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Title: The personal experience of dysmenorrhoea: an interpretative phenomenological analysis

Abstract

This study explored 6 women's experiences of primary dysmenorrhoea using semi-structured interviews analysed using interpretative phenomenological analysis. Rather than focusing on pain, participants broadened the study focus to coping with the menstrual process as a whole. This was seen to be mediated by menstrual taboos and by the theme of 'order', arising from a strong feeling of a menstrual timetable and the need for rational explanation. Another theme was pain as a separate entity, which was connected to the theme of order. Placing dysmenorrhoea in its context may be useful for healthcare professionals treating women with the condition.

98 words

Keywords: interpretative phenomenological analysis, qualitative methods, women's health, health psychology, adults [pain?]

Introduction

Primary dysmenorrhoea (abdominal pain and discomfort experienced during or before menstruation which is not associated with identifiable organic pathology (Warrington et al., 1988)) is estimated to affect between 17% and 81% of women (Latthe et al., 2006a). It is

believed to be the result of excessive prostaglandin release (Harel, 2002) and is associated with a number of factors including being under 30 years of age, body mass index less than 20, smoking, menarche less than 12 years, longer cycles/duration of bleeding, irregular or heavy menstrual flow, presence of premenstrual symptoms, sterilisation, and history of sexual assault (Latthe et al., 2006b). Differences in estimated prevalence rates result from studies using different definitions (for example, some include mild pain, some only moderate and severe pain), different age ranges (some focus on younger women in whom rates tend to be higher (Latthe et al., 2006a)), and different measurement instruments. Between 11% and 57% of women with dysmenorrhoea report moderate or severe pain, or pain which interferes with daily activities or requires analgesia (Latthe et al., 2006a), although other estimates are lower (for example, between 11% and 14% in UK studies, Zondervan et al., 1998).

Many health-related experiences, such as pain, are subjective (Melzack and Wall, 1965), contextualised by the personal meaning to the sufferer. However, research is often premised on an assumption that people respond to pain in the same way. Given the range of prevalence estimates and associated factors, this may not be the case for dysmenorrhoea. Qualitative methodologies have been used to explore the experience of pain, particularly chronic pain, such as chronic lower back pain (for example, Osborn and Smith, 1998) and pain associated with cerebral palsy (Castle et al., 2007). Findings show what pain *means* to sufferers. For example, Osborn and Smith (1998) found 4 themes (searching for an

explanation, comparing this self with other selves, not being believed, and withdrawing from others). The authors explored the 2nd theme further (Smith and Osborn, 2007), focusing on the negative impact of chronic pain on the self, with sufferers describing how they developed an unpleasant other self leading to a struggle with their identity. Snelgrove and Lioffi (2009) describe a number of aspects of the experience of living with pain. These include managing pain (medication, coping strategies and relationship with healthcare professionals), and maintaining integrity (respondents emphasise that the cause of pain was beyond their control and not a 'moral' failure). This was linked to a theme of not being believed, also found by Osborn and Smith (1998), and the result of the pain being a loss of social identity and a sense of pain as a threat, taking them over. In Castle et al., 2007, respondents describe their loss of independence and their need to have their pain acknowledged, which is similar to Osborn and Smith's theme of not being believed. Thus there are some similarities in the experience of pain regardless of disease area.

We could find no study examining the lived experience of dysmenorrhoea, despite it being a relatively common experience. Exploring its meaning to sufferers is important in understanding it in the context of women's everyday lives. We therefore aimed to uncover the experience of dysmenorrhoea from the point of view of sufferers using interpretative phenomenological analysis (Smith, 1996).

Method

Participants and sampling method

Fifteen potential participants were identified using a snowball technique via the lead researcher's contacts and the interviewees themselves. They were screened using an emailed questionnaire to ensure they had a regular menstrual cycle (a period every 21 to 35 days Dixon AF. *Primate Sexuality: Comparative studies of the Prosimians, Monkeys, Apes, and Human Beings*. Oxford: Oxford University Press. 1998. Johnson MH and Everitt BJ. *Essential Reproduction*, 4th Edition. Oxford: Blackwell Science. 1995.), and experienced pain which, so far as they were aware, did not result from organic pathology, and which interfered with everyday activity at least one cycle in three. To ensure that participants recalled recent pain experiences, they were required not to have been receiving medical treatment for dysmenorrhoea for more than three cycles at the time of interview, nor to be using oral contraceptives since these are used to treat dysmenorrhoea. The screening questions were phrased as closed-ended questions requiring negative responses to meet inclusion criteria. To preserve confidentiality potential participants were not required to reveal their answers to the researchers. Seven women met inclusion criteria, aged between 24 and 36 years (mean 29 years) and were white (further details on ethnicity were not recorded). Five were identified via the leader researcher's contacts and two from participants. One was later diagnosed with secondary pathology and her interview removed from the analysis.

The interview schedule

We developed a semi-structured interview schedule using the protocol suggested for interpretative phenomenological analysis (IPA) (Smith, 1995) which aimed to encourage participants to talk freely about their experiences and to minimise the influence of the researchers' pre-conceived ideas. Questions covered participants' experience of periods and period pain, coping strategies employed, the experience of painful periods, and the effects on others and on themselves. Two pilot interviews were undertaken to test the interview schedule. After the first, the schedule was improved by reducing and reordering the questions. Neither interview was used in the final analysis to ensure findings were based on a similar standard of interview. Pilot interviewees were informed of this beforehand.

Procedure

Interviews. Interviews took place in participants' homes, except for one, which was carried out at a participant's workplace. The lead researcher was alone with each participant during the interviews. Interviewees were at liberty not to answer questions if they did not want to. The lead researcher recorded and transcribed the interviews verbatim and only she heard the recordings or read the full transcriptions. Recordings were destroyed following transcription.

Data analysis. Data analysis followed the protocol for IPA (Smith et al. 1999) . IPA aims to help researchers understand an experience from the point of view of the person experiencing it, whilst acknowledging the researcher's role as 'interpreter' (Smith, 1996). It has been increasingly used to explore topics in health psychology (Brocki and Wearden 2006). Following iterative readings of each transcript, we summarised what participants said, and identified initial themes and interpretations. When no further insights could be gained, themes were generated, summarised and analysed for connections, resulting in a table of themes for each transcript, which was compared with the others.

Transcripts were checked for themes which had been identified in other transcripts resulting in a list of master themes. . Findings were verified by collating the transcript material using a word processor so that instances of each theme were put together. These data were re-analysed to uncover how each theme developed or any inconsistencies, such as the same label being given to different themes.

In addition, the lead researcher made self-reflective notes during the analysis process to aid reflexivity in the final analysis, and to provide a commentary on the analysis process. This informed both the development of the themes and methodological reflection, and helped to acknowledge the researcher's interpretative role.

Findings

(Names are changed to preserve anonymity. In quotations, square brackets [] indicate parts of recordings which were inaudible.)

Although the study focused on dysmenorrhoea, this shifted to a general topic of coping with the menstrual process. Coping therefore infuses the themes identified: dysmenorrhoea, just one of many menstrual symptoms, menstruation as taboo, pain as a separate entity, and order.

Dysmenorrhoea: just one of many menstrual symptoms

Period pain was just one of a range of symptoms described by participants. For example:

... and it sort of makes me feel sick, nauseous sick, erm, very headachy, very vague ('Moirá')

They also talked about pre-menstrual symptoms, such as water retention, acne and irritability, and about the cycle as a whole, for example:

... and then between you sort of have a couple of weeks of actually feeling normal and then the whole thing starts again ('Denise')

In addition, although for all participants pain was a major symptom, some had other symptoms which were more disruptive. For example, 'Ella', who found 'flooding' (i.e., heavy menstrual flow) disrupted everyday life more than pain because it made it hard for her to take part in activities without frequent breaks:

... in one sense the huge blood loss affects me more than the pain because [] going out. You know. It affects when, it affects whether I go on a long business meeting at work because I won't be able to get out to go to the loo ('Ella')

Another participant reported that vomiting during her period interrupted her usual daily activities, for example, preventing her from going to work. Despite not occurring during every period, this symptom was so debilitating it had become a prominent feature of her menstrual experience.

From this emphasis on the whole menstrual experience, the topic of coping with menstruation began to emerge. This was 'set up' by the theme of menstruation as taboo.

Menstruation as taboo

The accounts were particularly influenced by taboos surrounding menstruation, manifested by an emphasis on keeping up appearances during periods and 'getting on' with life. Participants employed coping strategies not only to minimise the effects of menstrual symptoms on their own comfort, but also because they were anxious to avoid appearing unreliable, particularly at work. To 'Ella', heavy menstrual flow was inconvenient and embarrassing rather than a potential medical crisis, such as the risk of anaemia.

Taboos were most evident when participants talked about their periods in relation to other people, in particular, telling others when they were in pain. However, several participants were ambivalent, for example:

... I don't think a lot of people need to know. Erm, I work in an office with mainly blokes, erm, but most of them are fairly good friends, erm, and very much confidants really, and they know that I'm not quite right and that I'm may be a bit down or not as shiny as I'd like to be for the day erm and obviously my partner needs to know, because I get a bit whingey during the day. Yeh, I do, I'm quite open about it really with my friends. I think if there's going to be something that affects me quite so painfully and quite so obviously, it's only fair to explain it, really, rather than just say [] Erm, so I do tend to ('Moira')

Thus 'Moira' starts by saying most people do not need to know that she is menstruating, but ends by saying that she tells people because she is so badly affected (i.e., she begins with menstrual taboos but ends more pragmatically). She also distinguishes between telling men and women, implying that it is acceptable to tell her male colleagues only because they are friends. This gender distinction also extended to doctors:

Erm, it was OK. At the time I went to see .. it was a female doctor who was understanding. I don't usually mind which doctor I see, but she happened to be there and er, she was quite a good listener, which a lot of doctors don't seem to have time for. Erm she ... it wasn't like ... she was erm helpful ... ('Moira')

Menstrual taboos also seemed apparent in family situations with none of the participants indicating that they were aware of their mothers suffering from dysmenorrhoea. 'Marie' was typical:

Interviewer: ... before you actually started your periods, did you know they could be painful?

‘Marie’: ... I don’t think I ever thought about it much. [] My mum never let on that any of this was happening to her although []... I think my mum had quite a lot of ... Well, she used to take quite a lot of paracetamol and she never told me why. Looking back it may have been that. I don’t know to be honest – we never really talked much about these things.

Menstrual taboos provided the *context* within which these women experienced menstrual symptoms, and coping mechanisms appear to be driven by this.

Pain as a separate entity

Participants talked about their period pain in the third person, as if it were a separate entity. The dominant metaphor was pain as a visitor or traveller. For example, participants talked about it ‘coming’ and ‘going’:

... I mean I sometimes I kind of take painkillers as often as possible whether I’ve got the pain or not to stop it coming (‘Fiona’)

This was also highlighted by the difference in the way participants talked about pain compared with other symptoms. Nobody said, ‘I was in pain’ or ‘I started to feel pain’ with themselves as the subject of the sentence as they did with other symptoms. Pain was either the subject or the direct object. For example:

... so after the pain comes ... (‘Denise’)

... to take kind of 800mg and above of ibuprofen to kind of stop the pain (‘Fiona’)

This traveller or visitor had a darker side frequently taking on the character of an unpredictable force of nature threatening to overwhelm. For example, 'Denise' referred to taking painkillers '... in order to keep it at bay', 'to keep it down' and 'to ward it down'. Pain became a sinister predator which had to be appeased:

... but once it's down, it's not usually nothing, it'll go to a dull ache just to remind me it's there, and then sort of start threatening again. And sometimes I just have to constantly take pills to keep it at bay ... so I've always got the dull threat of it. ('Moirá')

And:

Anyway, I do generally find even if I'm not, I'm feeling nauseous, and I haven't been bothered to eat, if I have some food, then it eases things. I've fed it. Don't know. ('Denise')

Linked to the theme of period pain as a separate being was the way participants described the pain as a *physical* being, frequently using adjectives based on movement verbs such as 'cramping' and 'dragging'. It also became violent:

I would say that throughout my teenage years and my early twenties ... I suppose it was as if someone was hitting my stomach with a fist. Now I would say it's just a dragging pain right through as if someone's gouging out my insides ('Ella')

And:

... like somebody's sort of grabbing you from the inside and twisting you ('Moirá')

However, the interviewees said very little to describe the pain, particularly the *quality* of the pain. Indeed, two participants did not say anything about this at all, describing the pain

simply in terms of where they felt it ('a real groin pain' ('Denise'), a 'pain in the stomach' ('Marie')).

Talking about the pain as if it were a separate entity with a personality and will of its own pervaded most other aspects of the accounts.

'Order'

A theme of 'order' was evident both in accounts of period pain itself and within the whole menstrual cycle. It manifested itself in two ways: the menstrual cycle following a 'timetable' of events, and menstrual symptoms being explicable in terms of cause and effect, i.e., by participants trying to find rational explanations for their symptoms. Thus 'order' becomes a coping strategy.

Menstrual timetable. A strong feature of the accounts was a timetable of events, where individual menstrual symptoms occurred at roughly the same stage of each period, allowing participants to navigate through each period .

erm, I would say the pain in my stomach just starts really, erm, could be about part-way through day one
... ('Ella')

Symptoms which were particularly incapacitating were also used as markers. For example, 'Marie', who was sometimes prevented from going to work by being sick:

If I'm not sick the morning of day one then I won't be sick. ('Marie')

She mentioned being sick on day one several times during her interview so that it came to 'frame' other symptoms including abdominal pain, even though she was not sick with every period.

'Ella' shows how this sense of a timetable extends to her whole menstrual cycle and is linked to the theme of a period as a separate entity.

I would say, when the period's just about to start, or just before, you know, within an hour before, I feel tearful. It's as if, it's like a central heating clock, you can hear the clunk can't you, when the boiler comes on to give you hot water at 6 o'clock at night? It's like that. It's as if my tears alert me. ('Ella')

The theme of 'order' was also apparent when order broke down. When participants discussed the overall regularity of their menstrual cycle two key aspects were identified: the importance of regularity, and that irregularity must be explained rationally.

Erm, well, it's usually quite regular, but, something like every 28 days, sometimes, though, it erm gets more varied erm [] it can be like, late, last time, it was 9 days late and sometimes it's only 19 days, so it's pretty ... It depends on how it wants to be really. But it was falling into a pattern but erm it doesn't stick to it ('Moirra')

'Moirra' indicates here that she believes that *normal* periods are regular, so that deviance must be explicable. However, when she is unable to do this she describes her periods anthropomorphically, in terms of them making a conscious decision to do their own thing.

Rational explanations. The need to explain the symptomatology of the menstrual cycle rationally links to the theme of pain as a separate entity discussed above. It followed three patterns: taking responsibility for symptoms oneself (i.e., doing something which leads to period problems); blaming something else (for example, stress); and citing a medical cause. 'Maira' illustrates two of these:

Yeh, missing meals and eating the wrong things because I [] stress or because I just like to eat the wrong things. Er, you know automatically sort of not having the vegetables because you don't have time to cook them. And erm, I find I'm better when I do. Just have. ... I need to eat, not at specific times, but at set times, [] problem really. Erm to make sure I have a proper meal a day as opposed to just [] grabbing a burger or something if I'm going out []. Erm, I think when I fall out of that pattern things tend to go haywire and erm again the stress increases and the pain, if that is the link. I don't know.

Thus 'Maira' blames her own health behaviour, in this case her eating patterns, as a cause of period pain, thus taking responsibility for her symptoms. However, other participants tended to give explanations in which they have less control. In the example above, 'Maira's stress is cited as a possible cause, and this was common for other participants too:

... I very much get the impression that if there's lots of stress at the time erm it made things more painful and closer ('Denise')

This devolves responsibility – the participants all portrayed stress as something unfortunate which happens to them over which they have little control. A further way of explaining symptoms was to use a medical explanation, thus relinquishing all responsibility. For example:

... it may be because there's acid there – I don't know? Might, might not, might – because if you, if there's acid, you get lactic acid causes muscles to cramp, doesn't it? ('Denise')

However, the evidence does not always fit neatly into such an explanation. For example:

... on the first day of my period if I have to do something where I have to use my abdominal muscles, then that really sets off the pain, erm, but having said that, I've sometimes woken up with really bad pain and presumably I'm relaxed when I'm asleep, so, that's a bit bizarre because I'll be asleep and I'll suddenly wake up with major cramping. ... But, erm, yeh, but I don't know what sets off the pain. ('Sara')

Thus, 'Sara' wants to find a rational cause-and-effect explanation for her period pain. An important point here is that she thinks *something* must set off the pain, and that it cannot be a random event. Occasionally, however, participants resort to talking about their symptoms in terms of luck, as if it has become a game of chance.

No pains today. Got off quite lightly this month. ('Maira')

This section has shown how participants want to explain what happens rationally, which is a kind of coping strategy. When they are not able to do so satisfactorily they talk about their menstrual cycle as if it is a separate entity by anthropomorphizing it.

Coping with menstruation

Coping strategies were mediated by menstrual taboos, trying to hide their symptoms and carry on as normal, and by the theme of order.

Amongst the most common method of dealing with period pain was medication , particularly ibuprofen (a non-steroidal anti-inflammatory drug). Warm baths, hot water bottles and bed rest were also mentioned. Painkillers were popular because they were a private method of pain control, enabling normal life to continue as far as possible. They were easy to take and hide the pain:

Pain, I can shut my door take some pain killers and I cope with it. ('Ella')

Painkillers were seen as a kind of insurance policy or even as a weapon against pain, which had to be brought under control because it threatened to overwhelm them.

... the thing is I now take it [ibuprofen] - as soon as I start getting period pain I'll take it. I know that if I don't I might suddenly get terrible period pains and have to go to bed for the next two days. I'll just take it straightaway no matter what. ('Sara')

However, participants were ambivalent towards drugs. On one hand they were a necessity, but on the other they were unnatural and bad for them. For example:

... so I just have to walk around with a huge tub of Nurofen or whatever ... because I shove painkillers down, so it's not continuous because I kind of knock it out ... I mean I sometimes I kind of take painkillers as often as possible whether I've got the pain or not to stop it coming ... when I'm not taking those tablets, like I said it wakes me up at night [] first two days, if I'm working, I just I really can't concentrate because all I can, it just overtakes everything, and once I shove painkillers down then it goes and I'm fine, it's just keeping the pain away because I can't focus otherwise ... But on the whole, you see, I hate having to take painkillers. I don't like having to shove tablets in my body, you know, every four hours for two days, but you don't really have any choice ... ('Fiona')

'Fiona' echoes 'Sara's' fear of being overwhelmed by the pain, and she also clearly brings out the theme of pain as a separate being. 'Fiona'

Another coping method was to try to impose normal behaviour patterns during a period, for example, eating regularly:

... but now I think I do sort of try to force myself to eat properly even though I don't really feel like it or just eat anything ('Fiona')

'Marie' also employed cognitive strategies to get herself through:

... erm I don't think it [paracetamol] really helps all that much to be honest. I don't know why. I think I just sort of, you know, have [] a couple of paracetamol and off you go to work you know [] gee myself along a bit.... I think I may be a bit quieter and especially if I'm in a lot of pain. Just don't say a lot, have a quiet day. Just try and get through the day yeh sort of if I'm at work [] and it's quarter past two. You know, I think, this time tomorrow I won't have this pain or three hours and I could have a hot water bottle if it were that bad. Just try and get through it like that. You know. Also, I tell myself you're doing really well. It's lunch time. I've kept at work, and I've been OK. It's really good. [] telling myself to keep positive and not let it affect me really, I think. ('Marie')

'Marie' takes paracetamol even though it is ineffective as part of a 'coping routine'. 'Ella' also employs coping strategies by organising her life to reduce stress. It is as if she only has a finite amount of energy, which is used up by her period and so cannot be used elsewhere.

Erm, it's as if, that to cope with the period means that you have to have less stress elsewhere ... but I suppose I have a better understanding of my body now, not a huge amount, but better than I did 10 years ago so I know what's coming so I can take mitigating steps to minimise disruption ... erm it's as if I'm walking a tightrope of surviving. ('Ella')

This echoes 'Sara's' view above of her period as a kind of threatened catastrophe. Having only a finite amount of energy is echoed in the way participants portrayed themselves during their periods. They lost their usual drive and energy, and became passive. 'Sara' was typical:

Erm, well, if I'm at work, it just makes me really sort of erm, again if it's the first or second day it'll make me really ... I know I'm not working as well as I should. So if I'm, I haven't got the energy or erm I can't, I'm just kind of getting through the day, I can't really think, I can't really be really pro-active, and erm, and working as well as I should do. And that's just like the first and second day and then it's fine after. ('Sara')

Thus coping with menstrual symptoms brings together the themes illustrated above. First, the way participants talked about the need to take painkillers in order to maintain normal life illustrates menstrual taboos. Second, the theme of order is seen in the need to impose everyday routines. Third, pain is clearly described as a separate entity which absorbs the women's energies.

Summary

The focus of the analysis shifted from dysmenorrhoea to a broader topic of coping with menstrual symptoms. This became apparent when participants focused on a whole range of symptoms in addition to pain, and when the themes identified seemed to emerge as a coping response to menstrual symptoms. The themes identified appeared to operate in 'layers'. The whole was contained within the theme of menstrual taboos which drove the coping process. Under this operated a theme of pain as a separate entity which pervaded much of the transcript material, and a theme of 'order', manifested by the way participants described a 'timetable' for their menstrual cycle and tried to impose rational explanations for symptoms.

Discussion

Given the range of prevalence estimates and associated factors for dysmenorrhoea this study has found that the experience of dysmenorrhoea follows a similar overarching thematic framework but there are individual differences linked to sufferers experiencing different symptoms. The findings are similar to some of those found in existing research on other pain experiences. However, other studies have concentrated on chronic pain (defined as continuous pain) whilst dysmenorrhoea is chronic only in as much as it recurs.

Dysmenorrhoea: just one of many menstrual symptoms

The finding that other menstrual symptoms were as important as pain was unexpected because the lead researcher had originally conceived the project based on her own menstrual experience, which is dominated by period pain. However, this is supported by the existing dysmenorrhoea literature, where pain is treated as the dominant symptom, although it is possible that aspects of the study method encouraged participants to talk about their whole cycle. Since the participants had a stake in the research process because they were giving up their time for the interview, this may have led to them trying to give the researcher as much information as possible in the hope that it might be relevant. There was a sense during some of the interviews of participants giving a medical history. The origin of the separation of dysmenorrhoea from the whole menstrual cycle may be a medicalised view of dysmenorrhoea as a problem – a deviance from ‘normal’ when it is in fact part of normal life.

Menstruation as taboo

Our finding that ‘coping’ meant more than just dealing with the symptoms, but meant hiding symptoms, too, supports research examining menstrual taboos (e.g. Jurgens and Powers, 1991) and menstruation as a social stigma (Kowalski and Chapple, 2000). The source of taboos is likely to be cultural, since the participants all indicated similar taboos and were from a similar cultural background. Taboos were particularly evident when participants talked about telling others about their period pain, clearly disingenuous

between telling men and women. The issue of cultural taboos around menstruation could be further explored.

None of the participants knew whether their mothers had suffered with dysmenorrhoea which casts doubt on whether women learn a dysmenorrhoeic response from their mothers as a kind of 'sick role' (Whitehead et al., 1986). This topic may also benefit from further investigation.

Pain as a separate entity

This theme is not apparent in the extant literature on dysmenorrhoea (although is in the wider pain literature, for example, Scarry 1985) but most vividly conveys the essence of the menstrual experience. Whereas the other themes identified provide a context for the topic, it most directly answers the question, what is it like to experience dysmenorrhoea?

This theme may also have cultural origins. The interviewer phrased her questions using this metaphor, for example, 'and is it [the pain] continuous or does it come and go?'. This is the way pain is talked about in English. However, the theme came through strongly in other aspects of the interviews, such as in the 'visitor' metaphor.

The pain itself was hard to describe, with participants using metaphors or describing it only in terms of where they felt it ('a real groin pain') rather than describing pain quality. A more

experienced interviewer may have been able to draw the interviewees out by asking supplementary questions to achieve a more in-depth description of the actual pain experience.

'Order'

The theme of order may have cultural origins, since imposing order, particularly trying to find rational explanations, could be considered a Western way of thinking. Without a comparison group, this can only remain a speculation. It is similar to the theme of searching for an explanation (Osborn and Smith, 1998; Snelgrove and Lioffi, 2009).

Menstrual taboos and 'order' became evident because participants talked about their whole menstrual cycle experience, not just dysmenorrhoea. This was also the case for the theme of pain as a separate entity, and reflects the theme of pain as a threat found by Osborn and Smith (1998).

Methodological reflections

Gathering data from interviews means that only people who are articulate, reasonably confident and willing to talk about a personal matter to a stranger, (albeit another woman in the present study), are included. One potential interviewee was too shy to be interviewed and did not like talking about 'women's problems'. Recruitment was based on self-diagnosis of pain which interfered with daily activities. Between 11% and 14% of women in

UK studies which estimate prevalence rates of dysmenorrhoea based on severity suffer from 'severe' pain (Zondervan et al., 1998). Those interviewed in the present study are therefore likely to be drawn from a relatively small proportion of women experiencing dysmenorrhoea. The study could be repeated with women with milder symptoms to further understand the phenomenon.

Conclusions

In the light of the findings of the present study it appears that research into primary dysmenorrhoea may focus too narrowly on menstrual pain. Shifting the focus from dysmenorrhoea to coping with the whole menstrual process points the way to a greater understanding of dysmenorrhoea from the sufferer's point of view, thus giving healthcare professionals a 'context-based' view of dysmenorrhoea, particularly in understanding the role of menstrual taboos which lead to sufferers wanting to be able to deal with their symptoms in private. There is also a need to increase understanding of dysmenorrhoea, particularly in the work place.

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