

# Coping with Premenstrual Syndrome: The role of Psychological Immunity

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*Premenstrual Syndrome (PMS) is a common health problem that women of reproductive age generally deal with. It is a cluster of physical as well as emotional symptoms that appear on a regular basis before the onset of menstrual cycles. It is often marked by various psychological impairments such as mood swings, irritability, anxiety, depression etc. The present study tried to understand the role of one's psychological immunity in ascertaining the extent of mental health issues experienced by such women and the coping mechanisms implemented by them. 120 women, experiencing severe as well as moderate level of PMS, were sampled for the study. The data was collected using Beck Anxiety Inventory, Beck Depression Inventory, Psychological Immune System Inventory and COPE Inventory. The results show a significant correlation between the mental health and the Psychological Immunity as well as the Coping strategies adopted by the women. Moreover, in order to find the extent of contribution the Psychological Immunity of the individual plays in determining the mental health and coping techniques used, multiple regression analyses were done. It shows that various dimensions of*

*Psychological Immunity stand as a significant predictor of anxiety as well as depression experienced by the individuals. Further it was found that Self-regulation (a sub-system of Psychological Immunity) emerged as a significant predictor of Psychological Distress (negatively explaining 28.9 % of variance in Anxiety and 15.3% of variance in Depression). Moreover, Synchronicity and Social monitoring capacity too stood as significant predictor of coping strategies implemented by such cohorts. The findings reveal that Psychological Immunity possessed by such women has a crucial and defining role in determining not only the extent of mental health issues experienced but also the techniques used by them to cope with PMS.*

**Keywords:** Psychological Immunity, Premenstrual Syndrome, Anxiety, Depression, Coping

## Introduction

Premenstrual changes are deemed to be a normal part of life of a menstruating woman. Females in their reproductive age often deal with dysphoria a week before and even during menstruation. Premenstrual Syndrome (PMS) is a common, cyclically recurring set of physical, emotional, and behavioural symptoms that occur during the luteal phase of the menstrual cycle, typically in the two weeks before menstruation (Steiner

et al., 2017). Premenstrual Syndrome affects more than 20 to 30% the women folk whereas Premenstrual Dysphoric Disorder affects from 5% to 10% of the women (Itriyeva, 2022). Premenstrual Syndrome is characterized by a constellation of physical, emotional and behavioural changes which affects the daily life of the women suffering from it. While PMS is primarily associated with physical symptoms such as bloating, breast tenderness, and headaches, it also encompasses a wide range of psychological symptoms including mood swings, irritability, anxiety, and depression (American Psychiatric Association, 2013).

Diagnosing PMS is all about determining the time of onset of symptoms during menstruation. There is a significant change between the severity and clinically significant severity of symptoms of premenstrual and post menstrual symptoms. Differential diagnosis to

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distinguish PMS from other medical and psychiatric facilities are essential for proper treatment. No hormones or any laboratory analysis indicates a diagnosis of PMS. The current diagnostic standard requires verification of subjective symptom reports with prospective daily diaries. Diagnostic criteria for PMS must recognize the broad spectrum of symptoms, the temporal pattern of symptoms and the critical issue of symptom severity that distinguishes clinically significant PMS from normal changes in the menstrual cycle (Freeman, 2003).

It not only impairs their functioning at work but also impacts their personal activities (Kessel, 2000). PMS can interfere with family relationships, work, social activities, and sexual relationships (Campbell et al., 1997). Women during this phase deal with various emotional symptoms which may or may not be accompanied by physical symptoms (Ussher & Perz, 2013). These symptoms are often mild, but it can be severe enough to substantially affect their day to day activities.

### **Psychological Distress and Premenstrual Syndrome**

Psychological distress is a broad and multidimensional concept that refers to a state of emotional suffering, discomfort, or mental anguish experienced by an individual. It is the negative stress response, often involving negative affect and physiological reactivity: a type of stress that results from being overwhelmed by demands, losses, or perceived threats. It has a detrimental effect by generating physical and psychological maladaptation and posing serious health issues. It encompasses a range of negative emotional and cognitive experiences, including symptoms of anxiety, depression, and other psychological disorders. Psychological distress can manifest as a temporary and mild state of unease or as a more severe and chronic condition with significant impairment in daily functioning.

Psychological distress in women with PMS is a common and often underestimated problem. Studies have shown that up to 90% of women experience some form of PMS symptoms, with around 20-40% reporting moderate to severe distress (Steiner et al., 2017). The severity and range of psychological symptoms can vary greatly among individuals, making it a complex phenomenon to study.

Psychological distress often includes feelings of excessive worry, fear, and apprehension. Individuals

experiencing psychological distress may have heightened levels of anxiety, leading to physical symptoms such as restlessness, muscle tension, and racing thoughts. Psychological distress can also involve symptoms of depression, including persistent sadness, low energy, hopelessness, and a loss of interest or pleasure in previously enjoyed activities. Premenstrual Syndrome has marked psychological distress as its one of the prominent etiology among such females. Some women may experience increased irritability and difficulty in managing their emotions when they are psychologically distressed. It can lead to physical symptoms like headaches, gastrointestinal issues, and sleep disturbances. Women experiencing psychological distress may withdraw from social interactions, isolate themselves, or have difficulty in maintaining relationships.

Psychological distress encompasses a wide array of symptoms experienced by individuals with PMS. Common psychological symptoms include mood swings, irritability, anxiety, depression, and increased stress levels. Several studies have highlighted the severity and impact of psychological distress during the premenstrual phase, often interfering with daily functioning, interpersonal relationships, and overall quality of life. Women with PMS show an increase in swings in mood which do not retain their stability during the days of menstrual cycle. Such women are found to be irritable and agitated during the luteal phase of the cycle. This instable mood pattern tends to get more depressive during the luteal phase (Bowen et al., 2011). Women with PMS often report anxiety and stress-related symptoms, including tension, restlessness, and increased stress reactivity (Rapkin et al., 2017). These symptoms can further exacerbate psychological distress and contribute to the negative cycle of PMS symptoms.

Mood swings, irritability, and emotional sensitivity are hallmark symptoms of PMS. Women with PMS may experience sudden and intense mood shifts, which can impact their interpersonal relationships, work, and overall quality of life (Freeman et al., 2011). Depressive symptoms, such as sadness and hopelessness, are also common during this phase.

It has been found that the rate of depression among women of reproductive age is twice the same in men of that age (Bhatia, 1999). Such prevalence is not found in females before puberty or after menopause. MacQueen and Chokka (2004) in their study regarding depression in women found PMDD as one of the

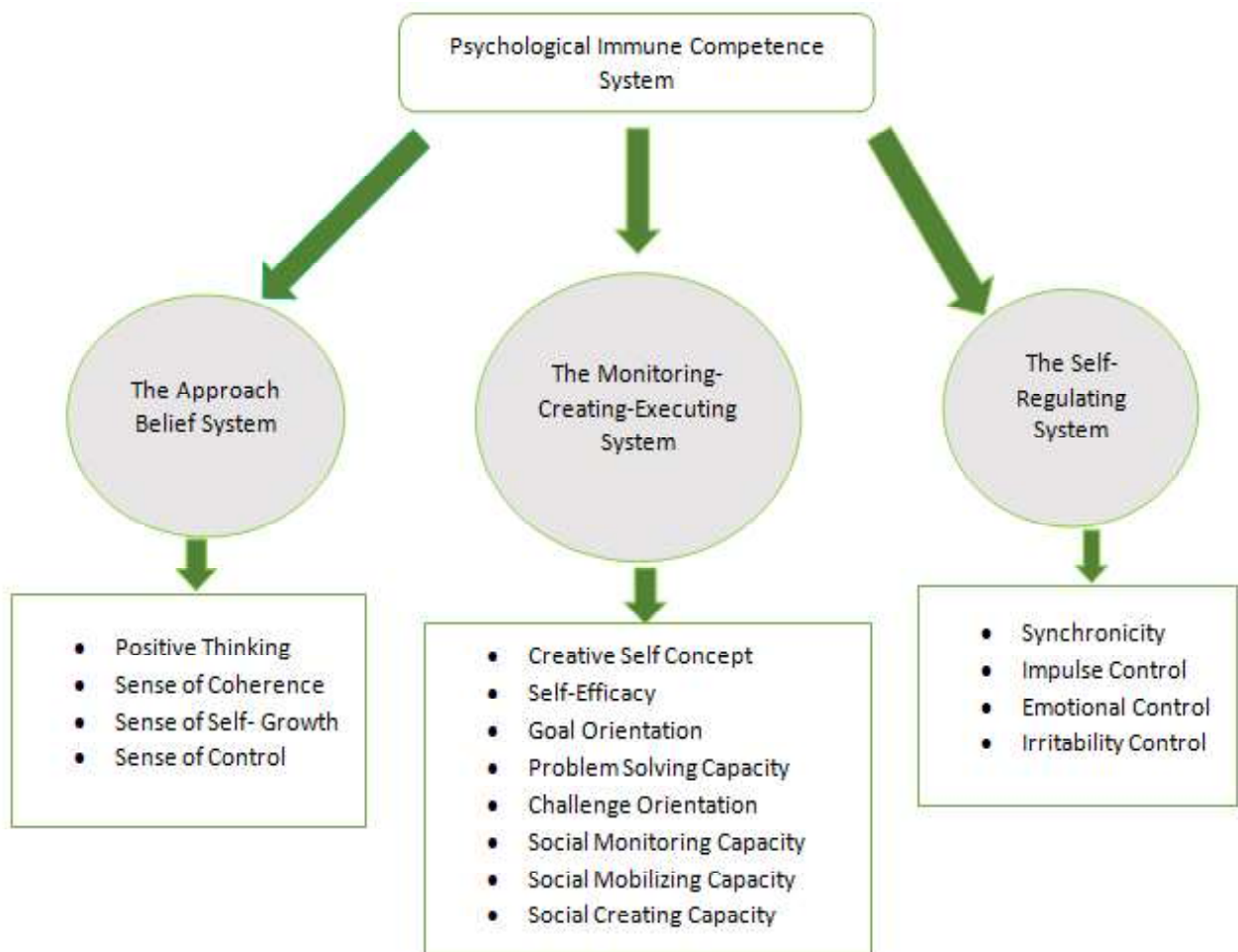
prominent reasons for their psychological condition. The women dealing with severe depression during this phase often go for SSRI (Selective Serotonin Reuptake Inhibition) treatments along with psychiatrist's help. Distressed individuals may exhibit cognitive distortions, such as negative thought patterns, self-criticism, and feelings of worthlessness. Psychological distress in women with PMS is a multifaceted issue, often influenced by hormonal fluctuations, societal factors, and individual coping strategies.

**Psychological Immunity**

Olah(1996,2002) had defined psychological immune system as “an integrated system of cognitive, motivational and behavioral personality dimensions that should provide immunity against stress, promote healthy development and serve as stress resistance resources or psychological antibodies”.

Psychological Immunity is a unified system of motivational, behavioural as well as cognitive factors that helps people to rebound from stress and deal with certain stressful situations. This Psychological Immune System is a defence mechanism that guards the person against negative situations, emotions and events of crises. This consists of psychological antibodies which frames the individual's psychological resources. The psychological antibodies which are implemented by our system are Positive Thinking, Problem Solving Capacity, Sense of Self growth, Self-Efficacy, Creative Self Concept, Emotion Control, Irritability Control, etc.

Olah classified Psychological Immune System into three sub- systems namely – The Approach – Belief System, The Monitoring-Creating-Executing System and the Self-Regulating System. Each of these sub-systems are built on the grounds of various psychological antibodies.



**Fig 1: Psychological Immunity, its sub-systems and dimensions**

In the context of PMS, psychological immunity may play a role in determining the extent of distress experienced by women. There is a negative correlation between resilience and high depressive symptoms (Victor, 2019). However, positive correlations have been found between stress, anxiety and PMS symptoms, therefore 88% of PMS symptoms in young people manifest as stress and neurosis (Le, 2020).

### **Coping**

Coping refers to the psychological and behavioural efforts individuals employ to manage, tolerate, or adapt to stressors, challenges, or adverse circumstances in their lives. Coping strategies can vary widely and may be influenced by individual differences, personality traits, and the nature of the stressor itself. These characteristic set of actions or thought process taken or implemented in response to stressful and unpleasant situations in order to manage the stress. Stress reduction techniques have been shown to be effective and can even be the first step in managing PMS (Babapour et al., 2021).

Lazarus and Folkman (1984) defined coping as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.” Their model emphasizes the role of cognitive appraisal in coping, wherein individuals assess the significance of a stressor and their ability to manage it, which then informs their coping strategies. Coping involves a continuous interaction between the individual and the environment. It comprises two main components: primary appraisal (evaluating the significance of a stressor) and secondary appraisal (evaluating one’s resources and options for coping). Coping strategies are subsequently employed based on these appraisals. Folkman and Lazarus (1980) emphasized that coping can be understood as adaptive responses aimed at restoring emotional equilibrium and reducing the psychological distress caused by stressors. These responses may include problem-solving, seeking social support, emotional expression, or avoidance behaviors.

Distinguishing between problem focussed coping (aimed at directly addressing the stressor) and emotion-focused coping (focused on regulating emotional responses to the stressor), Carver, Scheier, and Weintraub (1989) described coping as the process of constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands

that are appraised as taxing or exceeding the resources of the person.

These definitions provide insights into the multidimensional nature of coping and highlight the dynamic process through which individuals attempt to manage stressors and maintain their psychological well-being. Coping strategies can vary from person to person and situation to situation, reflecting the complexity of human adaptation to life’s challenges.

Seeking social support from friends, family, or support groups is a common adaptive coping strategy among women with PMS. Social support can provide emotional validation and practical assistance, reducing feelings of isolation and distress.

Akin (2023) found that positive affective activities for coping with PMS include personal orientations such as spending time doing things they enjoy, being entertained, generating positive emotions, engaging in hobbies, exercising, putting on a hot water bottle, and seeing friends. He even found that students’ depression, fatigue and irritable nature made them seek social support. Buddhabunyan et al. (2017) found that participants received advice from their friends (33.9%) and parents (22.8%) to manage PMS symptoms. Aperribai and Alonso-Arbiol (2020) found that patients with PMS had more mood symptoms and dealt with PMS by getting help and advice from people around them. Research suggests that social support can influence coping with PMS.

The role of partners in aggravating or alleviating premenstrual stress in women was found to be significant (Ussher and Perz, 2017; Rezaee et al., 2015). The increased understanding of the partners in the relationship as a result of CBT was also good for improving the relationship. The men’s coping responses influenced women’s symptom severity and symptoms for premenstrual anxiety (Ussher and Perz, 2017). Same-sex relationships have shown particular support in managing PMS (Ussher and Perz, 2008).

Chae et al. (2017) found that students show greater interest in treatment methods and better treatment of PMS when PMS symptoms are severe. Pharmacological interventions, such as antidepressants or hormonal medications, are sometimes prescribed to relieve severe PMS symptoms. In addition, psychotherapeutic approaches such as cognitive-behavioral therapy can help women develop efficient coping skills.

### Rationale of the Study

The biomedical model gets the upper hand over the entire healthcare fraternities and focuses predominantly on systematic diagnosis and particular prescription for treatment. But this outlook stands vacillating while dealing with culturally designed syndromes such as PMS. There are ample evidences suggesting the role of psycho-social factors in not only identifying such syndromes but also developing them (Ussher & Perz, 2006). Some even focussed on stress induced menstrual irregularities and menstrual dysphoria. Understanding and dealing with such issues demand a better and a holistic approach which must include both medical as well as psycho-social approach. The present study tries to accentuate the psycho-social correlates and their determining role in regulating the psychological distress and coping with them. The present study was undertaken with the purpose of understanding the role of one's psychological immunity in ascertaining the extent of psychological distress experienced by women dealing with PMS and the coping mechanisms implemented by them.

### Objectives

The present study was done with following objectives –

- ◆ To find out the role of Psychological Immunity in explaining the psychological distress experienced by women dealing with PMS.

- ◆ To explore the role played by Psychological Immunity in determining the Coping strategy applied by women in dealing with PMS.

### METHOD

#### Sample

The sample consisted of 120 women who were dealing with moderate to severe PMS. The majority of the sample were found to be moderately affected by PMS. The age range was 19 – 43 years with a mean age of 33 years. None of the participants were on any hormonal medication. Almost 90% of them had regular menstrual cycles. None of them were experiencing any major psychological illness or were prescribed any medicine for the same and were not pregnant or even lactating presently.

#### Tools Used

In order to assess the variables following tools were used -

**1. Premenstrual Symptoms Screening Tool (PSST):** The Premenstrual Symptom Screening Tool

is a questionnaire developed by Dr. Susan G. Steiner and her colleagues in 2003. This tool is designed to help assess and screen for premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD). The PSST consists of a series of questions that ask individuals to rate the severity of various symptoms commonly associated with PMS and PMDD, such as mood swings, irritability, anxiety, depression, breast tenderness, and bloating, among others. Respondents typically rate the severity of these symptoms on a scale from 0 (not at all) to 3 (severe). The total score is then calculated by summing the ratings for all the symptoms. The PSST has demonstrated good internal consistency, with Cronbach's alpha values ranging from 0.80 to 0.95 in various studies. The PSST has shown acceptable test-retest reliability, with correlations typically above 0.70 between two sets of scores (Steiner et al., 2003).

**2. Beck Anxiety Inventory (BAI):** Beck Anxiety Inventory was developed by Beck et al. (1988). The BAI consists of 21 multiple-choice questions or items that inquire about various common symptoms of anxiety, such as nervousness, fear, and restlessness. Respondents are asked to rate the intensity of each symptom over the past week on a scale of 0 (not at all) to 3 (severely - I could barely stand it). The total score is obtained by summing the scores for all the items, with possible scores ranging from 0 to 63. Higher scores on the BAI indicate greater anxiety severity. The BAI has high internal consistency (alpha = .92) and test-retest reliability of 0.75 over a week.

**3. Beck Depression Inventory:** Beck Depression Inventory was developed by Beck et al. (1961). The BDI consists of 21 multiple-choice questions that assess different aspects of depression, such as mood, behavior, and physical symptoms. Respondents are asked to rate each statement based on their experiences over the past two weeks. Each question is scored on a scale from 0 to 3, with higher scores indicating more severe depressive symptoms. The total score can range from 0 to 63, with higher scores indicating greater depression severity. The Spearman-Brown formula resulted in higher reliability of 0.91.

**4. Psychological Immune System Inventory (PISI):** The Psychological Immune System Inventory was developed by Olah (2005). The scale consists of 16 dimensions which are categorized into three sub-

systems namely Monitoring-Creating-Executing, Self-regulation and Approach beliefs. The scale consists of total 80 items including both positive as well as negative items. The response can be obtained on likert scale ranging from 1 (completely does not describe me) to 4 (completely describes me). The Cronbach alpha of the scale was between 0.73 to 0.89.

**5. COPE Inventory:**The Brief COPE is a 28-item self-report questionnaire developed by Carver (1977) which assesses a range of coping strategies. It includes items that represent various ways people choose to deal with stressful events. These items are classified in three sub scales – Problem Focussed Coping, Emotion Focussed Coping and Avoidant Coping. The items in the Brief COPE are rated on a Likert scale, and respondents indicate how frequently they use each coping strategy in response to stress or challenging situations. Respondents rate the frequency with which they use each strategy on a Likert scale, typically ranging from 1 (I haven’t been doing this at all) to 4 (I’ve been doing this a lot). The scale includes both adaptive and maladaptive coping strategies, allowing researchers and clinicians to gain a comprehensive view of an individual’s coping repertoire.

**Procedure**

The participants were visited in their natural settings. A brief introduction of the research was provided to them and further after getting informed consent, the participants were given the instructions to fill the questionnaires. The data was collected from them on various tools.

**Results**

The data collected were subjected to various descriptive as well as inferential analyses through SPSS Statistics 20 software. The correlational analysis revealed that Psychological distress experienced by

women dealing with PMS was negatively correlated with various dimensions of Psychological Immunity. These findings are clearly displayed in Table 1. It is evident from the table that Self-Regulation (a sub-system of Psychological Immunity) was found to be significantly and negatively correlated with Anxiety ( $r = -.516, p < 0.01$ ) and Depression ( $r = -.330, p < 0.01$ ). This means that women with lower Self-Regulation tendencies exhibit higher level of anxiety as well as depression thereby decreased mental health.

Moreover, various dimensions of Psychological Immunity were also found to be correlated with decreased mental health. The Sense of Self Growth was also found to be significantly and negatively correlated with Anxiety ( $r = -.189, p < 0.05$ ) as well as Depression ( $r = -.275, p < 0.01$ ) which means increasing sense of self-growth would decrease the extent of psychological distress experienced by such women. Another dimension of Psychological Immunity - Synchronicity was also found to be negatively correlated with both Anxiety ( $r = -.490, p < 0.01$ ) and Depression ( $r = -.375, p < 0.01$ ) which clarifies the role of Synchronicity in decreasing the perceived psychological distress.

Moreover, Goal Orientation was also found to be significantly correlated with Psychological distress – Anxiety ( $r = -.281, p < 0.05$ ) and Depression ( $r = -.344, p < 0.01$ ). This tells us women who are highly oriented towards their goal or situations experience lesser mental distress. Besides, Emotional Control was also found to be significantly related to Anxiety ( $r = -.534, p < 0.01$ ) as well as Depression ( $r = -.286, p < 0.01$ ). This finding unveils the role of Emotional control in reducing Distress experienced i.e. women with better emotion control would experience lesser anxiety and depression associated with PMS.

**Table 1**  
**Coefficient of Correlation in Psychological Distress and Psychological Immunity**

	Sense of Self Growth	Synchronicity	Emotional Control	Goal Orientation	Self-Regulation	Total Psy-Imm
<b>Anxiety</b>	-.189*	-.490**	-.534**	-.281*	-.516**	-.184*
<b>Depression</b>	-.275**	-.375**	-.286*	-.344**	-.330**	-.338**

Note - \*p < 0.05, \*\*p < 0.01

It can also be seen from Table 1 that Total Psychological Immunity was even found to be significantly negatively correlated with Anxiety ( $r = -.184, p < 0.05$ ) and Depression ( $r = -.338, p < 0.01$ ). This explains that women with higher Psychological Immunity would experience lesser Psychological Distress.

Further correlational analysis between Psychological Immunity and Coping revealed that Psychological Immunity plays a major role in defining

the kind of coping strategy opted by the PMS dealing women. As displayed in Table 2, Monitoring–Creating–Executing sub-system of psychological immunity was found to be positively and significantly correlated with Problem-focussed ( $r = .238, p < 0.05$ ) as well as Emotion focussed coping ( $r = .345, p < 0.01$ ). This proclaims the defining role of Monitoring as well as Social creating and Executing capabilities of an individual in determining the kind of coping strategy one would implement while dealing with their distress.

**Table 2**  
**Coefficient of Correlation in Psychological Immunity and Coping strategies**

	Problem Focussed Coping	Emotion Focussed Coping	Avoidant Coping
Sense of Control		.289*	
Challenge Orientation		.315*	
Social Monitoring Capacity		.376**	
Problem Solving Capacity		.322**	
SocialCreating Capacity		.310**	
Synchronicity			-.268*
Irritability Control			.265*
Monitoring-Creating-Executing	.238*	.345**	

Note \* $p < 0.05$ , \*\*  $p < 0.01$

Besides, various dimensions of Psychological Immunity were also found to be significantly correlated with the Coping strategies used. Sense of Control was found to be significantly correlated with Emotion focussed coping ( $r = .289, p < 0.05$ ) which clearly states that women with better sense of control would easily be able to manage their emotional symptoms. Moreover, Challenge Orientation was also found to be highly correlated with Emotion Focussed Coping ( $r = .315, p < 0.01$ ) which explains the role of women's orientation towards challenging situation leading to their choice of Emotional Coping. Further, the high significant correlation between Emotional Coping and Social Monitoring Capacity ( $r = .376, p < 0.01$ ) tells us about the defining role of one's capacity to monitor their social environment in implementing Emotional Coping strategies to deal with the stressful events. The Emotion Focussed Coping was also found significantly correlated with Problem Solving Capacity ( $r = .322,$

$p < 0.01$ ) and Social Creating Capacity ( $r = .310, p < 0.01$ ) of people which proclaims the role of better Problem-Solving capacity and their social creating capacity in defining their selection of emotion focussed coping strategies.

Further, Avoidant Coping was found to be negatively and significantly correlated with Synchronicity ( $r = -.268, p < .005$ ) which explains that women who lack synchronicity in their current life scenarios would have higher tendencies to implement avoidant coping strategies. Contrarily avoidant coping was found to be significantly correlated with Irritability control ( $r = .265, p < 0.05$ ). This explains that women who are focussed more onto dealing with the irritabilities associated with PMS and more likely to adopt avoidant coping i.e they try to avoid stressful situations, events, or challenging ideas and emotions. Avoidance reduces stress temporarily, but employing it excessively might make things worse. Thus, Psychological Immunity proves to

possess a defining and valid role in women's ability to cope with their distressing symptoms.

In order to assess the extent of contributing role the Psychological Immunity plays in determining their

Psychological Distress and Coping Strategies implemented by women dealing with PMS, multiple regression analyses were done.

**Table 3**  
**Psychological Immunity as predictor of psychological distress and Coping strategies**

Predictors	Criterion – Anxiety					
	R	R square	R sq Change	Beta	T	F
Self-Regulation	.538	.289	.289	-.538	-6.568**	43.136**
				Criterion – Depression		
Self-Regulation	.391	0.153	0.153	-.338	-.3677**	19.182**
				Criterion – Emotion Focussed Coping		
Social Monitoring	.296	.088	.088	.296	3.195**	10.206**
				Criterion – Avoidant Coping		
Synchronicity	.321	.103	.103	-.321	14.26**	12.156**

Note - \*p < 0.05, \*\* p < 0.01

The findings of multiple regression can be clearly seen from Table 3 which shows the predictive role of Self-Regulation (a sub system of Psychological Immunity) as well as various other dimensions of Psychological Immunity in determining the psychological distress experienced as well as the coping strategy implemented by women dealing with PMS.

Self-Regulation emerged as a significant predictor of Psychological Distress negatively explaining 28.9% of variance and 15.3% of variance in Anxiety and Depression respectively. This reveals that women with better Self-Regulation system (better Emotional Control, Synchronicity, Impulse Control and Irritability Control) would have better mental health and lesser psychological distress.

Further, Social Monitoring Capacity emerged as a significant predictor of Emotion Focussed Coping explaining 8.8% of total variance which reveals that people with better Social Monitoring Capacity i.e. one's who are open for contact with people, with developed empathic ability and public self-consciousness, highly motivated to explore & understand social behavior) are generally found implementing Emotion Focused Coping Strategy.

Moreover, Synchronicity emerged as a significant predictor of Avoidant Coping with negatively explaining 10.3% of total variance. That is to say, the ones who have better sync with their present environment are less likely to adopt Avoidant Coping Strategy.

## Discussion

The obtained results clearly articulate the mental health deterioration associated with increased severity of PMS symptoms. On the other hand, it was even found that an individual's ability to maintain psychological well-being and resilience in the face of stressors or adverse circumstances plays a vital role in abating such severe symptoms and even help them deal with it effectively. How women perceive and appraise the symptoms of PMS can impact their psychological immunity and in turn impacts the severity of such symptoms. Women who interpret PMS symptoms as a normal part of their menstrual cycle and have adaptive coping strategies in place may be less susceptible to psychological distress. According to the findings, psychological immunity has a negative relationship with both anxiety and depression; that is, the more psychologically immune a person is, the less likely they are to find a situation distressing. In addition, less psychological anguish would be experienced by people who demonstrate enhanced emotional regulation, effective growth, and personal advancement. It was also discovered that women who possessed greater competencies of goal orientation and self-regulation also felt less distressed. Reduced emotional distress is also anticipated by higher synchronization.

In addition to influencing how much psychological discomfort a person perceives, psychological immunity



also has a significant influence in the coping mechanism that women choose to use in these kinds of stressful circumstances. It has been found that the application of adaptive and more emotionally focused coping techniques in managing the distressing events associated with PMS is correlated with improved psychological immune competencies. It is evident that women who possess higher levels of sense of control, challenge orientation, social monitoring skills, problem solving abilities, and social creation abilities are better equipped to handle difficult emotions. Additionally, the better they monitor, create, and execute their social inclinations, the more problem-focused coping strategies the women would employ. The study revealed a negative correlation between synchronization and avoidant coping mechanisms. This implies that women experiencing a lack of sync in current situations are more inclined to resort to avoidant coping techniques.

On the other hand, it was discovered that avoidant coping and irritability management were highly connected. This explains why women who prioritize managing the irritabilities linked to PMS are more prone to use avoidant coping strategies, which involve avoiding difficult circumstances, occasions, or difficult concepts and feelings. Though overuse of avoidant coping strategy may exacerbate the situation, it does momentarily lessen the psychological tension.

Women's coping mechanisms for PMS-related suffering might vary depending on their psychological immunity. Resilience may be increased or decreased by elements including emotional intelligence, self-worth, and past stressful events. PMS symptoms can be lessened and general wellbeing can be enhanced by changing to a healthy lifestyle that includes exercise, food, and stress management practices. These modifications could have a beneficial effect on psychological discomfort.

### Implications

The present study has wide range of implications. It enabled us to understand the positioning of PMS, a reproductive health concern as a culturally designed syndrome. And therefore emphasizes on managing

menstrual abnormalities seeking treatments beyond pharmacological considerations. Various studies have revealed that psychological interventions are as effective as various medical treatments like SSRIs women were engaged into in ameliorating the symptoms reported by them. It not only reduces the distress associated with the syndrome but also helped women in repositioning the concept (Ussher, 2006).

The research indicates that enhancing Psychological Immunity among the women dealing with PMS can considerably reduce the psychological distress perceived by them. This in turn would lead to lesser stress induced menstrual abnormalities in such women. Besides, it would improve their mental health conditions. As found by Edozien, 2006, psychological distress impairs the ovarian cycle thereby causing menstrual cycle abnormalities therefore better psychological immunity ensures lesser distress hence regulated menstrual cycle. Moreover, better Psychological Immunity enhances the use of adaptive coping strategies which would help in efficient dealing with dysphoria associated with PMS.

### Conclusion

Premenstrual Syndrome is a complex condition that often entails significant psychological distress in affected women. This research paper has explored the prevalence and severity of psychological symptoms associated with PMS, as well as the coping strategies women employ to manage these symptoms. Additionally, the concept of psychological immunity has been introduced as a potential factor influencing psychological distress in women dealing with PMS.

Understanding the interplay between psychological distress, coping strategies, and psychological immunity in the context of PMS is crucial for the development of targeted interventions and support systems. Further research is needed to explore these factors in greater depth and to inform the development of evidence-based approaches for managing the psychological aspects of PMS. By addressing psychological distress effectively, healthcare providers and researchers can improve the quality of life for women affected by PMS and promote overall psychological well-being.

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