Coping in Women With Polycystic Ovary Syndrome: Implications for Practitioners

Rebecca Carron, PhD, FNP, Sarah Kooienga, PhD, FNP,
Diane K. Boyle, PhD, FAAN, and Ruben Alvero, MD

ABSTRACT

Polycystic ovary syndrome (PCOS) occurs in 6%-15% of women. Some international studies have demonstrated that women with PCOS use maladaptive coping to manage stress. In this study we examined coping strategies used to manage stressful situations in 72 women with PCOS in the United States. Most women used adaptive coping, including social support, problem-solving, and positive reappraisal. A subset of women with increased psychological severity scores used maladaptive coping, including increased escape-avoidance coping and less problem-solving and positive reappraisal coping. Nurse practitioners have a valuable role in assessing coping skills in women with PCOS and intervening with adaptive coping interventions.

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Nurse practitioners (NPs) may encounter women with polycystic ovary syndrome (PCOS), a common androgen-excess disorder, in various clinical settings. Women with PCOS often view the condition as a threat to their femininity.[1] These women simultaneously must manage an array of stressful symptoms, including hirsutism, acne, obesity, androgenic alopecia, menstrual dysfunction, potential infertility, as well as increased risk for type 2 diabetes mellitus and cardiovascular disease.[2] In one study, women with PCOS submitted pictures of their routines (tweezing, waxing, medications, cleansers, and weight scales) to manage facial hair, acne, and weight.[1] These same women experienced frustration with providers regarding diagnosis, treatment, and knowledge about PCOS.[1]

Systematic reviews and meta-analyses have demonstrated that women with PCOS, compared to control women without PCOS, have an increased risk for depression (odds ratio = 4.03)[3] and anxiety (odds ratio = 6.88).[4] Another study found that women with PCOS scored worse on psychological health-related quality of life (HRQL) compared to people with chronic conditions, such as diabetes, asthma, back pain, epilepsy, or coronary heart disease.[5] Managing body weight is an area of concern for women with PCOS.[6] Studies have not determined whether the increased risk for psychological disorders is from the disease itself or its symptoms.[7]

Few studies have examined coping strategies that women with PCOS use to manage stressful situations, which, in this study, is defined as a situation that is difficult either because of the person's reaction to the event or the amount of effort needed to manage the situation.[8] Studies of coping in women with PCOS in Turkey and Germany indicated women used maladaptive coping strategies that were associated with depression, anxiety, and diminished HRQL, including brooding, withdrawal, self-pity, or helplessness.[9,10] To our knowledge, no published studies have examined coping in women with PCOS living in the United States. We questioned whether coping strategies in US women with PCOS would be similar to those in other cultures, and if the severity of psychological scores or body mass index (BMI) affect coping in women with PCOS. The following research questions guided our study:

1. What coping strategies are used in stressful situations by women with PCOS?
2. Among women with PCOS, do coping strategies differ by (a) severity of psychological scores or (b) BMI?

OVERVIEW OF PCOS

PCOS occurs in approximately 6%-15% of women.[7] The cause is unknown, but the role of insulin receptor errors is one possibility.[2] Many women with PCOS are hyperinsulinemic, and insulin, combined with luteinizing hormone, further increases testosterone production by the ovary.[2] The Rotterdam criteria are often used to diagnose PCOS.[11] For a diagnosis, women must have 2 of the 3 following criteria: (1) oligo-ovulation and/or anovulation, often expressed as menstrual irregularities; (2) clinical signs of elevated testosterone/androgens (hirsutism, acne, androgenic alopecia) and/or biochemical signs of elevated androgens (total or free testosterone and/or dehydroepiandrosterone sulfate); and (3) polycystic ovaries (12 follicles < 10 mm or ovarian volume > 10 mL) on ultrasound. Related conditions were excluded, such as thyroid disease, androgen tumors, or Cushing syndrome. Obesity is not a criterion for PCOS, and the weight of women can vary from underweight to obese.[2]

Treatment seeks to improve symptoms and prevent long-term consequences such as type 2 diabetes mellitus or cardiovascular disease.[2,7] Weight reduction reduces androgen levels and improves symptoms.[2] Hormonal contraceptives regulate menstrual cycles, prevent endometrial hyperplasia, and lower androgen levels.[2] Ovulation induction agents such as clomiphene citrate can help with infertility.[2] Metformin can improve glucose control.[7]

COPING FRAMEWORK

Our study was based on the Transactional Model of Stress and Coping.[12] In this model, psychological stress is defined as an interaction between the individual and the internal or external circumstances that is viewed or appraised by the individual as beyond his or her ability to manage. Coping is defined as cognitive or behavioral attempts to manage psychological stress. Coping is termed a process because coping strategies can change over the course of an encounter. Depression and anxiety can be reactions to psychological stress.[12]

The coping subscales are often defined in the literature as problem-focused or emotion-focused coping.[10] Problem-focused coping helps people cope with the problem and find a solution, such as developing a plan of action.[10,12,13] Problem-focused subscales are confrontive coping, seeking social support, accepting responsibility, and planful problem-solving.[13] Emotion-focused coping tries to manage the emotions associated with a situation.[10,12,13] Emotion-focused subscales are distancing, escape-avoidance, self-controlling, and positive reappraisal.[13] People can use more than 1 coping strategy in a situation. Simultaneous use of problem-focused and emotion-focused coping can work together and promote adaptive outcomes, or they can work against each other causing maladaptive coping.[12] In general, research indicates that the maladaptive coping subscales are distancing, accepting responsibility (self-blame), escape-avoidance, and self-control.[10,13,14] Adaptive coping subscales are positive reappraisal, seeking social support, confrontive coping, and planful problem-solving.[10,13,15]

METHODS

Design and Ethics

We used a cross-sectional, descriptive-comparative design to examine coping in women with PCOS. Institutional review board approval was obtained. Participants provided informed consent and received a $20 gift card upon completion of surveys. We contacted participants with severe psychological scores (defined in the Data Analysis subsection) and provided referral to mental health facilities.

Participants and Sample Size

Women with PCOS were recruited from a western metropolitan area in the US. Inclusion criteria were: age 18-40; a diagnosis with PCOS using primary clinical records; not pregnant by self-report; and able to read and write in English. PCOS was confirmed using the Rotterdam criteria.[11]

The sample size was determined from a power analysis (www.danielsoper.com/statcalc/calculator.aspx?id=1/) with 5 independent variables and 1 dependent variable. The study required a minimum sample size of 70 to detect a small-study effect (0.2) with a power of 0.8 and statistical significance set at $P \leq .05$. Our study cohort consisted of 72 participants.

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