Chapter I

INTRODUCTION

Among the gynaecological diseases, menopause has become a potent problem in the field of obstetrics and gynaecology in terms of both preventive and clinical care of menopausal women. The menopause has perhaps been most common link with psycho-social problems. Notman (1979) argued that the menopause has often been ascribed preeminence as a causal factor responsible for psychological distress experienced by women during his life. The number of women living beyond the menopause has increased progressively over the centuries. The average woman now lives approximately one third of her life in the post menopausal period. By the year 2,000 A.D. five percent of the population in the developed regions will be over 65 years (W.H.O., 1983). The rapid emergence of large numbers of menopausal women during the last several years has created the sudden need for information about the especial medical problems unique to the menopause. A large number of women in the menopause suffer from clinical symptoms which drastically influence their lifestyle and well-being (Wu, 1985). Therefore, a psychological study of menopausal women is necessary especially with regard to
personality factors. The menopause is a phenomenon which has received little attention by psychologists, especially in India.

The Menopause: Concept and Definition

Menopause is derived from the Greek 'men' or 'Month' and 'Pauo' or 'to stop' and 'immeans' the cessation of menstruation. The terms menopause, climacteric, pre, peri- and post menopause are often used interchangeably but, strictly, apply to different stages at the end of the reproductive life in the human female. The Climacteric or critical stage is derived from the Greek 'Klimakter' (rung of the ladder) and has been defined as "a transitory phase in the women female between the ages of reproductive and non-reproductive ability" (First International Congress on the Menopause, 1976).

Since the two terms, namely, Menopause and Climacteric have frequently been treated as synonymous, it would be fitness of things to define both the terms and make a clear distinction between the two. Menopause is defined as the time at which menstruation ceases, whereas climacteric is the phase of waning ovarian activity and may start two or three years before the menopause and continue for two to five years after it. Menopause is also referred by the laity as 'the change of life'. Hougarten (1977) showed that the menopause is a discrete
physiological event marked by the cessation of menstruation, which occurs on average at the age of 51 years. In marked contrast to the menopause, the climacteric is a long-term physiological process, caused by involution of ovaries. It entails a variety of physiological changes, including the menopause. Studd and his colleagues (1977) indicated that the climacteric may last 20 years; beginning 10 years before the menopause and ending some 10 years after it. During climacteric, ovarian activity ceases. Differences in the operational definition of climacteric and menopause is rather difficult because of the insidious nature of the physiological changes associated with it. It can be defined by age.

The climacteric is the counterpart of puberty and is a transitional phase lasting from 1 to 5 years during which the genital organs involute in response to the cessation of gonadal activity. The menopause is the counterpart of menarche and refers only to the cessation of menstruation; it is mainly one manifestation of the climacteric and precedes complete cessation of ovarian function by several months or years. The interval between the two may in part be explained by secretion of oestrogen or by the ovarian stroma. There should be amenorrhoea of at least one year in women of above 40 years before concluding that she has reached menopause and a highly elevated plasma FSH level (40 IU/ml) (Wu, 1985). The menopause or the climacteric are peculiar to the human race; in lower animals ovulation and fertility continue into old age.
Menopausal Status

Menopausal researchers have used different methods for defining menopausal status. Neugarten and Kraines (1965) employed self-evaluation criteria to determine the menopausal status of the respondent. Other investigators relied on a subjective evaluation of menstrual regularities as adequate indicators to differentiate the peri-menopausal from the pre- or post-menopause phases (Sharma and Saxena, 1981). Jaszmann et al. (1969) used another method for defining menopausal status. The Methods used are:

A. **Pre-Menopausal**: Women who had normal menses during the year preceding the survey.

B. **Peri-Menopausal**: Women reporting a menstrual pattern different from the former pattern.

C. **Post-Menopausal**: Women who did not menstruate in the year preceding the survey.

McKinlay and Jefferys (1974) adopted a method for defining menopausal status is only woman 'at risk', i.e. between 40 and 55 years, and a clear distinction is made between menopausal women and pre and post-menopausal women. The criteria used are:

**Pre-Menopausal**: Menstruated within the last three months, with no change in regularity of volume in the previous year.
Transitional-Menopausal: Menstruated within the last three months, but with some change in regularity of volume in the previous year.

Menopausal: Last menstruated between three and 12 months ago.

Post-Menopausal: Last menstruated more than 12 months ago. The category can be further subdivided according to the time last menses.

There are many difficulties in defining menopausal status. However, using the above mentioned criterion, menopausal status is defined in terms of the cessation of menses rather than in terms of symptoms that are assumed to follow from the cessation of menses.

Menopausal Symptoms

Menstrual Symptoms: The three classical ways in which the periods cease are:

(a) Sudden cessation of menses.
(b) Gradual diminution in the amount of loss with each regular period until they disappear.
(c) Gradual increase in the spacing of the periods until they cease for an interval of six months.

Any patient who bleeds after a gap of six months must be considered to be suffering from post-menopausal bleeding and treated as such. Continuous bleeding,
menorrhagia, irregular bleeding or other menstrual abnormalities are not normal. They must be investigated despite the common belief that they are signs of change.

**Vasomotor Symptoms.** The commonest and most frequently repeated menopausal symptoms are hot flushing and sweating.

**Hot Flushes,** is thought to occur to some extent at sometime in about 75% to 85% of women. Hot flush patients experiences an uncomfortable and sometimes unbearable feeling of intense heat of sudden onset usually arising in the trunk, spreading towards the neck, face, forehead, chest, and sometimes, over the whole body, followed by acute perspiration and sometimes shivering. Frequently there are palpitations. Although the onset of the hot flush itself is sudden, there is often an awareness of an impending flush just before it occurs. The flushes vary, both in duration, from 1 minute to four minutes, and in intensity (Sturdee, Wilson, Pipili and Crocker, 1978). Studd et al. (1977) reported that hot flushes are due to combination of factors including the rate of withdrawal of oestrogen.

When the vasomotor attack occurs at night, patients complain of 'night sweats' which are associated with dreaming and probably related to episode of REM sleep (Erlik et al., 1981). Mental depression is due to disturbed sleep caused by night sweats. Coronary thrombosis is
alleged to occur more commonly in menopausal women due to oestrogen deficiency.

Hot flushes and sweating at night create other problems by disturbing sleep and personal, domestic and working life and can easily lead to other symptoms (Campbell and Whitehead, 1977).

Other vasomotor symptoms mainly migraine headaches and palpitations, have been reported. It has not been demonstrated that these are primarily symptoms of the menopause. An extensive survey of 20 symptoms in five year age groups of women from 20 to over 65 years revealed that headaches actually decrease from 45 years. Palpitations remain stable from age 40 to after 55, when there was a slight increase, not statistically significant (Wood, 1979). Bungay et al. (1980) found a similar decrease in headaches from age 40 in women and men. The International Health Foundation Survey mentioned above of 2,000 European women aged 46 to 55 found reports of palpitations in 24% of the women. Some older women complain of hot flushes sweating and tachycardia (Nieschlag, 1979).

**Genital and Urinary Symptoms.** Vulval pruritus and vulval dystrophies are much more common in post-menopausal women. Asso (1984) noted that there is considerable variability in the onset and severity of atrophy of the urogenital tissues.
Oestrogen deficiency causing atrophic changes of urethra and bladder leads to atrophic cystitis, urethritis, ectropion urethrae, kolpitis, bacterial and fungal infections, loss of tone of the bladder and urinary incontinence. Osborn (1976) reports that there is increase in nocturia among post-menopausal women than the pre-menopausal women. He has given explanation that this small rise could be a secondary outcome of waking with night sweating.

**Osteoporosis Symptoms.** Osteoporosis and the related features becomes a problem in women from about 60 years of age. Insufficient bone mass leads to increase porosity and brittleness and a rarefaction of normally mineralized bone, which predisposed to bone fracture. Worley (1981 b) reported that the bone loss starts at the menopause and early remedial steps are sometimes vital.

**Muscular Symptoms.** Various aches and pains during the climacteric have not often been systematically investigated. Jaszmann, Vanlith, and Zatt (1969) reported that aches in joints, bone and muscles were observed in 30 percent of women who menstruated normally. There was a rise to a maximum 46 percent through the menopause, with a subsequent decline to 33 percent at 5 to 10 years after menopause. Bungay, Vasseys and Mc Pherson (1980) compared different age groups found that specifically low backache decreased from
about 48 years of age in women, whereas in men the symptoms increased from about age of 57.

**Sleep.** Insomnia does not appear to be a distinct symptom directly related to the menopause inspite of several anecdotal reports to that effect. Campbell and Whitehead (1977) noted that in some women any additional insomnia appears to be a by-product of the hormone related hot flushes and night sweating. Some older men also complain of sleeplessness (Nieschlag, 1979) and in both men and women it is probably related to age.

**Memory Function.** Memory function declines with age in both men and women. Campbell and Whitehead (1977) found that poor memory in menopausal women responded to oestrogen replacement therapy and this did not appear to be a secondary benefit of reduction in vasomotor symptoms. Although there is an increasing incidence with age of memory in women is somewhat exacerbated by ovarian failure or by its effects.

**Sexual Behaviour and Sexual Feeling.** Sexual behaviour and sexual feeling in the climacteric phase have been widely studied. As regards sexual behaviour, there appears to be a pattern of declining sexual activity with age in women. In all age groups the frequency of sexual intercourse is lower for women then men (Pfeiffer et al., 1972). In a survey of peri-menopausal women in Sweden (Hallstrom, 1977) the data
confirm a decline of sexual activity in women from 38 years to 58 years. This study also reported that the majority of woman have sexual interest beyond age 50, and many well beyond that.

Bungay, Vessey, and Mc Pherson (1980) conducted a survey in Britain of men and women aged 30-64 years, with regard to sexual feeling or interest. They found that all ages women have less interest than men in sexual relations. Pfeiffer and Davis (1972) found that women and men experience a significant decline in sexual intercourse with increasing age. Men had more frequent intercourse at all ages but the rate of decline in both groups reached the same level of significance.

There is general agreement in these findings that sexual feelings and sexual behaviour decline with age and most authors conclude that the rate is somewhat similar in women and in men. It is difficult to identify all the determinants of this decline.

**Coronary Heart Disease.** The rise of Cholesterol and triglyceride levels after the menopause, by upto 20 percent of pre-menopausal levels. Most authors also report an increased risk of coronary heart disease with the menopause. The exact nature of the relationship between all these changes is not clear. As regards changes with age, up until 50 years mortality from cardiovascular disease is
many times higher among man than woman. Non smoking women enjoy virtual immunity from coronary heart disease before the menopause. There are reports of a rise in levels of cholesterol and triglyceride and an increased incidence of coronary heart disease in post-menopausal women especially after age of 45 (Oliver, 1976).

It is assumed that in women ovarian hormones have a protective effect. As regards the post-menopausal women, the results are conflicting with findings of detrimental effects (Gordon et al., 1978), beneficial effects (Hammond et al., 1979 a), or no effects (Nachtigall et al., 1979, Pfetter, et al., 1978) on the development of coronary heart disease.

The inconsistent findings may reflect some faulty assumptions. There is a widespread belief in the protective effect of the functioning of ovary, probably through blood lipid levels, against coronary heart disease.

Psychological Symptoms. Bungay et al. (1980) conducted a study on both sexes, men serving as controls, showed that the peak of prevalence of flushing and sweating were closely associated with the climacteric and difficulty in making decisions and loss of confidence also peaked around this times. Similar responses were obtained for anxiety, forgetfulness, difficulty in concentration and feelings of unworthiness.
Apart from changes in mood and psychological symptoms directly related to endocrine changes; many women experienced psychological problems and symptoms at the climacteric/menopause which are the result of the changes in their life situation. These symptoms are depression, tension, irritability, aggressiveness, nervous exhaustion, mood fluctuation, frustrations, and feelings of decreased energy and drive, reduced power of concentration and feeling of inadequacy and loneliness.

The present study employed three personality dimensions namely, self-esteem, self-consciousness and social support for understanding the prevalence of the personality trait among menopausal women. Of these, self-esteem is one of the potent dimension in terms of its implications for menopausal women.

**Self-Esteem**

A dictionary of psychology defines self-esteem as "a term given to the evaluation an individual makes of and applies to himself. It can express positive or negative feeling and indicates the extent to which the individual believes himself or herself to be significant, capable and worthy". Although self-esteem is a concept which may be applied to specific areas of experience, it is almost always applied to general feelings of worthiness.
There are so many concepts and terms which are interchangeably used as an aspect of self-esteem. The terms are: self-love, self-confidence, self-respect, self-acceptance, or rejection, self-satisfaction, self-evaluation, self-appraisal, self-worth, sense of adequacy or personal efficacy, social competence, self-ideal congruence, ego or ego-strength. There are two self terms that seem especially important in the literature, self-esteem and self-concept. Fleming & Courtney (1984) considered self-concept to be a more gender term, which subsumes self-esteem in Wylie’s (1974) self-concept writing, the term self-regard is used in a more specialised sense that is self-concept, herself regard appears to be close to our idea of self-esteem. Coopersmith (1967) self-esteem was a global construct having to do self-appraisal or evaluation of one’s self which seem compatible with Shavelson et al. (1976) and also with Rosenberg (1965, 1979) because he recognised that a number of facts contribute to this global a general perspective though most researches in self-esteem would probably agree with the view, there are a wide range of opinions and the dimensionality issue. Self-concept on the other hand, includes pure self-description which are distinguishable from self-esteem because such description do not necessarily imply judgements.
Shavelson et al. (1976) used the terms self-esteem and self-concept interchangeably, arguing that the distinction between the two concepts is not clear conceptually and that such a distinction has not been demonstrated empirically. In a more recent and deliberate attempt to disentangle evaluative from non-evaluative aspects, Shepared (1979) reported modest, though favourable results. However, the distinction between these constructs seems quite thoroughly ingrained in psychological thought, dating back at least to William James (1950/1890). James first recognised that self-awareness and self-evaluation were distinct ideas. According to Rosenberg (1979), "a person's global self-esteem is based not solely on an assessment of his constituent qualities but on an assessment of the qualities that count" (p. 18). Thus, centrality bears upon the self-esteem/self-concept distinction.

Many self-concept measures do seem to measure more than we have called self-esteem. Some good examples are Fitt's (1965) Tennessee Self-Concept Scale (TSCS) and the Aers-Harris Children Self-Concept Scale (SCS; Piers, 1969). Both are multi-dimensional instruments. The TSCS contains not only self-acceptance items but also self-identity and behaviour items which indeed seem logically different from self-esteem (though they are highly correlated in practice: Wylie, 1974). The CSCS includes "adjustment" as well as
self-esteem items (e.g. anxiety and happiness). On the other hand, Coopersmith's (1967) Self-Esteem Inventory, Rosenberg's (1965) Self-Esteem Scale, and our revision of the Jennur-Field scale contain items that are concerned primarily with the evaluation of self-worth, as opposed to self-identity or self-description. Furthermore, these do not attempt to measure anxiety, personal happiness, or other adjustment constructs.

Self Consciousness

A theory of objective self awareness was given by Duval and Wicklund (1972). The theory postulated that when an individual's conscious attention is directed at self-as-object, the typical consequence is aversive motivational arousal. This arousal was viewed as stemming from the individual's necessary confrontation with the discrepancy between what one sees of self and what one idealizes self to be the theory goes on to specify the consequent reactions to the arousal of silent self-ideal discrepancies during self-awareness and a set of tactics or adaptation designed to relieve the aversive motivational press of objective self-focus.

The main tenet of the theory of objective self-awareness is that conscious attention is a dichotomous phenomena. It can either be directed toward self or toward the environment. While individuals are viewed as capable of
vaccillating between these two conscious foci, it is viewed as implausible for a self-focus and environmental focus in consciousness to be simultaneous. The particular direction of one's conscious attention is determined by external stimuli which either evoke self-reflection or pull attention outward. Wicklund (1978) says: "stimuli that remind a person of this objective status will increase objective self-awareness while all other stimuli tend to draw attention outward" (p. 466). Stimuli evocative of attentional self-focus can vary widely and include images or symbols of self as well as the studies of attention of others toward the self.


In recent psychological research, the trait of self-consciousness has been shown to play an important role in shaping a person's behaviour. Self-consciousness has been defined as the consistent tendency of a person to direct attention inward or outward. Fenigstein et al. (1975) have identified three aspects of self-consciousness.
(1) **Private self-consciousness** which accounts for the tendency to attend to one's inner thoughts and feelings.

(2) **Public self-consciousness** which refers to an awareness of the self as a social object.

(3) **Social Anxiety** refers to degree of discomfort felt in the presence of others.

This factor of self-consciousness presumably is derived from public self-consciousness in the sense that a person keenly aware of himself as a social object may become apprehensive. Although awareness of oneself as a social object does not automatically result in anxiety, public self-consciousness may be a necessary antecedent of social anxiety.

A large number of studies existed on the relationship between one or more of these aspects of self-consciousness and self-esteem (Ickes et al., 1973), a person's cognitions and behaviour in such varied domains as accurate self report of other traits in one self (Turner et al., 1978), self prediction of aggressive behaviour (Scheir, 1976), self attention and social interaction (Feningstein, 1979), more periodical expression of private opinion for public consumption (Scheir, 1980), prediction of audience impression of one's acting (Tobey & Tunnell, 1981) use of make-up (Miller & Cox, 1982), choice of dinner-menu to be prepared for a party when quest's opinion are
important, (Burnkrant and Page, 1982), perception of self as a target (Fenigstein, 1984), self disclosure and loneliness (Franzoi and Davis, 1985), self assessment (Carver, 1985), consumer behaviour (Rook, 1985), processing of self relevant information (Hull et al., 1988), living sphere (Kawasaki, 1989), self-disclosure reciprocity during the acquaintance process (Shaffer and Towarelli, 1989), and social behaviour (Triandis, 1989).

**Relationship between Self-esteem and Self-consciousness**

If self-esteem is the evaluation of test of self-concept then self-consciousness is the degree to which people attend to self (Rosenberg, 1979). Buss and his associates (e.g., Buss, 1980; Fenigstein et al., 1975) made a distinction between the state of self awareness and the trait of self-consciousness. Fenigstein et al. (1975) have developed scales to measure private versus public self-consciousness and social anxiety. Private self-consciousness scale items are related to attention to feelings and inner state, whereas public self-consciousness items relate to the self as a social object. Turner et al. (1978) explored the correlates of self-consciousness scale with self-esteem measure. They found that the negative relationship between the self-esteem measure and each of the self consciousness subscales. This finding was consistent with the reasoning proposed by Ickes et al.
Buss (1980) summarised evidence for the construct validity of the scales (e.g. only public self consciousness is associated with social anxiety.

The important point for self-esteem theory is that self-consciousness is conceptually distinct from self-esteem. For one thing, self-consciousness need not imply self-evaluation; for another, interesting and testable propositions can be made about the relations between items constructs. Consider, for example, the proposition that giving an increased attention to the public self which leads to increased social anxiety and lowered self-esteem in some people (Buss, 1980). As Buss (1980) put it; "Public self-awareness need not lead to social anxiety or diminished self-esteem .... Good hostesses and successful politicians are keenly aware of themselves as social objects yet suffer neither low self-esteem nor social anxiety (p. 36).

**Social Support**

Observations in a variety of settings have led to the idea that social support (a) contributes to positive adjustment and personal development and increased well-being in general (Cohen and Wills, 1985; Brenda et al., 1990) and (b) provides a buffer against the psychological consequences of exposure to stressful life events (Cohen and Syme, 1985; Cohen and Wills, 1985; Kessler and Mcleod, 1985).
According to Caplan's theory (1974), social support implies enduring pattern of continuous or intermittenties that play a significant in maintaining the psychological and physical integrity of the individual over time. For Caplan, a social network provides a person with "psychosocial supplies" for the maintenance of mental and emotional health.

Social support is usually defined as the existence or availability of people on whom we can rely, people who let us know that they care about value, and love us. Bowley's theory of attachment (1969, 1973, 1980) relies heavily on this interpretation of social support. When social support, in the form of an attachment figure is available early in life, Bowley believes children become self-reliant, learnt to function as support for others, and have a decreased likelihood of psychopathology in later life. Bowley has also concluded that the availability of social support bolsters the capacity withstand and overcome frustrations and problem solving challenges. There are some studies which seems to support this concept of social support among children and adolescents and in addition to these there is also evidence of the detrimental effects of lack of support in adults (see review Sarason et al., 1983). The studies reported by Sarason et al. (1983) were on the medical surgical, and psychiatric disorder patients. Much of the research on social support has been directed toward
developing measures of social support. The diversity of measures of social support is matched by the diversity of conceptualization concerning its factors.

Despite strong support for a positive relationship between perceived social support and adjustment to stressful life-events, much more empirically derived evidence is needed to provide a basis for theoretical advances in the area of social support (Heller, 1979). Theoretical reviews of the social support literature have increasingly called for research to move beyond simple demonstrations of the effects of social support to analysis of the mechanisms by which support exerts its beneficial effects (e.g. Cohen, 1988; LaRocco, et al., 1980; Thoits, 1986; Wallston et al., 1983).

Recent research suggests the value of exploring personality-social support relationship. How individuals describe their personal characteristics seems to be related significantly to their self described support levels. Social support correlates positively with self-esteem, extraversion and negatively with neuroticism, depression, hostility, loneliness, anxiety and lack of protection in diverse samples. Findings concerning relationship between social support as an individual difference variable and the personality factors suggests the need for conducting the present study.
The purpose of this research is to determine the relationship of self-esteem and self-consciousness with social support (i.e. actual and ideal) among pre-menopausal, transitional menopausal, menopausal and post-menopausal women. One potential risk for negative psychological outcomes following menopause is a lack of actual or ideal support from spouse, family, friends etc. during the menopausal phase. Social support may be particularly important for successful adjustment between the menopausal women and their family members because of the strong social stigma attached in this culture. Many women who develop menopause are reluctant to inform others about this disorder, especially during the treatment period. The theoretical perspective with regard to the relationship between social support and self-esteem and self-consciousness suggest that the actual and ideal support may directly influence self-esteem and self-consciousness. No direct links were observed between social support and these measures.

Research Objectives

The main objectives of the present study are as follows:

1. To determine the relationship between scores on self-esteem and self-consciousness among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.
2. To determine the relationship between scores on self-esteem and actual social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

3. To determine the relationship between scores on self-esteem and ideal social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

4. To determine the relationship between scores on self-consciousness and actual social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

5. To determine the relationship between scores on self-consciousness and ideal social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

6. To determine the partial correlations between self-esteem and self-consciousness (when the variable of actual/ideal social support is partialled out) among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

7. To determine the partial correlations between self-esteem and actual/ideal social support scores (when the variable of self-consciousness is partialled out) among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.
8. To determine the partial correlations between self-consciousness and actual/ideal social support scores (when the variable of self-esteem is partialled out) among the pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

9. To determine the significance of partial $r (r_{12.3}, r_{13.2}, r_{23.1})$ at the 0.95 confidence interval among pre-menopausal transitional menopausal, menopausal and post-menopausal women.

10. To determine the multiple coefficient of correlations between scores actually earned and scores predicted on the self-esteem from the two variables—self-consciousness and actual/ideal social support scores among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

11. To determine the significance of multiple $R$ at the 0.95 confidence interval among the pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

12. To show the relative incidence (in percentages) of hot flushes, night sweats and sleeplessness among pre-menopausal, transitional menopausal, menopausal and post-menopausal women on Section A of menopause symptoms checklist.

13. To determine the difference between pre-menopausal and transitional menopausal, pre-menopausal and menopausal, pre-menopausal and post-menopausal, transitional menopausal and menopausal, transitional menopausal and post-menopausal, and menopausal and post-menopausal women on Section B scores of MSC.