Psychological Distress and Sexual Dysfunction Among Premenopausal, Perimenopausal and Postmenopausal Women

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Abstract

In Pakistan, when it comes to women's health and sexuality, traditional social and cultural practices often apt for modesty and discretion. Menopause is not even recognized as a health issue by even women themselves. Menopause, in Pakistan is usually marked out and stigmatized. Women going through menopause, most of the time cannot contemplate the phase, due to lack of knowledge and support, social isolation and unmet medical assistance. Another superior taboo, held in Pakistan, that requires serious attention is sexual dysfunction. Lack of awareness and education regarding their sexuality, in Pakistan, immensely leads women towards sexual health issues. Menopause and sexual dysfunction combined, pave path for psychological distress. Untreated menopause and sexual dysfunction can trigger psychological effects, such as stress, anxiety, and depression. Therefore Pakistan, is in a dire need of breaking these taboos, establish prevention plans, and implement awareness programs, in order to achieve well-being of women in health sector precisely.

Key words: Menopausal, Sexual dysfunction, Psychological distress

Introduction

Pakistan is among the top ten countries of the world yet the female population of Pakistan is deprived of basic health facilities. Women suffer menopausal symptoms in a variety majorly just because of their weak understanding about menopausal conversion and when complete cessation has happened. Pakistani women go through a lot and to manage these symptoms become hard for them. On investigating the level concerning awareness about symptoms once the menopause has occurred, and what preventive measures should be taken to overcome the problems, majority admitted that they have neglected to take preventive measures or seek timely care during and following menopause, during menopausal period or after menopause as they were unaware of the risks (Kafeel & Ishaq, 2019).

Midlife years by every woman are experienced distinctly. The changes that women go throughout the phase consists of multiple variations, specifically in sexual well-being. Menopause is predominantly a worrisome subject in Pakistan. Pakistan women live one-third of their lives in postmenopausal conditions. Unfortunately, a significant number of women lack basic knowledge about menopause, and majority have no hint about what menopause is. In Pakistan, 44% of the women are affected in undesirable manner during menopause phase (Mahajan, Kumar, & Fareed, 2016).

The menopausal transition has a profound impact on the quality of life and socio-economic prospects of Pakistani women. Moreover, with lack of knowledge spread as a curse among Pakistani culture, women's psychological and physical health is at a greater risk mainly due to the unaddressed concerns. Regrettably, the women who do have knowledge regarding menopause and

sexual dysfunction, ignore the symptoms either due to shame or fear of being stigmatized (Khan, Shukla, & Ansari, 2016).

On inspecting the relationship between depression, anxiety, research indicates that menopausal women experiencing psychological distress are more likely to report decreased quality of life, underscoring the need for holistic care. (Masood, Rashid, & Musarrat 2016). On assessing the prevalence of sexual dysfunction in association with menopausal symptoms in women during the menopausal transition, the results appeared to be unsightly as more than a half of women are suffering from impaired sex life. Ratio of sexual dysfunction is higher in menopausal women than in non-menopausal women (Eftekhar et al.,2016).

The menopausal transition profoundly impacts women's psychological, physiological, emotional, and sexual well-being. However, in Pakistan, societal stigma and traditional norms discourage open discussion of these concerns. Despite the need for support, many Pakistani women hesitate to seek help, instead shouldering the burden of menopausal symptoms, sexual dysfunction, and psychological distress in silence.

Menopause

The word menopause was originated out of Greek word *menos* (month) and pauses (ceasation). According to the dictionary the word refers to the period of decline in sexual activity and infertility. The following definition does not cover the intense and complex variations which are carried by cessation of ovaries. Ovaries of menopausal women stop producing Estrogen and Progesterone, leading to severe somatic, psychological, vasomotor and sexual symptoms, disturbing the cycle of a woman’s life (Nisar & Sohoo, 2010).

Menopause is characterized as a constant caseation of menstruation and is marked following one year of amenorrhea, in the absence of any other medical reason (Sadrzadeh, Verschuuren, Schoonmade, & Lambalk, 2018).

Worldwide the time of occurrence of natural menopause is in the middle of 45-55 years of life. Symptoms of menopause are inescapable as well as complex, majority of women experience different symptoms because of menopause. Usually, these symptoms last around 2-5 years after a woman have had her last meses. Physical symptoms are experienced as a direct consequence of menopause. Vasomotor symptoms VMS, sleep disturbance and sexual difficulty are the most bothersome (Youri, 2019).

The prevalence of anxiety symptoms in menopausal women is extensive, with estimates of as high as half of the women report nervousness and tension (Reddy & Omkarappa, 2019). Menopause is three phasal process: Pre, Peri and Post-menopause. Premenopausal stage is referred as the entirety of a woman's reproductive life counting from first occurrence of menstruation to menopause. Perimenopausal stage: the transitional stage starts from reproductive years to permanent infertility that occurs nearly before menopause. The average age of perimenopause is 47, some might experience in their late 30's, stage can last from 3-10 years. Post-menopause once there is complete cessation of menses a woman is known to be menopausal. Women in this stage experience an extension in symptoms linked with absence of estrogen and progesterone (Cucinella, Nappi, & Ceausum 2019). Approximately 1.5 million women enter menopause annually, with the majority (70-80%) experiencing vasomotor symptoms, such as hot flashes. However, only 15-20% seek medical help due to significant interference with their quality of life. The average duration of hot flashes is around 5.2 years, beginning a year before the final menstrual period and gradually declining thereafter. Additionally, menopause is often accompanied by other symptoms, including

vaginal dryness or dyspareunia (27-60%), sleep disturbances (50%), and an increased risk of major depressive episodes (three-fold) during perimenopause (Koothirezhi R, Ranganathan S. Postmenopausal Syndrome, 2023-24).

Factors Affecting Menopause

The menopausal transition can have an impression a woman's health as it greatly is accompanied with bodily as well as mental fluctuations in her life. Either physical, psychological, social or sexual changes that are caused in the menopausal evolution disturbs women's quality of life undesirably and adversely. Menopause related symptoms are reported by almost every woman and claimed that these symptoms not only affect their quality of life bodily and emotionally, but moreover socially.

Age. Every woman is different from the other, but generally after 40 years of age most women move in menopausal phase. Although there are multiple factors affecting the stage of development of menopause onset, including: mother's age at which she experienced menopause, the age at which menses occurred for the first time, time duration of pregnancy known as gestational age, use of medicines to control pregnancy, menses occurring irregularly, the number of pregnancies of a woman, BMI and physical activity (Ceylan & Ozerdogan, 2015).

Education. Education and socioeconomic are thought-out to be an important feature playing a part in experiencing, the intensity of menopausal symptoms. Psychological factors and their way of life, bodily perception, interpersonal relations, character, as well as sociocultural aspects which are great predictors of depression and anxiety in the menopause can never remain overlooked. Along with psychological factors, community aspects and cultural beliefs also influence on symptoms of menopause but variations across cultures can be witnessed. In developing countries,

it has been noticed that women even after menopause expect to bear children especially male child (Afridi, 2017).

Socio-Economic Status. Women who belong to low socio-economic class experience more menopausal symptoms. They never sought for treatment neither consider menopause as an issue, which could lead to harmful consequences. It was found that women who belong to low class experience menopause more or less four years earlier than the women who belong to middle and upper class (Afridi, 2017). Women with early menopause show higher stress intensity than the normal menopause. There are several women aspects that might be affected by menopause along with mental health (Erbil, 2018).

Psychological Distress

Psychological distress is a prevalent mental health issue marked by emotional suffering, typically manifesting as feelings of despair and anxiety. This condition often co-occurs with physical complaints, medically unexplained symptoms, and various chronic illnesses, highlighting the complex interplay between mental and physical well-being (Arvidsdotter et al., 2015). A substantial positive correlation is observed between anxieties, depression in addition to psychological distress in menopausal women. Significant differences are noticed between: the standard of life of women with and without menopause. The conclusion drawn is that: anxiety, depression as psychological suffering occurs as solid interpreters of devalued life for menopausal women (Masood et al., 2016).

Research indicates that women in different menopausal stages face distinct mental health risks. Specifically, women in the perimenopausal stage are more susceptible to depression, while those in the postmenopausal stage are more likely to experience anxiety symptoms. Notably, both

perimenopausal and postmenopausal women can develop depression and anxiety without a prior history of these conditions, with a higher incidence observed during the perimenopausal phase. This highlights the importance of monitoring mental health throughout the menopausal transition and providing targeted support to address these emerging mental health concerns. (Mulhalla, Andel, & Anstey, 2018).

Sexual Dysfunction

According to DSM-V, dysfunction or disturbances in the process of having sex or to respond sexually, or when the individual is unable to derive pleasure and engage in sex, is considered sexual disorder. Sexual dysfunction is typically influenced by a variety of predisposing, precipitating, maintaining and contextual factors, predisposing factors include both constitutional and previous negative life experiences. Later in life, for some women, these predisposing factors may be associated with sexual dysfunction and/or mental health problems. Damaged self-confidence by repetitive or problematic sexual experiences, such as sexual violence, conflict in divorce, a disabling accident, or unsatisfying sexual experiences can generate sexual dysfunction, even in reasonably resilient women (Althofa, & Needleb, 2013).

Historically women's sexuality has been measured by assumptions made for men, which serves as a deterrence in research purpose. Decreased sexual desire and sexual problems for instance dyspareunia occur often in women in menopausal evolution or after menopause. The most common diagnostic category is hypoactive sexual desire that is used for menopausal women who have lost their interest in sexual activities and desires. Almost every woman in menopausal or after the occurrence of menopause reports decline in sexual desire or sexual activity, due to loss of libido. Loss of libido serves as an undesirable consequence for aging women. Prevalence of sexual

dysfunction among menopausal women specially in peri and post-menopausal phase is immensely observed. Postmenopausal women are at the highest risk of sexual dysfunction (Nazarpoura, Simbar, & Tehranic, 2016)

The time of sexual dysfunction caused by mesopause varies in women. Women who have positive attitude towards their partners and the women who are physically healthy, these factors serve as an important predictor of good production of libido in them. As a woman's contentment with her psychological well-being and sexual relationship plays a crucial role on her sexual desire during menopause. Typically, when women enter pre- or perimenopausal the experience these symptoms for around five years, many report that the symptoms are perennial, along with sexual distress (Dawson, Mcdonell, & Scott, 2016).

Relationship between Psychological Distress, Sexual Dysfunction and Menopause

Comparatively limited work has assessed connection between psychological distress and menopause. Psychological distress has a string connection with irregular menses in midlife. It is essential to control whether the distress caused due to irregular or diminished menses is linked to hormone levels and to what amount cultural causes and socio-economic status have an influence on hormone of mood. Rates of psychological distress were found to be at peak in early postmenopausal phase and lowest in premenopausal phase and perimenopausal phase. In relationship with premenopausal women, perimenopausal women were at a larger risk of distress (Bromberger et al., 2016).

Menopausal transition is a threatening period for women to develop extreme anxiety and depression. Symptoms at this are thought to be qualitatively different from those in childbearing years, and to present with milder symptoms of depression, increased agitation, and fatigue

(Kauntiz, Pinkerton, & Mason, 2019). Sexuality is an important component of emotional and physical affection yet sexual dysfunction is a subject that is not well studied and women immensely lack awareness about the issue which is why it is ignored most of the time. Among the menopausal group it has been proved that sexual impairment is higher in postmenopausal women in contrast with the other two menopausal groups but sexual dysfunction as a whole is experienced by all three groups. The symptoms that have been frequently reported are diminished sexual desire, difficulties with arousal, incapable of reaching orgasm, painful intercourse and destructive body image in addition to minimized sexual appeal (Ambler, Bieber, & Diamond 2019).

Menopause accompany psychological distress which together results in decreased sexual activity and a feeling of decreased sexual attractiveness and sexual potency, which eventually leads to diminished sex life, Significant number of women claims to experience sexual impairment later or sooner in the menopausal phase and post-menopausal phase. Sexual instability caused in women with menopausal transition is caused dua to multiple reasons and psychological distress is on the top. It is detected that better mental health of a woman, the better the sexual function and vice versa. It has also been suggested that counselling and promotion of awareness are likely to diminish menopausal and mental problems ultimately fosters better sexual health. These actions might reduce the confrontational feelings menopausal women have towards intercourse (Yazdanpanahi, Nikkolgh, Akbarzadeh, & Pourahmad, 2018).

Psychological Distress and Sexual Dysfunction among Pre-, Peri-, and Postmenopausal Women in Pakistan

A growing body of research has shown that menopause significantly impacts the mental health of women, with the transition often marked by heightened levels of depression, anxiety, and stress.

In Pakistan, studies indicate a positive correlation between menopause and psychological distress, with depression and anxiety emerging as key factors affecting the quality of life. According to Masood, Rashid, Mussarat, & Mazahir (2016), depression and anxiety play a central role in determining the life satisfaction of menopausal women. The intensity of menopausal symptoms often exacerbates mental health issues, as women struggle to cope with both somatic symptoms (e.g., hot flashes, insomnia) and psychological changes.

Somatic Symptoms and Psychological Problems: Studies have also shown that somatic symptoms (such as hot flashes and night sweats) are closely linked to the development of psychological problems. Aqeel, Arbab, & Akhtar (2018) found that these physical changes in menopause are not only disruptive but also play a crucial role in triggering psychological distress, highlighting the interconnection between physical and mental health during menopause.

Menopause can also significantly affect a woman's marital satisfaction and relationship dynamics, especially in the post-menopausal phase. Emotional Intelligence and Marital Satisfaction: Heidari, Shahbazi, Ghafourifard, & Sheikh (2019) explored how emotional intelligence impacts marital satisfaction among postmenopausal women. They found that the emotional competence of women during menopause declines, leading to a negative impact on marital satisfaction. This decline in emotional stability and marital fulfillment is often accompanied by changing roles and increased responsibilities, both within the family and society, contributing to relationship dissatisfaction.

Psychological Changes and Marital Discord: Interestingly, many postmenopausal women do not view sexual dissatisfaction as the primary cause of marital discord. Rather, they attribute marital dissatisfaction to psychological changes and lack of support from their partners during the menopausal transition. This finding supports the idea that emotional and psychological shifts

during menopause contribute more significantly to relationship difficulties than physical or sexual changes. A major challenge in Pakistan is the lack of awareness about menopause and its symptoms. Although some women are familiar with physical symptoms (such as hot flashes and irregular periods), many remain unaware of the long-term consequences of menopause, especially in terms of mental health and physical well-being.

Research reveals that while Pakistani women may recognize menopausal symptoms, they are largely unaware of the psychological and physical health consequences of menopause. Most women experience severe menopausal symptoms but fail to seek medical advice, often due to a lack of knowledge about available treatments, such as hormone replacement therapy (HRT), and the stigma surrounding menopause. The lack of evidence-based information regarding menopause in Pakistan means that many women endure the symptoms without adequate medical support. emphasizes the need for community-based education programs to raise awareness about the physical, psychological, and social aspects of menopause, and to promote open discussions within families and communities (Khokhar., 2013).

Healthcare access plays a crucial role in how women experience and manage menopause. Women in Pakistan often face significant barriers to accessing quality care, which affects their ability to cope with the physical and psychological impacts of menopause. Research suggests that women in lower socioeconomic brackets tend to experience earlier onset of menopause, often accompanied by more severe symptoms (Aqeel et al., 2018). Women from these backgrounds are also more likely to experience limited access to healthcare, including counseling and HRT. This can result in a deterioration of mental health, as women are less likely to receive the necessary medical intervention to manage their symptoms.

On a positive note, social support and physical fitness were associated with a more satisfactory relationship with spouses and fewer menopausal symptoms. Women who were supported by family and friends, and who maintained a healthy lifestyle, reported a better overall quality of life during menopause. This highlights the importance of both social and healthcare support in managing menopausal symptoms effectively (Jamil, & Khalid ,2016)

The onset of menopause and the nature of climacteric symptoms (the physical and psychological symptoms associated with menopause) are influenced by regional and ethnic factors. Studies have shown that Asian women, including those from Pakistan, experience menopause at a younger age compared to women in Western countries. There are also significant ethnic differences in the severity and type of symptoms women experience. However, because of variations in study methodologies and cultural factors, it is difficult to draw firm conclusions about the exact nature of these differences. Nevertheless, it is important to acknowledge that these regional variations can inform a more tailored and culturally sensitive approach to managing menopause in different populations (Khokhar., 2013).

Majority of the studies regarding this subject has focused on any one or might be two of the menopausal groups. A very few studies have been conducted in Pakistan focusing on all the three phases of menopause; pre, peri and post-menopause, along with their severity of symptoms and how these symptoms affect the personal, psychological and sexual and social life experiences of menopausal women. Lack of awareness among Pakistani women about menopause is evident from previous literature. Evidence-based information about the menopause should be provided to Pakistani women. Several local studies regarding menopause have emphasized on prevalence.

Inferences of this Study

This study makes an understandable connection between psychological distress experienced by women in all three phases of menopause, also the present study provides directional data to understand and add to the gap in literature regarding psychological distress among women during menopause and post-menopause.

Pakistani women massively ignore the distress caused due to sexual dysfunction. Pakistani women lack in sex education and in distress caused due to menopause. They simply ignore the facts due to lack of awareness. Most common reason for lack of awareness is their inability to relate their symptoms to menopause and their common notion that these symptoms experienced by them were due to some other medical ailment. This obliviousness may lead to complications after menopause (Aqeel, Arbab, & Akhtar, 2018).

Majority of the women are not aware the symptoms and the harmful effects on life of these women menopause has. Even the women suffer a lot of distress as well as dysfunction during or after menopause still they are not bothered by the symptoms and do not visit doctor for consultation due to lack of awareness and low socio-economic status or shame. Menopause is the most affecting period of a woman's life. Women are among the most important part of the society and family. Appropriate training to menopausal women should be provided as they are most important part of any society. Training would help in improving the quality-of-life women and will promote health (Aqeel, Arbab, & Akhtar, 2018).

Culturally sensitive education and mental health support are essential for menopausal women in Pakistan to address the lack of awareness and stigma surrounding menopause. Many women, especially from low socioeconomic backgrounds, misattribute symptoms to other ailments, leading

to untreated psychological distress. Providing culturally appropriate education and mental health services, including counseling, can help women understand and manage menopause's physical and emotional challenges, improving their overall well-being and quality of life.

Methodology

This study was conducted on the women of Islamabad and Rawalpindi, and designed with the assistance of available literature. This study aimed to explore the intricate relationships between psychological distress and sexual dysfunction among pre-, peri-, and postmenopausal women, while also examining how demographic factors like education, socio-economic status, and family system influence these experiences. Below is a structured overview based on your provided details.

Method

Objectives

1. To investigate the relationship between psychological distress (depression, anxiety, stress) and sexual dysfunction in pre-, peri-, and postmenopausal women.
2. To analyze demographic differences (education, socio-economic status, family system) related to psychological distress and sexual dysfunction among these groups.

Hypotheses

1. There is a positive correlation between psychological distress and sexual dysfunction in pre-, peri-, and postmenopausal women.
2. Postmenopausal women report higher levels of psychological distress and sexual dysfunction compared to pre- and perimenopausal women.

Operational Definitions of Variables

- **Menopause**: The natural biological process marking the end of a woman's reproductive years, defined as the absence of menstruation for 12 consecutive months. Includes symptoms such as hot flashes, sleep disturbances, and cognitive changes (Heinemann, 1996).
    - **Premenopause**: Regular menstrual cycles with potential variations and premenstrual symptoms.
    - **Perimenopause**: Irregular cycles preceding menopause with reduced estrogen production.
    - **Postmenopause**: No menstrual periods for 12 months, indicating the end of reproductive capability (Obstetrics & Gyne, 2019).
- **Psychological Distress**: Measured using the Depression Anxiety Stress Scale (DASS), where high scores indicate greater distress.
    - **Depression**: Feelings of uneasiness and devaluation of life (Lovibond & Lovibond, 1995).
    - **Anxiety**: Experiences of anxious affect and physiological responses (Lovibond & Lovibond, 1995).
    - **Stress**: Prolonged tension and difficulty in calming (Lovibond & Lovibond, 1995).
- **Sexual Dysfunction**: Defined by disorders related to desire, arousal, and orgasm, assessed through the Female Sexual Function Index (FSFI) (Rosen, 1999).

Sample

- **Participants**: 150 women from Islamabad and Rawalpindi, categorized into premenopausal (46), perimenopausal (65), and postmenopausal (39) groups.
- **Demographics**:
    - Education: Varied levels, from no formal education to higher education.
    - Socio-economic Status: 60% low income, 30% middle class, 10% high class.
    - Family System: 47.3% joint families, 53% nuclear families.

Sampling Techniques: Purposive and snowball sampling, including participants from clinics and community sources. Exclusion criteria were set for women with other gynecological issues.

Instruments

1. **Demographic Sheet**: Captures age, education, income, and family system.
2. **Menopause Rating Scale (MRS)**: Measures health-related quality of life specific to menopausal symptoms, with reliability ranging from .80 to .96 (Heinemann, 1996).
3. **Female Sexual Function Index (FSFI)**: Assesses various dimensions of sexual function with a reliability of .88 (Rosen, 1999).
4. **Depression Anxiety Stress Scale (DASS)**: Measures levels of depression, anxiety, and stress with a total of 42 items. Reliability scores range from .82 to .87 (Aslam, 2007).

Procedure

- **Data Collection**: The researcher personally administered questionnaires in clinics and community settings, ensuring informed consent and confidentiality.
- **Questionnaire Administration**: Participants were read the questions, filled them out on-site, and were allowed to withdraw at any time.
- **Ethical Considerations**: Emphasis on confidentiality and the voluntary nature of participation, with no identifying information collected.

This structured methodology is designed to provide insights into the psychosocial aspects of menopause and their implications on women's health, while also considering the impact of demographic factors.

Limitations and Suggestions

No research minus downsides. Even after fulfilling the gaps in the best way possible some aspects are still left behind to be addressed in future. The limitations of the present research as mentioned below:

1. Current study includes women population from Rawalpindi and Islamabad only, so generalizability of the results is limited. Inclusion of women from all over Pakistan would diversify the spectrum: a requirement.
2. Women were hesitant in filing the questionnaires regarding the topic of the research -sexual dysfunctioning and menopausal concerns are still considered taboo to be addressed and discussed. Prevention plans should be established to remove the taboo of discussing about the variables of the present study.

3. Women included in the sample were experiencing menopausal symptoms but they were not diagnosed clinically. Further work could be done by comparing clinically diagnose and non-clinical sample.

4. Awareness programs should be run to provide women with complete sex education and menopause.

5. Women should get them checked in every six months on regular basis, to improve the quality of their life and relationship with spouse.

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