Psychosocial factors associated with perceived psychological health, perception of menopause and sexual satisfaction in menopausal women and controls

H. O. Osinowo

Clinical Psychology Unit, Department of Psychology, Faculty of the Social Sciences, University of Ibadan.

Summary

Objectives

The study investigated factors associated with attitude towards sex-role, self-image and marital satisfaction on psychological health status, perception of menopause and sexual satisfaction in climacteric women in Ibadan, Nigeria.

Subjects and methods

45 female participants were randomly selected from Ibadan. The mean age was 51.42 ± 8.05 years (range = 36 - 70 years). The mean age for the 13 non-menopausal women was 42.79 ± 3. 91years (range = 42 - 47 years) while the mean age for the 32 menopausal women was 5.16 ± 6.08 years (range = 47 - 70 years). The mean age of the children of the participants was 16.05 ± 8.09 years (range = 1- 36 years). A questionnaire having several subsections (consisting of the psychological health status of women in the climacteric, attitude towards sex role, perception of menopause, social support, marital satisfaction, self-image and sexuality scales was used for the assessment.

Results

Post-Menopausal women reported better psychological health compared to the pre-menopausal women (t = 1.86, p <.05) but no significant differences in their attitude to sex role. Post menopausal women had more positive attitude to sex (t = 3.15, p <.01) and were more knowledgeable about menopause (t = 2.15, p <.03). Women with conservative/reactionary preference for traditional sex roles reported negative perception of menopause compared to those with liberal attitude toward sex role (t = 1.82, p <0.05).

Menopausal Status, Educational level and social support predicted positive attitude to sex, (F = 3.62, P <.01). Age, self-image and attitude to sex domain of the marital satisfaction scale predicted better psychological health, and marital cordiality predicted better psychological health as measured by GHQ (R^2 = 25, beta = -43, t = -2.38, P <.02). Marital satisfaction significantly predicted better sexuality, (F = 5.47, R square = 0.11, p <0.05). Sources of information on menopause included health institutions, books, doctors, and books/health workers.

Conclusion

The study highlights the need for sensitizing menopausal Nigerian women on how to improve their self-image, marital satisfaction, and sexual satisfaction. Conventional treatment options emphasizing hormone replacement therapy, need for nutritional supplement, dietary changes, marital and sex therapy are emphasized.

Keywords: ***Menopause, Sex role, Self image, Marital satisfaction, Nigerian Women, Health Status.***

Résumé

Objectifs

Cet étude a examiné des facteurs associés avec le comportement envers rôle sexuel image que l'on a de soi-même et la satisfaction conjugale sur la situation de la santé psychologique, la perception sur la menopause et satisfaction sexuelle chez des femmes climateres à Ibadan au Nigeria.

Sujets et méthodes

45 partcipantes ont été selectionnées au hazard à Ibadan. L'âge moyen etait 51, 42 + 8,05 ans (de 36 a 70 ans). L' âge moyen pour 13 femmes non menopausales était 42, 79 + -3,91 (de 42 a 47 ans) tandis que l'âge moyen pour 32 femmes menopausales était 55, 16 + -6,08 ans (de 47 a 70 ans). L'âge moyen des enfants de participantes était 16, 05 + -8,09 ans (de l à 36 ans). Un questionnaire, ayant des subdivisions diverses (consiste en situation de la santé psychologique des femmes dans le climatère, comportment envers rôle sexuel, la perception de la menopause, soutient social, satisfaction conjugale, image de soi, et pèse sexualité), a été utilisé pour l'évaluation.

Résultats

Le rapport qu' on a fait sur des femmes postmenopausales était mieux en ce qui concerne la santé psychologique par rapport aux femmes pré-menopausales (t = -1.86, p <.05) mais il n'y avait pas de la différence importante à l'égard de leur comportement en matière du rôle suxuel. De femmes post-menopausales avaient plus de comportement positif en matière du sexe (t = 3, 15, p <01), et elles étaient bien informées sur la menopause (t = 2,15, p <03). Des femmes avec la préference conservatoire ou réactionnaire pour le rôle sexuel traditionnel ont donné des résultats en matière des perception négatives de la ménopause plus que ceux avec un comportement libéral envers rôle sexuel (t = 1,82, p <05). État ménopausal, niveau d' enseignement et soutien social sont des éléments qui avaient prédit le comportement positif en matière du sexe F = 3,62, p <01. L'âge, image de soi et comportement à l'égard du domaine suxuel du scale de la satisfaction conjugale ont prédit une amelioration de la sante psycologique, et la cordialité conjugale a prédit une amélioration de la santé psychologique comme mesuré par (GHO, R2 = 25, beta = -43, t = -2.38, p < .02) satisfaction conjugale a sensiblement prédit une amélioration de la sexualité, F = 5, 47, R carre, = 0, 11, p <0,05). Des sources de l'information sur la menopause compris des institutions sanitaires, livres, médicines, livres, inspecteur de la santé.

Conclusion

L' étude souligne la nécessite de la sensibilisation de la femme ménopausale nigériane par rapport à l' amélioration de leurs image de soi, satisfaction conjugale, et satisfaction sexuelle. On a bien insisté sur des options du traitement conventionnel qui attirent l'attention sur l' hormonetherapie, le besoin du supplement nutritionnel, changement alimentaire, la thérapie conjugale et sexuelle.

Introduction

Menopause is a normal development process for women, however, only few studies of healthy menopausal women and African - American women have been reported.[1] There exists a paucity of information on the menopausal period and its effects in African women.[2] Some multi-ethnic studies have shown that there is no universal menopausal syndrome that can be applied across socio-cultural divides.[2-7] The problems of the menopausal period of life have reached the status of a major public health concern because of the size of the ageing population.

For the last ten years prior to the cessation of menses, a woman receives signal that her reproductive organs are changing. The ovary begins to show signs of impending failure. Thus menopause in itself marks the end of menstruation, but as with menarche in relation to puberty, it only reflects one aspect of a series of changes.[8] Accordingly, Dorres and Siegal[8] medically divided menopause into three time periods. These are pre-menopausal, peri-menopausal and postmenopausal periods. The peri-menopausal period (or

Correspondence

climacteric) is the period immediately prior to the menopause at which time the endocrinological, biological and clinical features of approaching menopause commence. A more appropriate term for this whole period of change, from the gradual transition and from the normal ovarian activity of reproductive years, to the relatively inactive ovary of the menopausal years is the "climacteric," while the ceasing of menstrual period is appropriately referred to as the "menopause." However, the term menopause is commonly used for both events.

The menopause occurs at a point in women's lives when other life events are taking place simultaneously. The woman is faced with the task of adjusting to the physiological symptoms of the personality changes, job security anxiety (career changes), maintaining an economic standard of living, managing a home adjusting to children growing or leaving home (empty nest syndrome), etc. The symptoms associated with the climacteric syndrome are caused by an interaction between endocrine, socio-cultural and psychological factors, and perhaps concurrent ageing phenomena as well.[9]

Three sets of factors have been identified as determinants of the health status of the women in the climacteric period. These are the biologic, psychological and social factors. Marital satisfaction, attitude toward sex role and self-image are good indicators of these factors. Marital satisfaction refers to an individual's evaluation of the extent to which his or her individual needs are fulfilled through husband-wife interactions or the extent to which each marital partner feels or receives from the other partner, the feelings, attitudes, services, and goods needed. Attitudes towards sex roles refer to learned predisposition to respond consistently in a positive or negative way towards sex role comprising the attitudes, beliefs and behaviour patterns that people generally associate with femininity or masculinity. These attitudes are unique and are, to a large extent, socially acquired. These attitudes in turn affect other aspects of the individual's life. Multiple meanings have been assigned to menopause and women experiencing it and this in general affects the woman's perception of menopause and consequently her health status.[10] Educational level and understanding of why menopause occurs is an additional factor that affect a woman's perception of menopause. Social elements (norms, values) and the social support network similarly determine one's health status.

It had been estimated that by the year 2000, 1 in every 14 women will be over the age of 65 years or older. Menopaue is a natural part of life, not a disease or health crisis state, yet 80% of women experience some symptoms. For some, this transition period is relatively smooth with minimal disruption to or from their life style but not so for others. A vast majority of Nigerian women have very scanty knowledge about the menopausal period.[2] Despite the fact that the most common sources of advice or treatment are medical doctors, there is a great deal of apathy amongst health workers in helping the women's quest for information about what to expect in the menopausal period.[2] The primary concern of these women seems to be their self-image and dwindling sexual functions[11] rather than the health implications such as the development of osteoporosis, increased prevalence of lipid metabolism disorders, atherosclerosis, carbohydrate metabolism disorders, hypertension and coronary heart disease.[12, 13] These attitudes influence their not seeking medical help. Contrary to widely held beliefs, menopause has been reported not to be associated with an increase in psychiatric illness though there is a slight increase in minor psychological symptoms, just prior to menopause and the prevalence rates of depression fall post-menopause.[14]

Genazzani[1], Spinetti, Gallo, et al.[15] suggested that psychological disturbances such as depression, anxiety, irritability, and mood fluctuations are related to estrogen - induced change in the limbic system during the climacteric period. Estrogen therapy exerts a positive effect on vasomotor instability and improves psychological disturbances.[15] However, menopausal discomforts have been exaggerated, and most of the reported symptoms are not directly attributed to declining estrogen levels but to other biologic and mood variables.[16] A change in perspective might have the beneficial consequence of providing women with effective and probably safer forms of therapeutic intervention.[16] Thus, menopause heralds the loss of youth and also that of reproductive capabilities at a point in time when other life events are taking place.

Research into the experience and knowledge about climacteric and menopause in women in Mexico City[17] showed that the most frequent climacteric symptoms were: hot flushes (70.9%), depressison (60.2%), insomnia (53.5%) and menstrual disturbances (37.8%). Care-seeking behaviour was also studied and it was found that 51.1% of women sought medical care due to climacteric symptoms but only 12.1% received treatment, mainly hormones (81.6%). The result of the survey also showed that 83.8% of women had some knowledge about main symptoms of the climacteric and 90.1% knew about osteoporosis but only 37.2% had some knowledge about cardiovascular risks after menopause. Most men and women remain sexually active into mid-life and beyond.[18] However, sexual functioning in peri - and postmenopausal women and their partners, varies widely.[18] Sexuality and one's perceived quality of life may be affected by somatic symptoms, psychological issues, partner's physical, psychological, and relationhip status. The assessment, diagnosis, and subsequent management of sexual problems may become more complex because of these factors. Sexual functioning in menopausal women can be influenced also by age-related changes that are unrelated to menopause such as change in drive, body image, and general health status. Beliefs about menopause and sexuality impact sexual functioning in women. Also, changes in relationship status and the physical health of a partner may also influence sexuality.[18] Health care providers have a role to play in treating sexual problems and enhancing sexuality in ageing patients. Women should be educated about sexuality and sexual functioning, normalizing sexual activity in aging adults. In addition, medical management of symptoms or problems that are interfering with sexual desire or activity should be included in treatment. Women with the least education, stressful lives, or a previous history of poor physical and psychosocial health at age 36 also reported more symptoms at 47 years compared with other women.[19]

The present study investigates the correlates of psychological health status, attitude towards sex role, perception of menopause, sexual satisfaction and marital satisfaction in pre-menopausal and post-menopausal women.

Method

Design and participants

The *ex post facto* design was employed in this cross-sectional study. Variables of this study were: Attitude towards sex role, self-image, marital satisfaction, psychological health status, perception of menopause and sexual satisfaction.

Participants

Forty-five (45) women with a mean age of 51. 42 $\pm$ 8.05 years (range = 36 to 70 years) were purposively sampled from a population of urban women who were attending a seminar on ageing in Ibadan. Fourteen (14) (31.1%) of the women each worked in the health sector and commerce sectors respectively, 9 (20%) in the civil service, 5(11.1%) in the educational sector, 1(2.2%) in the agricultural sector and 2 (4%) were unemployed. Forty (40) (88.9%) of the women were married, 4 (8.9%) were separated from their husbands, and 1 (2.2%) was divorced. Their educational status showed that 2(4.4%) had primary education, 10(22-2%) attained secondary school level , 10 (22.2%) had diplomas, and 23 (51.2%)

had postgraduate degrees.

Instrument

The scale of measurements used for all the independent and dependent variables were self-report measures. The bias attitudes survey: a sex role questionnaire designed by Jean & Reynols (1980)[21] made up of 35 items with a Likert scoring format yielded a reliability estimate of 91 ranging from "Strongly agree", "Agree", and "Disagree" to "Strongly disagree." The reliability coefficient obtained for this scale using Nigerian women was 0.87. The scale was designed to explore and assess attitudes towards male and female roles. The present author revised the response format by adding "undecided" option for the purpose of this research.

The Marital Satisfaction Scale (MSS-W) was developed by Osinowo and Oyefeso[21] and consists of 15 items, with subscales. The MSS assesses interspousal conflicts, attitudes to sex which emphasizes the importance of sex in marriage, and emotional attachment which reveals the scaling importance of role expectation in marriage. The authors reported a coefficient alpha of 0.94. The (MSS-W) was pilot tested using a 5-point interval scale with the following response choices:- strongly agree, agree, undecided, disagree and strongly disagree. Item total analysis yielded a reliability coefficient of 0.89 using a 5 point response format.

The Perception of Menopause Scale (PMS) consists of 35 items. The scale used a 5 point interval scaling similar to the MSS-W. The reliability coefficient of the scale was 0.74. The perception of menopause scale measures knowledge and beliefs, causes, sexuality beliefs and affective aspects of menopause.

Golombok-Rust Inventory of Sexual Functioning Scale[22] (GRISS) is an instrument designed by Rust and Golombok[22] to assess sexual functioning of adults. The scale is in two (male and female) versions. It is used for research purposes and clinical assessment of sexual functioning of adults. The response format include Never = 1, Hardly and ever = 2, Occassionally = 3, Usually = 4, and Always = 5, High scores indicate adequate sexual functioning and high sexual satisfaction of respondents. A reliability coefficient of 0.05 ($p < .001$, $N = 52$) was established for women before it was used for the present study.

Social Support was also assessed by asking the women about those who have offered information and were instrumental for this support regarding menopause and the degree of support.

The Self-Image Scale (SIS) consists of 19 items. The reliability coefficient of the scale was 0.87. Response format ranged from "Strongly agree", "Agree", "Undecided", "Disagree" to "Strongly disagree." The scale assesses perception of body image and how the woman perceives herself generally.

The Psychological Health Status Scale (PHSS) consists of 54 items. These include 42 items measuring psychological well-being and the 12-item version of the General Health Questionnaire (GHQ) with response format of "Less than usual", "No more than usual", "Rather more than usual" and "Much more than usual". The scale had a reliability coefficient of 0.95. The items assess a variety of health-related and menopausal symptoms such as hot flushes, night sweats, mood changes, vasomotor symptoms, vaginal dryness, decreased sex drive, depression, anxiety, loss of memory, tiredness, insomnia and irritability.

The 12-item version of the General Health Questionnaire (GHQ) by Goldberg and Williams[23] was included as a measure of psychological health. Respondent's composite score included the GHQ and the psychological well-being Inventory scores.

Procedure and Statistical Analysis

The participants were approached at a seminar on ageing and the purpose of the survey was explained to them and they were invited to participate. The questionnaires were distributed to the women and they were provided with instructions on how to fill them. They filled the questionnaires and then return them. Forty-five (45) of the questionnaires that had complete information were used for data analyses for this study. The data were processed on a personal computer and analysed using the SPSS programme. Descriptive statistics such as simple percentages, chi-square analyses, t independent tests and regression analyses were computed.

Results

Demographic Characteristics

Thirty-two of the women (71.1%) were menopausal while 13 (28.9%) were non-menopausal. The mean age for the 12 non-menopausal women was 42.79 ±3.91 years (range = 36 - 47 years) while the mean age for the 32 menopausal women was 55.16 ± 6.08 years (range = 47 - 70 years). The mean age of the children of the subjects was 16.05 ± 8.09 years (range = 1 - 36 years).

The women's sources of information about menopause and helpfulness of those providing it are shown in Fig. 1. The women were also asked if they would have preferred not to have stopped menstruating. Six of the menopausal women reported that they would prefer not to have stopped menstruating while the majority (86.7%) were pleased that they had stopped menstruating.

Psychological health status, perception of menopause and predictors

The results showed that pre-menopausal and post-menopausal women reported significantly better psychological health status, {t = -1. 86, df= 43, p <.05 (one tailed)}, positive attitude to sex, and better knowledge of causes of menopause (t = 2.16, df = 43, P <.04, t = 3.16, df = 43, p <.01). Women who had conservative attitudes towards sex role reported poorer perception of menopause than those women with liberal attitude towards sex role (t = 1.82, p <0.05). (Table 1).

The result displayed in Table 2 shows the influence of education on psychological health, perception of menopause, marital satisfaction and sexual functioning for post and pre-menopausal women. Post-menopausal women with higher educational level reported better marital satisfaction, (t = 2.70, df = 30, p <.01) but there was no significant difference obsserved between those with high and low education for marital satisfaction

Table 1 Mean scores of pre and post-menopausal women on knowledge, attitude and psychological health status.

	Post menopausal (n = 32)		Pre-menopausal (n= 13)				
	Mean	SD	Mean	SD	df	t	p
Knowledge of causes of menopause	22.63	6.35	19.46	3.41	43	2.15	.03
Attitude to sex subscale of marital satisfaction scale	14.06	2.03	11.77	2.28	43	3.15	<.01
Psychological health status	85.10	16.15	96.62	19.78	43	-1,86	.05
Attitude towards sex role	89.59	16.30	88.95	16.70		14	>.05

Table 2 Influence of education on psychological health, perception of menopause, marital satisfaction and sexual satisfaction

	Post-menopause							Pre-menopause						
	Low Education		High Education (n=16)					Low Education			High Education (n=7)			
	Mean	SD	Mean	SD	Df	t	R	Mean = 6	SD	N	Mean 7	df	t	p
Psychological health Status	82.94	18.74	87.25	13.33	30	-75	46	96.17	8.28	97.00	26.93	11	-10	.94
Perception of menopause	42.94	8.25	41.06	12.01	30	51	.61	45.67	4.80	42.14	12.10	11	.70	.50
Marital satisfaction	62.38	6.93	67.88	4.46	30	2.70	.01	61.17	8.86	64.14	7.17	11	.60	.53
Sexual functioning	46.88	4.51	50.06	4.49	30	2.00	.05	50.83	7.14	49.71	.31		.31	.53

Table 3 Effect of marital cordiality on psychological health status

Independent	General Health Status			Dependent	Psychological Health Status		
	Good Health Status	Poor Health Status		Low Cordiality	Good 17(68%)	Poor 8(32%)	
Low marital cordiality	8(32%)	17(68%)	$X^2 = 7.88$, $p < .01$	High Cordiality	23 51.1%	22 48.9%	$X^2 = 6.42$, $p < .01$
					Good	**Poor**	
High marital cordiality	14(70%)	6(30%)		Low Marital Satisfaction	6 (33.3%)	12 66.7%	
				High marital satisfaction	14 (68.7%)	7 (33.3%)	$X^2 = 4.31$, $p < .04$

Table 4 Influence of age and education on sexual satisfaction

	Low Sexual satisfaction	High sexual satisfaction	
Negative attitude to sex	14 63.6%	8 36.4%	
Positive attitude to sex	8 34.8%	15 65.2%	$X^2 = 3.74$, $p < .05$
Education			
Low	7 31.8%	15 68.2%	
High	15 65.2%	8 34.8%	$X^2 = 5.02$, $p < .03$
Age			
36 - 40		4 100%	
41 - 50	7 38.9%	11 61.1%	
51 - 70	15 48.9%	8 51.1%	$X^2 = 7.00$ p = .03(2 sided)

Table 5 Multiple regression analyses showing the predictors of psychological health

	Somatic and psychological health status			Psychological health as measured by the GHQ		
Socio-demographic factors	**Beta**	**t**	**p**	**Beta**	**t**	**p**
Age	.43	2.09	.05	.14	.675	ns
Education	.27	1.51	.14	.07	.40	ns
Psychosocioal						
Self image	-.43	-2.13	.05	-.06	-32	ns
Social support	.14	.81	.42	-.20	-.97	ns
Perception of menopause						
Knowledge of menopause	.02	.08	.94	-08	-.41	ns
Positive feeling towards menopause	-.06	-.31	.76	.26	1.22	ns
Perception of causes	.04	.17	.86	.07	.32	ns
Menopause sexuality belief	.00	.02	.98	-.13	-.69	ns
Marital satisfaction						
Factors 1: Cordiality & harmony	-.39	-2.44	.03	-.43	-2.38	.02
Factors 2: Attitude to sex	-.13	-.62	.54	-.24	-1.08	ns
Factors 3: Emotional attachment	.06	.32	.75	.01	.06	Ns
	R Square .28 *F = 1.16, .35*				*R Square .25* *F = 1.02, .45*	

Table 6 Predictors of attitude towards sex subscale of the marital satisfaction scale.

	Beta	t	Sig.
Age	.01	.04	.97
LMP	.02	.08	.93
Frequency	.12	.89	.38
Flow	-.40	-3.02	.01
Education	-.28	2.05	.05
Self image	.21	1.42	.16
Social support	.38	2.82	.01

R^2 .41, F = 3.62, P <.01

among pre-menopausal women. Among post-menopausal women with higher education expressed better sexual functioning (X = 50.06 (SD = 4.49), t = 2.00, df = 30, p <.01).

Table 3 shows that among those with low marital cordiality 32.0% expressed good health status, those with high marital cordiality 70% reported good health status ($x^2 = 7.88$, p <.01) 68.0% of those with low marital cordiality reported poor psychological health as measured by (GHQ) compared to 32% with high marital cordiality who reported good health status ($X^2 = 6.42$, p <.01) of those with low marital satisfaction 33.3% expressed good health status, compared to 66.7% who endorsed poor health status. 66.7% of the women with high marital satisfaction expressed good health status ($x^2 = 4.31$, p <.04).

Table 4 shows the effect of age/educational level on sexual functioning as affected by 63.6% of the women with negative attitude to sex were less sexually satisfied and only 36.4% of the women with negative attitude to

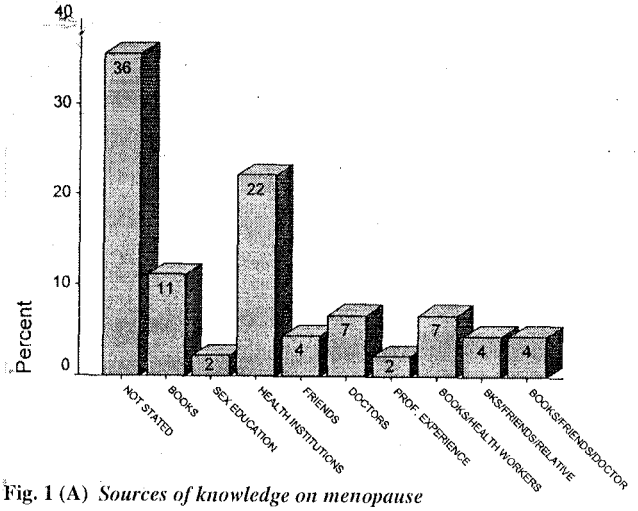

Fig. 1 (A) *Sources of knowledge on menopause*

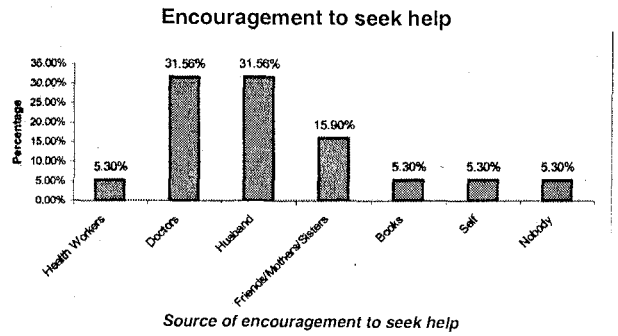

Fig. 1 (B) *Encouragement to seek help*

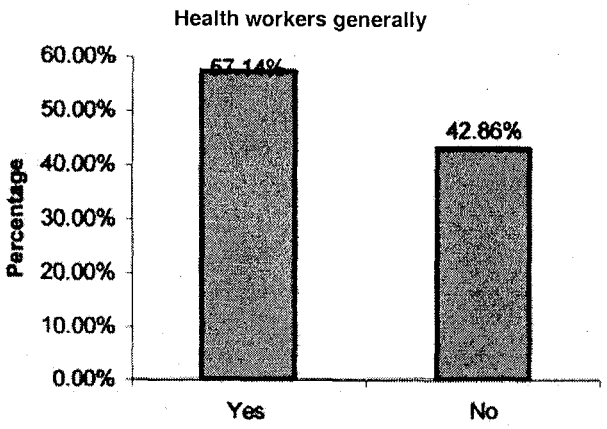

Fig. 1 (C) *Helpfulness of health professionals*

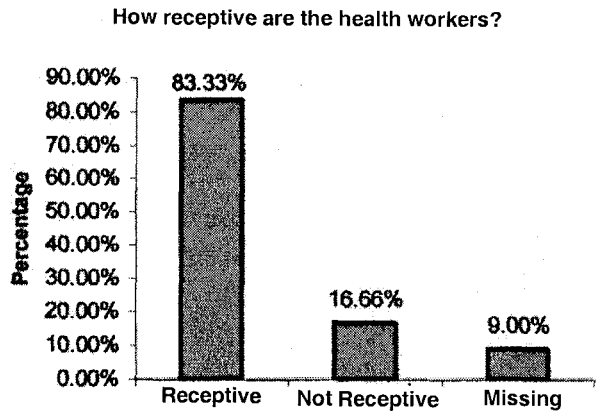

Fig. 1 (D) *Receptiveness of health professionals*

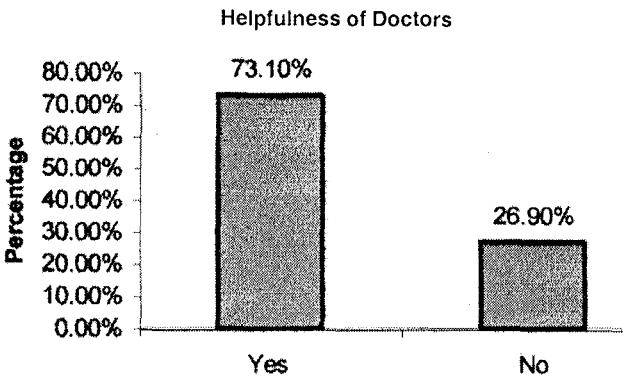

Fig. 1 (E) *Helpfulness of Doctors*

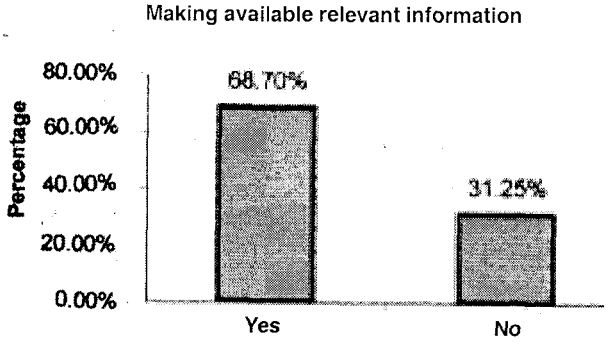

Fig. 1 (F) *Making available relevant information*

sex were highly sexually satisfied compared to 53.6% of women with positive attitude to sex who had better sexual functioning (x^2 = 3.74 p <.05).

Regarding influence of age on sexual functioning, revealed that (all the women 36 - 40 years of expressed high level of sexual satisfaction. Among the 41 - 50 year-olds, 61.1% expressed high sexual satisfaction. Among the 51 - 70 year-olds 51.1% expressed satisfactory sexual functioning.

Table 5 provides the values of the parameters of the regression analysis between the predictor variables: socio-demographic factors, psychosocial, perception of menopause and marital satisfaction. From the table, it is demonstrated that all the variables did not jointly predict general psychological well being (F = 1.16, P > .05). However, age, self-image, and marital cordiality independently predicted psychological well-being (High scores denote poor psychological well being). Self-image predicted psychological health, (Beta -.43, t = 2.13, p <.05), while age predicted psychological health (Beta = .43, t = 2.09, p <.05). Marital cordiality predicted psychological well being. (Beta = -.39, t = -2.44, p = .03). The predictor variables taken against the criterion variable yielded a coefficient of correlation square (R^2) = .28 which accounted for 28% of the observed variance in general psychological well being. Cordiality in marriage was the only predictor that predicted GHQ score, (Beta = -43, t = -2.38, p <.02).

Table 6 shows that age, LMP, frequency of menstruation, flow, education, self-image and social support jointly predicted attitude to sex (R^2 = .41, F = 3.62, p <.01). Menopausal status measured by menstrual flow independently predicted attitude to sex, (Beta = -.40, t = -3.02., p <.01), as did education (Beta = -.28 , t = 2..05, p < .05) and social support (*Beta* = .38, t = -2.82, p < .01). All these variables explained 41% to the overall variance in attitude to sex.

Age, self-image and attitude to sex domain of the marital satisfaction scale predicted better psychological health. Age, self-image, social support, marital satisfaction, education, knowledge,

positive feeling towards menopause, myths, sexual intercourse beliefs, marital satisfaction jointly predicted sexuality. Only education singly significantly predicted sexual satisfaction positively, (t = 2.47, beta 40). However, all the variables jointly did not predict, sexual satisfaction F(7, 44) = 1, 42, p>0.5).

Discussion

In order to explain the psychological, physiological and social changes during menopause and characterise women's reaction to these changes, several theoretical frameworks are useful. These are the transitional stage theory,[24] the psychological theory of Erikson, [25] self-schema theory of Barlett,[26] and the social learning theory[27] Post-menopausal women had better health status and more positive attitude to sex compared to pre-menopausal women. Women who endorsed liberal sex role attitude reported perceived menopause positively. Menopausal status, education and social support predicted attitude to sex. Age, self-image and attitude to sex predicted better psychological health and marital cordiality predicted better psychological health.

The generalization which stated that marital satisfaction will predict better health status and sexual functioning were confirmed. In line with these are the findings of Cattabiano and Holzeimer[18, 28] which concluded that psychological factors appear to be important predictors of psychological complaints and severity of physiological complaints. Marital satisfaction is an index of life satisfaction.[12] Several studies have shown that women who are satisfied with their lives are less apt to report psychological reactions than unhappy women (e.g. those with a low marital satisfaction).[12] The findings from this study showed that women with conservative values for traditional role expressed a negative perception of menopause. One explanation for this finding could be that, because of their conservative stance, they have failed to seek clarifications about the changing sexist assumption about menopause which has deserted society's perceptions of menopause being viewed as a "deficiency disease"[16] Thus, a woman's attitudes, beliefs, ideas and cognition about matters concerning appropriate masculine and feminine behaviour affects her understanding and views about menopause which is a state experienced only by the female gender, [29, 32] which indicates that the perception of menopause by women from different cultures (Western and Afro - Asiatic) differed significantly.[29 - 31] British subjects were more likely to associate menopause with loss of femaleness,[31] while Asians and Africans were more likely to associate it with physical and psychological changes.[28 - 30] Thus, a universal menopausal syndrome consisting of a variety of vasomotor and psychological symptoms does not reflect the observed situation in different cultural settings[27] The multivariate nature of human sexuality has been supported by the multiple factors affecting sexuality in this study.[32] It is important that in the treatment and understanding of menopausal women, both physiological and socio-psychologial factors be considered. Marital and sex therapy are therefore, recommended. Treatment of sexual dysfunction should include basic education about sexuality and sexual functioning and how to improve marital satisfaction. Sex therapy should include changing partner's views through rational emotive therapy. Lifestyle change may be helpful, Sedentary women are more likely to have moderate or severe hot flushes compared to women who exercise. In one trial, menopausal symptoms were reduced immediately after aerobic exercise. Women should be discouraged from becoming preoccupied with negative self-image and should seek more social support.

Implications and Conclusion

The conceptual framework for this study recognizes the importance of biological, sociological and psychosocial factors as they affect the health status and perception of menopause, sexuality of women in the climacteric. The results of this study emphasize the importance of encouraging Nigerian menopausal and climacteric women to seek solutions for their complaints so that they can cope and adjust better to these midlife changes. Thus, the implication are at the micro level (climacteric woman's and significant others) and at the macro level (medical experts, psychologists, social workers, and the society at large).

While considering intervention, an attempt should be made to assess and address the problem of poor self-image and appropriate therapeutic measures should be instituted. Knowledge of the menopause was obtained from reading materials (43%) or friends (22%). The level of recognition of menopausal symptoms especially vasomotor symptoms is lower than that of Western women and higher than that of women in Hong Kong and Southern China.[34] Psychologists working with the medical team or the medical experts should refer affected patients to the psychologists who can provide psychotherapy counselling along side the prescription of drugs to alleviate physiological and psychological distress.

Psychological counselling would enable the climacteric women with conservative sex role attitudes to understand more about the menopausal period and the accompanying problems. These reporting symptoms deserve to be given adequate explanations of the physiologic events they are experiencing in order to dispel their fears and minimize symptoms such as anxiety, etc. It should also be explained to them how their belief system (attitude, etc) can aggravate and maintain symptom experience (both physiological and psychological). There is the need to pass on realistic and factual information about menopause to all women.

This study highlights the need for the enlightenment of women and the society at large about menopause and the significance of psychosocial factors. Clinical and health psychologists need to explore climacteric Nigerian women and develop therapies specially suited for this unique group of people. During therapeutic intervention, all heatlh workers (medical, psychological, and social experts) should work together to enhance their effectiveness. Further studies would need to be carried out to compare urban and rural women and the sample size should be increased to improve generalization. Conventional treatment options emphasize hormone replacement therapy. Nutritional supplements may be helpful and clinicians should encourage all post-menopausal women to maintain a diet adequate in calcium and vitamin E and perform weight - bearing exercises for 20 minutes daily. With decreased sex drive, the clinicians should encourage water soluble lubricants, other forms of sexual behaviour or changing of coital position to allow for easier penetration. Herbal medicine, homeopathy, acupressure, dietary adjustments, life style changes - exercise, stress reduction and others are common non-hormone replacement therapy treatment options.[35 - 37] Integrative approaches that may be helpful include acupuncture which may help normalise some biochemical changes associated with menopausal disturbances of memory, mood, and other functions.[38]

References

1. Strickland O L and Dunbar S B: The perceptions of menopause of African - American and white women and effect on willingness to participate in a Hormone Replacement Therapy Clinical Journal of National Black Nurses Association 2000 January; 11(1): 43 - 50.

2. Olawoye E, Olarinde and O Aderibigbe: "Women and menopause in Nigeria" SSRHN Research Report No. 1, The Social Science and Reproductive Research Network 1998.

3. Avis N E: Sexual function and aging in men and women: Community and population-based studies J Gend specif med 2000; 3(2): 37 - 41.

4. Gold E B, Bromberger J, Crawford S, Samuels S, Greendale G A, Harlow S D and Skurnick J: Factors associated with age at natural menopause in a multiethnic sample of mdilife women. Am J Epidemiol

2001; 153(9): 865 - 74.

5. Berg. G, Gottwall T, Hammar M, Lindgren R and Gottgalll T.: Climacteric symptoms among women aged 60 - 62 in Linkoping Sweden, in 1986, in 1986 Maturitas 1988; 10(3): 193 - 9.

6. Donnerstein L, Smith A M and Morse C: Psychological well-being, mid-life and the menopause Maturitas 1994; 20(1): 1 - 11.

7. Punyahotra S and Dennerstein L, Lehert P: Menopausal experiences of Thai women Part 1: Symptoms nd their correlates Maturitas 1997; 26(1): 1 - 7.

8. Dorres P B and Siegal D L: Ourselves, Growing older: Women aging with knowledge and Power Simon and Schuster, New York 1987.

9. Utian W H: Ovarian function, theraphy-oriented definition of menopause and climacteric experimental gerontology 1994; 29(3 - 4): 245 - 251.

10. Estok P J and O'Toole R: The meaning of menopause. Health Care for Women International 1991; 12(1): 27 - 39.

11. Boughton M A: Premature menopause: multiple distruptions between the woman's biological body experience and her lived body. J Adv Nurs 20002; 37(5): 423 - 30.

12. O'Dea I, Hunter M S and Anjos S: Life satisfaction and health related quality of life (SF - 36) of middle-aged men and women. Climacteric 1999; 2(2): 131 - 40.

13. Nadel I, Cypryk K, Pertynski T, Sobezuk A and Stetkiewicz T: Studies on the incidence and clinical significance of the metabolic syndrome in postmenopausal women in Lodz region. Po. Arch Med. Wewn. 2001; 106(3): 823 - 8.

14. Robinson G E: Psychotic and mood disorders associated with the perimenopausal period: epidemilogy, etiology and management Central Nervous System drugs 2001; 15(3): 175 - 84.

15. Gengzzani A R, Spinett A, Gallo R and Bernardi F: Menopause and the central nervous system: Intervention options Maturitas 1999; 31(2): 103 - 110.

16. Alington - MacKinnon, D and Troll L E: The adaptive function of the menopause. A devil's advocate position. Journal of American Geriatric soc. 1981; 3291(8): 349 - 53.

17. Kinsberg S A: Postmenopausal sexual functioning: a case study int. J Fertil. Women's medicine 1998; 43(2): 122 - 8.

18. Kuh Wadsworth and Hardy: Women' health in mid life. The influence of the menopausal social factors and health in earlier life. British journal of Obstetrics and Gynaecology 1997 August; 104(8): 923 - 33.

19. Jean, J P and Reynolds C R: Development of the Bias in attitude survey: A sex-role Questionnaire. The Journal of Psychology 1980; 104, 269 - 277.

20. Osinowo O and Oyefeso A O: The development of a scale of marital satisfaction for women. International Journal of Sociology of the Family 1990; 20: 229 - 237.

21. Golombok S, and Rusi J: The Golombok - Rust inventory of sexual satisfaction (GRISS) British Journal of Clinical Psychology 1986: 24: 63 - 64.

22. Velasco-Murillo V, Navarrete-Hernandez E, Ojeda-Mijare R I, Pozos-Cavanzo J L, Camacho-Rodriquez M A and Cardona-Prez J A: Experience and knowledge about climacteric and menopause in Mexico City Gac. Med Mex 2000; 136(6): 555 - 64.

23. Goldberg D and Williams P: A user's guide to the General Health Questionnaire, Windsor NFER - Nelson 1988.

24. Sowers M F: The menopause transition and the aging process: a population perspective. Aging (Milano) 2000; April 12(2): 85 - 92.

25. Holte A and Mikkelsen: A psychosocial determinant of climacteric complaints Maturitas 1991: 13(3) L: 205 - 15.

26. Segal C V: Appraisal of the self-schema construct in cognitive models of depression psychological bulletin 1988: 103(2): 147 - 62.

27. Bandura A: Social cognitive theory: an agentic perspective. Annual rev psychological 2001: 52: 1- 26.

28. Caltabiano M L and Holzheimer M: Dispositional factors, coping and adaptation during menopause climacteric 1999; 2(1): 21 - 8.

29. Sukwatana P, Meekhangvan J, Tamrongterakul T, Tanapat Y, Asavarait S and Boonitripimon P: Menopausal symptoms among Thai women in Bangkok. Maturitas 1991: 13(3): 217 - 28.

30. Moore B, Kombe H: Climacteric symptoms in a Tanzanian community Maturitas 1991: 13(3): 229 - 34.

31. Ramoso-Jalbuena J: Climacteric Filipino women: a preliminary survey in the Philippines. Maturitas 1994: 19(3): 183-90.

32. Deeks A: Sexual desire, menopause and its psychological impact. Australian family physician 2002 May; 31(5): 433 - 9.

33. Pan H A, Wu M H, Hsu C C, Yao B L and Huang K E: The perception of menopause among women in Taiwan Maturitas 2002: April 25; 41(4): 269 - 74.

34. Ivarsson T, Spetz A C and Hammer M: Physical exercise and vasomotor symptoms in postmenopausal women. Mauritas 1998; 29: 139 - 46.

35. Hammer M, Berg G and Hindgren R: Does physical exercise influence the frequency of postmenopausal hot flushes? Acta Obstet Gynaecol Scand 1990; 69: 409 - 12.

36. Slaven L and Lee, C: Mood and symptom reporting among middle-aged women: the relationship between menopaual status, hormone replacement therapy and exercise particpation. Health psychology 1997; 16: 203 - u8.

37. Torrizuka K, Okumura M and Ligimak et al: Acupunture inhibits the decrease in brain catecholamine contents and the impairment of passive avoidance task in ovariectomized mice. Acupunct electrotherapy research 1999; 24: 45 - 57.

38. Hardy R and Kuh D: Reproductive characterstics and the age at inception of the perimenopause in a British National Cohort Am J Epidemiol 1999; 149(7): 612 - 20.