physical catharsis and authentic pain relief

Another strategy that significantly helps the informants is experiencing the pain in its full authenticity through emotional-physical catharsis, including emotional, vocal, movement, or physiological catharsis (vomiting). These were ventilation/reaction strategies in the form of crying, screaming, wailing, whimpering, yammering, "calling for help", getting angry and venting into a substitute object, and movement stereotypes in the form of body swaying. The more a woman could authentically express pain through this emotional-physical catharsis, the better. However, it was necessary to be in privacy for the possibility of a full experience.

Diversion of attention

Another option was diverting attention from the pain, in any form, usually through social communication and interaction with loved ones: *"The presence of other people during painful menstruation ... one has the opportunity to distract oneself a little and come up with other thoughts than the current pain"* (Sára). Or by searching for all kinds of pleasant and positive stimuli: *"Not to think about the pain and the menstruation and divert the attention to what I have positive emotions from, which will essentially divert attention from the observation of the pain"* (Liliana). As positive stimuli, positively tuned (comedic) films and music were most often sought, while informants avoided those that could provoke melancholy.

An extreme form of diversion was the creation of a substitute pain that would be more tolerable for the informant: *"I even inflict another pain on myself no matter how many times, that will overcome it so that I don't feel THIS. So, I just take hot water and scald myself; it sounds like I'm hurting myself, but the pain is simply greater and I perceive it, but it's more tolerable for me than the pain in the stomach"* (Kamélie).

Social and emotional support

The main source of social and emotional support was parents, partners, colleagues, and classmates. They provided a sense of security and peace, a space to complain and cry, and at the same time, allowed attention to be diverted. Support takes the form of emotional support, including compassion, understanding, consideration and care, such as caressing, hugging, and soothing, but it is instrumental when the environment provides women in acute seizures with a supply of analgesics, fluids, transportation to home or the hospital, etc. Objects were also used as substitutes to emotional support, such as a pet or a "teddy", to help women overcome pain.

DISCUSSION

The strategies used by our informants to alleviate problems during painful menstruation are by no means unique. While the use of painkillers is logical and expected, some of the other strategies were more surprising.

The influence of relaxation techniques on the change in the perception of the unpleasantness of pain is confirmed by several studies (e.g., Gorczyca et al., 2013). This is similar to the case of attention diversion (Carroll et al., 2004; Gureje, 2008; Larson et al., 2004), which is also used as a technique in working with pain in cognitive behavioural therapy (Gorczyca et al., 2013). Social support was mentioned quite often, and is generally considered to be the main source of coping with stress, as well as a source of positive emotions. According to Latthe et al. (2006), a lack of perceived social support may generally lead to a worsening of painful menstrual symptoms. In the article "The Influence of Social Support on Chronic Illness Self-Management: A Review and Directions for Research" (Gallant, 2003), the author deals with the influence of social support on chronic illness management. These studies show that social support has a positive effect on the quality of life, fewer depressive symptoms, and a higher level of patient adaptation.

The strategy of withdrawing from people appears to be a certain opposite of social support in the form of meeting people. However, this is also one of the procedures used in coping with chronic pain (Bruce et al., 2023).

In our results, the importance of emotional-physical catharsis and the authenticity of experiencing pain is very interesting. Here,

it is possible to assume that suppressed emotions represent a certain added stressor that can worsen the woman's condition. The possibility of their ventilation should, therefore, lead to emotional and physical relief (Staňková, 2022).

Dysmenorrhea cannot be objectified. Its degree and experience depend on personality type, psychological adjustment (and certainly upbringing), and the attitude of the environment – as shown in our results and those of the study by Ní Chéileachair et al. (2022). A meta-analysis by Armor et al. (2019) showed that young women with painful menstruation often use a combination of different strategies, including physical activity, pharmacological and non-pharmacological treatments (e.g., herbal medicine, heat) or psychological strategies (e.g., prayer or meditation). Interestingly, these strategies are usually carried out without seeking medical advice. We encountered a combination of several procedures to relieve painful menstruation.

Ní Chéileachair et al. (2022) highlight the challenges of managing primary dysmenorrhea. It is often a self-directed approach based on the trial-and-error method, sometimes without the possibility of finding effective coping strategies. Like our informants, Fernández-Martínez et al. (2021) state that the home was a safe haven, where women could more openly address their problems. Another interesting finding is that women often hide menstrual pain from those around them.

CONCLUSION

Painful menstruation represents a frequent yet neglected health and social problem. The women with dysmenorrhea interviewed in our research mentioned many active and passive factors that help them to manage and reduce the pain and psychological discomfort. While pharmacological treatment reduces pain, other strategies alleviate psychological discomfort in addition to pain – or have a two-way effect. Of course, the strategies described may vary in effectiveness for different women.

Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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