PSYCHOLOGICAL WELL-BEING, SELF-CONCEPT, AND MARITAL SATISFACTION AMONG PRE-, PERI-, AND POSTMENOPAUSAL WOMEN

BY

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CERTIFICATE

Certified that Ph.D dissertation titled **"Psychological Well-Being, Self-Concept, and Marital Satisfaction among Pre-, Peri-, and Postmenopausal Women"** prepared by **Ms. Remona Salik** has been approved for submission to Quaid-i-Azam University, Islamabad.

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Abstract

Present study was undertaken to investigate the phenomenon of menopause and its impact on women's psychological well-being, self-concept and marital satisfaction. This study was divided in four phases. Focus groups were conducted in Phase I to get baseline information from Pakistani women in their menopausal stages (pre, peri and post) about menopausal symptoms and other selected variables. Information was collected from working and non-working women. The collected information laid the foundation for the formulation of hypotheses as previous researches had diverse findings. Four instruments were selected to measure menopausal symptoms and other variables. The Ryff Scale of Psychological Well-Being (Ryff, 1989), translated into Urdu by Ansari (2010), and ENRICH Marital Satisfaction Scale (Olson, 1989) translated into Urdu by Iqbal (2010) were used to measure psychological well-being and marital satisfaction. Whereas Tennessee Self-Concept Scale, (TSCS-2) (Fitts & Warren, 2003) and Green Climacteric Symptoms Scale- GCSC (Greene, 1998) were translated in Phase II of the present study. The test-retest reliability of the TSCS-2 and GCSC were found to be satisfactory. Pilot study was conducted in Phase III on sample (N=60) to evaluate psychometric properties of the instruments and preliminary analysis was also conducted. Results of pilot study gave satisfactory psychometric properties of instruments and other analysis paved the way for main study. Premenopausal women (n=116), Perimenopausal women (n=116), and Postmenopausal women (n=116) were selected for main study and the collected data was statistically analyzed. Results revealed acceptable range of item-total and inter-scale correlation coefficients and satisfactory reliability coefficients of the instruments. Results revealed that perimenopausal women experienced more menopausal symptoms than pre and postmenopausal women. Post-hoc differences

revealed that women from perimenopausal and postmenopausal groups had low level psychological well-being, relatively negative self-concept, and low level of marital satisfaction as compared to women from premenopausal group. Hierarchical multiple regression analysis indicated significant predictive relationship of peri-menopausal symptoms and self-concept. Mediation analyses were conducted and results revealed that marital satisfaction and psychological well-being are mediating the relationship between self-concept and menopausal symptoms. Analysis of demographic variables indicated that working women experienced fewer menopausal symptoms than non-working women. The perimenopausal women with lower level of education experienced more menopausal symptoms as compared to women from other two groups. Perimenopausal women belonging to lower income families have high mean scores than other two income groups. The implications based on the findings for health care as well as further research have been discussed.

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Chapter-I

Introduction

Development is always considered to be a continuous process. Midlife is considered to be one of the most significant events during development. It is envisioned to be a transition from one phase of development to another phase. In woman especially, along with the changes in other aspects of her life, she faces a major change in her physiology often known as menopause.

Centuries of our history folklores and fairy tales have cast women, after the biological transition as witches, hags and crones. The phase encompasses a significant range of life stages. Some women are having their first babies when they are over the age of 40 years. Others are dealing with infertility. Some have made a considerable decision not to have children. Some would have like to have children in the context of a committed relationship but did not find a satisfactory relationship, or must make their peace with a lifelong inability to conceive, there are also women who by forty have teenager children or are grandmothers. Menopause is recognized as a developmental milestone which marks the transition to another phase of life that affects the women's self-image, sexual identity, and quality of life (Tandon, Mahajan, Sharma, & Sharma, 2010).

A women's experience of menopause is majorly shaped by her own psycho-social, and cultural contexts in which she lives; her observations; her expectations and reactions of significant people in her life (Lock 1988; Olosfsson & Collins, 2000; Winterich & Umerson 1999).

Menopause is one of the most significant stages in women's life. They face many changes during this stage which are not only biological but also psychological.

Menopause is not a disease but causes severe physical and psychological problems in women's health (Rostami, Ghorfranipour, Ramazanzadeh, & Kazemnejad, 2004). The biological changes during this phase influence their daily life activities including physical and emotional health (Blumel et al., 2000; Oldenhave, Jaszmann, Haspels, & Everaerd, 1993). Further research about menopause will help in discovering variables that have significant relationships with menopausal symptom and will also helpful for health professionals dealing middle aged women.

Well-being among women in Menopausal Transition (MT) is affected by the bio-psycho-social changes. It is unclear whether there is variation in women's well-being across the MT, and if so, how it can be explained. In a longitudinal study that modeled Australian women's health during MT, change in well-being (measured as the difference between positive and negative mood scores) was related to symptoms, other life events, feelings for partner, and exercise; there was non significant direct association of well-being with hormonal status (Dennerstein, Dudley, Hopper, Guthrie, & Burger, 2000). Study of bio-psycho-social changes and their association with menopausal symptoms will help in prevention, intervention and treatment of variety of problems associated with menopause.

For most of the women menopause means aging and that is frightening for them. Women mostly pretend that they are just half way through their lives, rather than appreciating the maturity conferred by the years. Women in some cultures other than West pay no particular attention to menopause, or experience it as an opportunity for greater freedom (Stewart, 2003; Webster, 2002).

Perception of self is an important variable among women playing vital role in psychological development. Self-concept of women also undergoes a significant

change during menopause. A study conducted by Bertero (2003) revealed the cases of women reporting to have developed a sense of loss and devaluation of their physical and psychological role as a social entity during menopause. Other studies by Bloch (2002) and Elavsky (2005) believe in the undeniable role of the self-concept as one of the symptoms of menopause in women.

Menopausal women hold the stereotype of depressed, irritable, wrinkled, and asexual. In 1907, the German Psychiatrist Kraeplin (as cited in Brown, Sweeney, Loutsch,, Kocsis, & Frances, 1984) coined the term *involutional melancholia* to refer to the unavoidable full-blown depressive episode of menopause. This belief continues today, i.e, anxiety, depression, irritability, and fatigue increase after menopause. Since, in patriarchal societies, women are valued largely for their reproductive capacity, their fertile years are designated as 'normal' and the end of fertility as 'abnormal'. Thus, women are assumed to be at their happiest and most fulfilled when pregnant, giving birth, or taking care of small children and to experience grief and depression when no longer able to reproduce (Gannon, 1999).

Mathews et al. (1990) reported that there were rather negative psychological consequences occurring as a result of the menopause, than there were either '… null effects (and a trend for a few positive effects) on various indices of psychological functioning in contrast with other studies' (p. 350).

In midlife, most of the women are adept at running a household. Society, including many women does not acknowledge women's domestic organizational responsibilities. Women in midlife are responsible for teenagers and aging adult relatives (Misra as cited in Stewart, 2003). The meaning of menopause and the nature

of the so-called generation gap vary from subculture to subculture and family to family within the larger society (Stewart, 2003).

The changes arising during the middle years have complex influence on relationships. Women may experience breakdown in their marital relationship. Such a transformation may be perceived differently e.g., some women may find it as worsening whereas others perceive it as a source of freedom from a long-term, monotonous, and cumbersome routine (Ballard, 2003).

In Pakistan and other researchers as well have found that it is not being married but the marital satisfaction and interactions within the marriage that positively or negatively confluence the physical and mental health of spouses (Fielder & Kurpius, 2010; Hashmi, Khurshid, & Hassan, 2006; Qadir, Khalid, Haqqani, Huma, & Medhin, 2013). In earlier research (Gove, Hughes, & Briggs-Style, 1990) being unhappy in one's marriage was found to be more detrimental to one's psychological well-being than being single, divorced, or widowed (Suhail & Chaudhry, 2004; Mohsin, Adnan, Sultan, & Sabira, 2013).

The biological and psychological changes during this phase are affecting the women in their global functions. The above mentioned relationships among variables in this transitional phase in women are worthy of further scientific exploration. But first the term menopause and the associated features need to be understood in detail.

What is Menopause?

The word menopause is derivative of Greek *menos* (month) and pauses (cessation). The term is generally referred to the climacteric (*klimakter* meaning rung of the ladder). The dictionary defines climacteric as referring to the period of sexual

decline and infertility. Such a definition does not capture and describe the complex and intense changes which are brought about by cessation of ovaries (Peterson, Thacker, Corso, Marchbanks, & Koplan, 2004).

In 1980, the World Health Organization (WHO) defined the term natural menopause as the permanent stoppage of menstrual cycle as a result of the loss of follicular function of ovaries. Hence, the term *induced menopause denotes to* the cessation of menstrual periods caused by either surgical removal of both ovaries (with or without hysterectomy) or iatrogenic (illness caused by medical examination) ablation (medical treatment of removing tissues) of ovarian activity e.g., by chemotherapy or radiation (Kaewbronthum, 2003).

Menopause is the medical term that strictly defined, means women have not had menstruating for a 12 months (Utian, 2001). Menopause is the time of cessation of ovarian function resulting in a permanent amenorrhea (absence of menstrual periods). 12 months of amenorrhea confirms that menopause has set in, and therefore it is a retrospective diagnosis. Menopause naturally occurs at the age of 51 years, although many women cease to menstruate a few years before or after this age (Ballard, 2003).

Menopause usually occurs between ages of 45 and 54 years with an average of 51 years (Jassim & Al-Shboul, 2008). Research conducted in Lahore by Yahya and Rehan (2003) found mean age at menopause is 49 years. However, it is not uncommon to see a menstruation well beyond the age of 50 years. This delayed menopause may be related to good nutrition and better health (Padubidri & Daftary, 2005). Menopause setting before the age of 40 is known as premature menopause (Ballard, 2003; Barbo, 1998; Padubidri & Daftary, 2005). In addition, other factors

also contribute to the age of the menopause, some women experience ‘premature menopause.’ Only 1% women experience premature menopause and may suffer considerable distress (Ballard, 2003). Menopause age is not related to menarche, race, socioeconomic status of pregnancies and lactation, or taking of oral contraceptives (Padubidri & Daftary, 2005).

According to the WHO meeting in Geneva in 1996, natural menopause was defined by the scientific group as absence of menses for consecutive 12 months with no other obvious reason, such as being pregnant, lactation, use of hormone replacement therapy (HRT), malnutrition, or removal of the ovaries or uterus.

In accordance with the definitions of menopause mentioned earlier, this phase is a transition and developmental theorists divided it into three phases.

Phases of menopause

In women’s life, menopause is a period that is characterized with certain physical and biological changes due to the estrogen deficiency and divided into three types (Hunter & Rendall, 2006; Kaewbronthum, 2003) as follows:

1. *Premenopause* include women who have regular menstruation within the previous 12 consecutive months.
2. *Perimenopause refer*s to changes in menstrual flow for the last 3 months or less than 12 months ago.
3. *Postmenopause* refers to the cessation of menstrual bleeding for last 12 months.

The most obvious sign of menopause is a change in women’s normal menstrual flow. Irregularity in bleeding when there is no ovulation. In addition to the

irregularity, most women report heaviness of their periods during the time leading up to the menopause. The explanation of the heaviness of menstrual bleeding is the loss of over 80ml of blood in one menstrual cycle. Eventually, whether spontaneously or because of surgical intervention, all women stop having periods. Although it has been suggested that the absence of periods can make women feel less feminine, most women seem to welcome not having to deal with what they see as the inconvenience of menstruation (Nisar & Sohoo, 2010).

In addition to the experience of menopausal symptoms like hot flushes, sweating at night, and dryness of vagina, women having premature menopause also exhibit concerns about their ability to have children (Ballard, 2003).

The perimenopause is the phase before and after the last menstrual period when hormone levels vary considerably and symptoms of menopause may be present. The postmenopausal phase extends for the remainder of life (Barbo, 1998). Despite of average age of menopause most women report experiencing symptoms from age 45 years onwards. Symptoms, therefore, tend to occur over a number of years, often quite subtle when they start. Since the only sure sign that women have reached the menopause is the cessation of menstruation for 12 consecutive months, recognition of symptoms as 'menopausal' may occur after the event (Norman, 1981). It is important that menopausal symptoms may begin long before the cessation of menstruation (Campbell & Monga, 2000). The study by Neugarten and Kraines (1965) reported low frequency of menopausal symptoms among women of postmenopausal stage.

Symptoms of menopause. Menopausal symptoms cluster into three factors as given by Elavsky and McAuley (2005).

The three clusters of symptoms are:

1. Vasomotor symptoms
2. Somatic symptoms
3. Psychological symptoms

Vasomotor Symptoms. Vasomotor factors include symptoms like hot flushes and night sweats (Greene, 1998). Classical vasomotor symptoms are hot flushes and night sweats. These are common and occur in at least 70% of perimenopausal women. Vaginal dryness is vitally important symptom of menopause; not least because it is frequently missed the vaginal skin is dependent on estrogen for the depth and lubrication. Furthermore, with loss of plasma estrogen the skin becomes thin and poorly moisturized (Campbell & Monga, 2000).

Hot flushes. The hot flush is the most commonly recognized and reported symptom of menopause. It is a sensation of warm to intense heat and very different from a blush, which characteristically occurs over the face and chest. Usually it is followed by the hot flush, a vasodilatation of blood vessels and flushing of the skin. Hot flushes occur in 60% to 85% of women; 10% have none. About 10% to 15% have them severely enough to interfere with daily living activities and/or sleeping. Many women recognized hot flushes and are able to tolerate them with some mild living adjustments; they may not seek medical advice. The common duration is 2-3 years, but in 50% they persist up to 5 years. However, there is a group of women in whom hot flushes persist more than 15 years and occasionally into the 70s and 80s. Hot flushes may also be referred to as night sweats and vasomotor instability (Barbo, 1998).

The symptoms that accompany hot flushes (e.g., facial flushing, perspiration, and palpitation) contribute to the discomfort, inconvenience, and even embarrassment

reported by women in some cultures. At the opposite end of the culture spectrum are women from Japanese, Chinese, and Mayan cultures, where there is not even a word to describe hot flushes (Speroff, Glass, & Kase, 1999).

A Swedish study of women aged 52 to 54 years showed that women who were physically active experienced around half the amount of flushes as women who were not physically active. This is may be due to an increased level of brain chemical, endorphin which is released during exercise (Ballard, 2003)

Other factors such as diet, climate, genetics, and reproductive history undoubtedly play a role in the attribution of discomfort from hot flushes (Robinson, 1996).

Some of the studies in Bangladesh also reported that hot flushes were experienced by women in menopausal stage. Rahman, Salehin, and Iqbal (2011) reported that 35.8 percent of the women from the sample selected from Kushtia, Bangladesh experienced hot flushes as a significant symptom.

Pakistani women also reported hot flushes as an important and disturbing stimulus (Nisar & Sohoo, 2009). The study reported that 66.3% women reported to have experienced hot flushes in menopausal stage. Another study conducted in rural Sindh reported that 69.4% women experienced hot flushes (Nisar, Sohoo & Sikandar, 2012). Adhi, Hassan, Shoaib, & Tauheed (2007) reported that 82% women from Karachi, Pakistan reported hot flushes in menopausal stages.

Night sweats. Ballard (2003) described that in addition to hot flushes, women frequently report experiencing night sweats, which often leads to considerable sleep disturbance. Night sweats may continue for many months, and occasionally a couple

of years, additional symptoms may result from an ongoing lack of sleep. Symptoms such as low mood and lack of concentration are just as likely to be caused by a lack of sleep as they are to be caused by changes in estrogen levels.

Bangladeshi women in menopausal stages also reported to have experienced night sweats. In a study 35.8% woman in menopausal stages reported night sweats as a common symptom (Rahman et al., 2011).

Night sweat is also a common symptom reported by Pakistani women in their menopausal stages. In a study 46.5% of the women were reported to have experienced night sweats (Nisar & Sohoo, 2009). Another study conducted in the rural areas of Sindh province Pakistan reported that 69.4% rural women in menopausal stage reported night sweats (Nisar et al., 2012). Another study reported that 5% of the women in menopausal stages experienced night sweats (Adhi et al., 2012).

The somatic symptoms. Somatic symptoms like feeling dizzy or faint, pressure or tightness in head or body, parts of body feeling numb or tingling, headache, muscle and joint pains, loss of feeling in hand and feet, and breathing difficulty.

Vaginal dryness and loss of libido. Vaginal dryness is a vitally important symptom of menopause because it can lead to significant disharmony between partners in a relationship. The vaginal skin is dependent on estrogen, the loss of plasma estrogen it becomes thin and poorly moisturized; although, this does not happen to all women. The women's health study revealed that around one-third to a half of women report experiencing sexual problems during and after the menopause. The key concern was a lack of sexual desire. Changes in sexual function associated with aging ad menopause are very common. Avis et al., (2009) reported that about

40% of women ages 51-61 years (*N*=200) had lower sexual desire than they did when they were in their 40s. Women may feel guilty about their lack of sexual interest and the impact that it has on their relationship with their husbands (Ballard, 2003; Conboy, Domar, & Connel, 2001; Defey, Storch, Cardose, Diaz, & Franandez, 1996; Devi, Hahn, Massimi, & Zhivotovskaya, 2005; Huerta, Mena, Malacara & Leon, 1995; Khademi & Cooke, 2003; Obermeyer, Chorayeb, F Reynold, 1999; Yangin, Sozer, Sengun & Kukulu, 2008).

Women in menopausal stages from Asian countries also reported similar difficulties in sexual functioning and termed vaginal dryness as one of the major reason responsible for it. Nisar and Sohoo (2009) found that 16.8% of women in menopausal stages reported vaginal dryness. Findings of another study revealed that 26% women in menopausal stages experienced vaginal dryness and related sexual difficulties (Nisar, et al., 2012). Research conducted in Bangladesh affirmed that 36% women in menopausal stages reported vaginal dryness and sexual difficulties (Rahman et al., 2011).

Urinary symptoms. Urinary symptoms also occur as estrogen levels decrease. There is thinning of urethral lining and shortening of the urethra. Relaxation of the muscles of the pelvic floor may also distort the anatomical position of the bladder neck. These changes often lead to incontinence and recurrent urinary tract infections. About 30% of women experience urinary incontinence, although less than half of these women seek medical help for the condition (Grodstein, Clarkson, & Manson, 2003). Studies also have that, following the menopause, over a quarter of women experience some form of urinary symptoms. The most frequently reported symptoms are urgency and frequency in passing urine, incontinence and pain on passing urine

(Ballard, 2003b; Conboy et al. 2001; Devi et al. 2005; Obermeyer et al. 1999; Rizk, Berner, Ezimokari, Hassan, & Micallef, 1998).

Studies in Asian countries also narrated urinary problems among women in menopausal stages. A study conducted in Pakistan declared that 52% women in menopausal stages in the sample reported high frequency of urination and 41% reported involuntary urination during laughing or coughing (Nisar & Sohoo, 2009). Another study reported urinary problems among 32% of the women in menopausal stages (Nisar, et al., 2012). A research from Bangladesh found that 36% women in menopausal stages reported urinary problems (Rahman, et al. 2011).

Aches and pain in joints. Two third of the women in the Women's Health Study surveyed reported experiencing aches and pains in their joints around the time of the menopause, these were not generally rated as being severe (Ballard, 2003; Conboy et al., 2001; Nagar & Dave, 2005; Obermeyer et al, 1999; Rizk, et al. 1998).

Studies in Asian countries also seconded that aches and pains are common among women in menopausal stages. In a research conducted in Pakistan, 81.7% women in menopausal stages reported pain in muscles and joints and 73% women aches in the back of neck and head (Nisar & Sohoo, 2009). Another study found that 33.1% of the women in menopausal stages reported aches and pain (Nisar, et al., 2012). Similarly a study conducted by Adhi et al., (2007) reported 2% women with experiences related to aches and pain. Bangladeshi women also reported similar problems. In a study conducted by Rahman, et al (2011), 77.6% women reported headache and 76.2% women reported muscles and joint discomfort.

Tiredness. In addition to losing sleep because of night sweats, changes in the estrogen levels may also affect the women's ability to sleep which causes feeling of tiredness. Tiredness may be a general feature of getting older (Ballard, 2003).

Tiredness is also a common symptom reported by Asian women in their menopausal stages. In a study 62.4% of the women were reported to have experienced tiredness (Nisar & Sohoo, 2009). Another study conducted in the rural areas of Sindh province, Pakistan reported that 83.7% rural women in menopausal stage reported tiredness and fatigue (Nisar, et al., 2012). Another study reported that 3% of the women in menopausal stages experienced tiredness (Adhi et al., 2012).

Bangladeshi women in menopausal stages also reported to have experienced night sweats. In a study, 60.9% women in menopausal stages reported tiredness as a common symptom (Rahman et al., 2011).

The psychological symptoms. during menopause women also experience some psychological symptoms like reduced energy and drive, difficulties in concentration, irritability, aggressiveness, fatigue, and variation in mood, anxiety, depression, introversion, senses of internal obstruction and inadequacy, loneliness, marital distresses, as well as attacks of panic and insomnia. The most frequently reported psychological symptoms are irritability, depression, hot flushes, tension, headache, and skin related issues (Kaewboonthum, 2003; Nisar & Sohoo, 2010; Yahya & Rehan, 2003). The physiological symptoms of menopause are partnered by a set of psychological symptoms that can be equally distressing and disabling. It is not known that whether these symptoms are due to lack of estrogen or chronic sleep deprivation. In addition, the perimenopausal years are frequently marked by life events such as divorce, departure of children, death of partner or parents and other

stressful occurrence that may contribute to the overall psychological pictures. Intrinsic personality type may also exert influence with the symptoms being more marked those with tendency to anxiety, neurosis and low self-esteem (Campbell & Monga, 2000).

Research evidence stressed that the severity, duration and nature of menopause symptoms are highly variable. Symptoms may be absent, fleeting, and mild or they may be severe and continue for years (Campbell & Monga, 2000).

Sleep disturbances. Large numbers of perimenopausal and menopausal women have complaints related to insomnia. Studies have shown that following the menopause, mostly women experience some form of alternation in sleep pattern. Women also reported difficulties regarding falling asleep and maintaining sleep (Conboy et al., 2001).

Studies in Asian countries also narrated sleep problems among women in menopausal stages. A study conducted in Pakistan declared that 58.2% women in menopausal stages in the sample reported sleep disturbances (Nisar & Sohoo, 2009). Another study reported sleep disturbances among 78.8% of the women in menopausal stages (Nisar, et. al, 2012). A research from Bangladesh found that 54.4% women in menopausal stages reported sleep problems problems (Rahman, et al., 2011).

Poor memory and lack of concentration. Many women noticed a change in their ability to remember things. Loss of memory and poor concentration may be related to falling estrogen levels, a lack of sleep can also be the cause of these symptoms (Ballard, 2003; Conboy, Domar, & Connell, 2001; Hachul, Bittencourt, Soares, Tufil, & Baracat, 2009; Mathews et al., 1990; Obermeyer et al., 1999).

Pakistani women also reported having difficulties in registering and remembering new information as an important and disturbing stimulus (Nisar & Sohoo, 2009). The study reported that 47.5% women in menopausal stage had poor memory and 37.6% reported to have problems in concentration and achievement.

Emotional disturbances. Life changes such as, problems with teenage children, the need to care for elderly relatives, relationship difficulties, and changing body image have all been shown to contribute to the experience of emotional symptoms at the time of the menopause. (Ballard, 2003; Conboy et al., 2001; McKinley & Lyon, 2008).

Some of the studies in Bangladesh also reported that hot flushes were experienced by women in menopausal stage. Rahman, et al. (2011) reported that 25.4% of the women in menopausal stages from the sample selected from Kushtia, Bangladesh experienced anxiety, 37.3% reported depression and 29.5% reported irritability.

Pakistani women also reported emotional disturbances in various studies. One such study found 54.5% women in menopausal stages felt depressed at times, 57.9% reported to have been impatient with other around them, 39.6% reported feelings of loneliness and 53.5 reported feeling of anxiousness and nervousness (Nisar & Sohoo, 2009). Another study conducted in rural Sindh reported that 76.7% women in menopausal stages experienced symptoms of depression and 71.8% reported feelings of anxiety (Nisar, et al., 2012). Adhi et al. (2007) reported that 1.5% women from Karachi, Pakistan reported anxiety in menopausal stages.

Crawling sensation under the skin. Although women of all ages often report skin sensation related to menstruation, this is to be increased during the menopause (Ballard, 2003; Conboy et al., 2001).

Women's experiences of menopause vary greatly, and are often influenced by social, cultural, and biological factors. Some women experience hot flushes, parasthesia, dizziness, and insomnia before the cessation of menses while for some women these symptoms coincide with the menopause and still others, may not experience them for several years (Neugarten & Kraines, 1965). There are several conceptual models that help us to understand the menopausal transition and changes in health that come with it.

Menopausal symptoms and different cultures. Researches in various cultures gave different findings related to menopausal symptoms. Ayranci, Orsal, Arslan, & Emeksiz, (2010) reported that socio-cultural factors affect the onset of menopause. According to Fuh, Wang, Lu, Juang, and Chiu (2001) hot flushes, sweating and vaginal dryness are main menopausal symptoms. High rates of these symptoms have been reported among women of North America and Europe as compared to women of Asia (Dennerstein, 1996). Japanese Americans reported significantly less frequent symptoms as compared to Europeans and Americans (Brown, Sievert, Morrison, Reza, & Mills, 2009). Studies with Caucasian women revealed high prevalence of menopausal symptoms ranging from 40% to 70% (Avis, Crawford, & McKinlay, 1997; Dennerstein, et al., 1993; Nedstrand, Perti, & Hammer, 1996).

The experience related to the menopause is a bio-psycho-socio-cultural process. For the majority of women, the menopause is a relatively neutral event,

although women living in Western countries, in general report more symptoms than those from nonwestern cultures. Psychological factors including anxiety, stress, thoughts and beliefs and self-esteem influence the experience of hot flushes and a cognitive behavioral model is described which compatible with a bio-psycho-socio-cultural perspective (Hunter & Rendall, 2006).

Conversely the study on Asian Women reported low rates of menopausal symptoms ranging between 10%-50% (Boulet, Oddens, Lehert, Vemer, & Visser, 1994). Another study in Turkey showed prevalence of 35%-90% (Carda et al., 1998). The studies conducted in United Arab Emirates found the most frequent symptoms experienced by women were hot flushes and urinary inconsistency (Rizk et al., 1998). In Hyderabad, Pakistan, women experienced symptoms like backache, body aches, insomnia, and loss of memory, hot flushes, mood swings, and depression (Nisar, Zehra, Haider, Munir, & Naeem, 2008). The severity of symptoms was found more distressing for perimenopausal women than for women at other status of menopause (Nisar & Sohoo, 2010).

Few studies conducted in Pakistan reported that mostly women do not consider menopausal symptoms much severe and consider them as natural (Nisar et al., 2008; Yahya & Rehan, 2003). Physical and psychological symptoms were highly significant in Asian women (Nisar & Sohoo, 2010). The type of experiences women face during or before menopause, build their attitude regarding menopause. Women who face less troublesome experiences have mostly positive attitude towards menopause as compared to women who have face more troublesome experiences and symptoms (Jassim & Al-Shboul, 2008; Pradhan & Srivasta, 2003).

Menopause has been a topic of interest for many researchers for decades. The findings are consolidated in the form of different researches and afterwards other researches cross-validated them. The models of menopause help the researchers to understand the phenomenon from different perspectives.

Models of menopause. It is probable that any single model is not sufficient, and all are necessary to explain the complex experience of menopause.

Biomedical model. According to the Biomedical model both physical and psychological changes associated with midlife in women are viewed as the direct result of estrogen withdrawal or the result of biochemical changes concomitant with estrogen withdrawal, such as gonadotropin levels found in menopausal women. Since medical model is focused on the identification and treatment of problems, only changes reflecting loss or deterioration were studied, whereas positive aspects of menopause have been outside the purview of medicine. Unfortunately, the medical view of menopause has becomes the public view of menopause (Gannon, 1999).

At the time of birth a woman has almost seven million ovarian follicles, having egg cells. The number of follicles keep decreasing soon after birth, until becomes nil after menopause. This decrease is found to be rapid by the age of mid-thirties and the most significant reduction in follicles is observed by the mid-forties. Over the next few years the body increases its efforts to stimulate the remaining follicles to produce egg cells. Irregularity in the form of heavier or lighter menstrual bleeding may occur during this phase. By the age of mid-forties the ovarian follicles become less sensitive to stimulation by the hormone, Follicle Stimulating Hormone (FSH) when women enter their forties. During forties the follicles in female ovaries happen to be less sensitive to stimulation by Follicle Stimulating Hormone (FSH). At

premenopausal period the production of FSH is liable to be 10-15 times greater than the rate of production at the time of menopause. Ballard (2003) suggests to measure the degree of FSH through blood test to check if the woman is about to have menopause.

The period preceding menopause is highly susceptible to fluctuations in menstrual cycle. The length of menstrual periods changes most frequently at this time. Women may find their menstruation cycle shortened to 18-24 days followed by long menstrual periods. Occasionally, the cycle is missed which culminates in the cessation of menses. The level of estrogen and progesterone decreases at the age of 30 years. At the initial stage the reduction in the production of estrogen is slow but this decrease gets faster as the menopause approaches (Stewart, 2005).

Estrogen and progesterone serve several functions in woman's body. A female body undergoes many physical changes during postmenopausal period when it produces a comparatively lesser amount of female hormones. The areas sensitive to the estrogen are: breast, heart, brain, blood vessels, urinary and genital organs, skin and hair (Ballard, 2003; Stewart, 2005).

The biomedical model explains that physiological symptoms are result of biochemical changes experienced by midlife women. So, menopause is a biological/physical concept and present research will differentiate participants into pre-, peri-, and postmenopausal women on the basis of biological changes.

Apart from medical or physical aspects, there are some social variables playing significant role in the midlife of women. Such an impact was explained by psychosocial perspective.

Psychosocial perspectives. Qualitative studies have shown that many females consider menopause either as a positive or neutral phenomenon. The findings draw on the subjects' positive responses and feelings towards menopause such as relief from menstruation and the risk of pregnancy. On the other hand studies have also shown bleak concerns of the subjects like infertility, old age etc. (Hunter & Rendall, 2006; Nisar et al 2008; Yahya & Rehan, 2003).

While it has been suggested that there are over one hundred symptoms associated with the menopause, hot flushes, night sweats, and urino-genital symptoms (for example, frequency and urgency in passing of urine, and vaginal dryness) have been shown to have a definite link with changing levels of estrogen. Such symptoms include tiredness, emotional disturbances, crawling sensation under the skin, poor memory, and alternation in sleep pattern (Hunter & Rendall, 2006; Tandon et al., 2007).

Overall, the experience of psychosocial factors has been found to have a much stronger association with psychological symptoms than stage of menopause. Socio-cultural factors incorporate personal ways of living such as diet and exercise as well as reproductive system of the woman. Such factors are likely to affect not only the biological processes but also a woman's whole set of ideas and approach to menopause. Cultural explanations of these differences need to include lifestyle (diet, exercise, social factors, as well as reproductive patterns) which can affect biological processes, population differences in biology, as well as beliefs and attitudes towards the menopause and the social status of middle-aged and older women. So to speak this may be labeled as bio-psycho-socio-cultural process which is liable to change culturally, socially and temporally (Hunter & Rendall, 2006).

Psychological well-being is one of the major variables of present research and psychosocial perspective narrated dimensions/aspects of social variable.

Coincidental stress model. Hypothesis that particular stresses, common in midlife such as children living in home or the illness, or the death of a parent, predisposed women to aversive physical and psychological changes. Greene and Cooke (1980) interviewed 408 midlife women and noted that women experience the greater number of stressors and the most severe one between the ages of 35 to 54 years. Other theorists have found that hot flushes, and osteoporosis are caused by the hormonal imbalance, whereas some other somatic and psychological symptoms are due to the aging, personal history, and stressful events (Fogel & Woods, 1995; Rakoff, 1975). Marital unhappiness can be another stressful event for midlife women due to the dynamic changes in sex hormones and therefore becomes a source of stress for women (Santoro & Perry, 2009).

One of the objectives of present research is to find out the effect of menopause on marital satisfaction.

Cultural Relativism Model: This model suggested that in western cultures women have limited, relatively low status, and primarily to biological roles. Women are valued for their youthful attractiveness and for their capacity for bearing and raising children. When the women in western cultures are no longer capable to fulfill these major roles they view themselves negatively and experience adverse psychological and physical consequences. Porter, Penny, Russell, Russell, and Templeton (1996) studying Scottish women and Holte (1992) studying Norwegian women found that only classic menopausal symptoms hot flushes, and vaginal

problems were related to menopausal status while other reported difficulties were due to stress or aging.

There is a different picture in Eastern cultures. Indonesian postmenopausal women experienced most common symptom are fatigue, weight gain, atrophic vaginitis, and hot flushes, although the percentage of women reporting hot flushes was about half that in the US (Flint & Samil, 1990). Boult et al. (1994) found that there was a low rate of complaints in far eastern cultures. Women in only two countries complained of anxiety, and women in five countries complained of painful sexual intercourse. The lack of complaints in other than Western cultures is due to the women being unwilling to acknowledge the menopause.

There is difference of experience of menopausal symptoms in various cultures (Flint & Samil, 1990). Boult et al. (1994). Present research focuses on study of menopause in Pakistan which is considered one of the eastern cultures.

Apart from the famous models of menopause there are some other factors linked with this experience by women. These factors are not included in a specific model but their influence on women cannot be denied.

Factors effecting experiences related to menopause. Factors found to be associated with experiencing of symptoms during the menopause transition include, past psychological problems; social, educational and occupational status, poor health, stressful life events, body mass index, cigarette smoking, sexual orientation, number of children, level of physical activity, marital satisfaction, attitudes towards menopause and aging, and early life circumstances and experiences (Kaewboonthum,2003; Nisar et al., 2008; Sharma et al., 2007; Trivedi, Mishra, & Kendurkar, 2007; Yahya, & Rehan, 2003).

Smoking has been found to be one of the factors which affect the age of menopause. It has been reported that smoking triggers the menstrual cessation. The smoking women are likely to have their menopause on an average of one and a half to two years earlier as compared to those women who do not indulge in smoking practices (Ballard, 2003; Hunter & Rendall, 2006). Child bearing is another factor affecting the phenomenon of menopause. Ballard (2003) has pointed out the child production as one the determining factors which influence the menopause age. He suggests that the women who go through the process of child birth reach their menopause later than those who do not produce babies. Likewise, genetic inheritance also plays an important role in determining the age of menopause. Studies show that daughters tend to have their menopause at the same age when their mothers experienced theirs (Ballard, 2003).

The beginning of the menopause and symptoms accompanied it vary greatly from one woman to another (Bloch, 2002). Symptom is the perceptual data which a person draws as the experiences reflecting change in a person's biological, psychological, emotional, and sensational or cognitive status i.e., characterized or defined as illness. The person factors are dependent on the psychological factors because the person's factors depend on the nature of the women's character (Kaewboonthum, 2003).

Personal variables. There is a close relationship between pre-existing personal variables and the symptoms of menopause. Personal variables and menopause symptoms play a vice versa role: these variables influence the perception of the symptoms and in turn are sometimes influenced by the symptoms. Personal variables like age, gender, ethnic, marital, economic status and psychological variables such as personality traits, cognitive capacity, and motivation incorporate with sociological

variables which include the family unit, culture, and religion. Not less important part of personal variables are physiological variables including rest and the nature and pattern of physical activity. The context in which a symptom is addressed will determine the specific dimensions that should be emphasized.

Social factors. A change in women's social roles, the stress of child-rearing, adolescent children, empty nest syndrome, the illness partner, or the death of old age parents significantly influence experiences of menopause in the form of stress and tiredness which mostly women report while facing menopause or their symptoms (Stewart, 2005). As mid- and old-age women have decreased sexual activity, which leads to marital conflicts, and experiencing of menopausal symptoms (Gannon, 1999). Although many menopausal symptoms are likely to be caused by a lower estrogen level, they also appear to be influence by a number of social, psychological, and cultural factors. Women from a lower social class report more severe symptoms than their higher social class counterparts. In addition, women experiencing a higher level of satisfaction in their relationship with a partner have been found to experience a lower level of menopausal symptoms. It is difficult to know, whether relationship dissatisfaction cause a higher level of menopausal symptoms or whether menopausal symptoms lead to dissatisfaction with relationships (Ballard, 2003).

Biological factors. Health problems unrelated to the menopause such as diabetes and experience of menopausal symptoms has a psychological impact on self-esteem, self-confidence, self-image, and decision-making. As the stereotype of the sexual, postmenopausal women, and the emphasis on menopause as the most crucial developmental milestone for aging women derives from the myth, that throughout the life she is directed, determined, and governed by hormones, particularly estrogen, which have an emotional and psychological impact on women's life (Gannon. 1999).

The timing, nature, severity, and presumed importance of menopausal symptoms vary as well. The experience of menopausal symptoms is closely related to woman's expectations of symptoms (Bloch, 2002). Menopause is associated with a wide variety of symptoms and related experiences and some of these may have a negative impact on the quality of life of women as in perimenopausal women it is more their perception and expectation regarding menopausal experiences which make their phase very problematic (Kakkar, Kaur, Chopra, Kaur, & Kaur, 2007).

Environmental variables. Environmental variables are the aggression of conditions, circumstances, atmosphere and context within which the symptoms are perceived. Physical environment include home and work. Social environment include ones social network. Cultural aspect includes belief values, and practices. The environment characters are dependent on the socio-cultural factors because the sociocultural factors depend on women's environment (Kaewboonthum, 2003). Cultural factors like, a negative evaluation within society of older women, as western societies view older women a stigma, which is also a cause why they keep the old ladies in old houses. According to research conducted in various regions of the world constituting European and Asian countries, it was commonly noticed that among midlife women of different ethnic groups report certain ethnic differences in menopausal symptoms. White women reported that classic menopausal symptoms of midlife women are hot flushes, sweating, and vaginal dryness. A small number of Asian midlife women were reported to experience the typical menopausal symptoms. In Mexico none of the Mayan women participants reported any significant symptoms during menopausal transition. In some other cultures, women's health can simply be overlooked in the name of respecting other forthcoming needs of their family members. Furthermore, in some cultures; discussing women's bodily experiences like

menopausal symptoms might be forbidden. Thus, women in that particular culture would not report their menopausal symptoms and try to ignore the symptoms while hoping the transition would end soon (Im, 2007).

Women's biological, psychological, and social development across the life span is compromised by cultural, political, and economic factors creating long-long lifestyles, habits, expectations, and roles that place women at risk is to understand it, and to promote understanding of the physical and psychological well-being as they age (Gannon, 1999).

Menopausal transition affects different aspects of women including physical and psychological health. This transition also plays a role in the women's personal opinion about themselves. Ballard (2003) explained the following environmental factors that influence the women's experience of menopause.

Caring for elderly relatives. Changes in transportation and employment over the last century have resulted in a more mobile society, with family members' often living considerable distances apart. However, with an increased life expectancy, the aged relatives need support from their family members especially when they are less able to fend for themselves due to illness. Since women usually remain the main carers for elderly relatives, whether they are biologically related or related through marriage, the impact of a mobile society is generally greater for women than for men. The increasing need for women's support, however, often arises amidst a number of other life changes. Thus, women may find themselves torn between meeting the changing demands from teenage children or increased hours of employment, and helping to meet the needs of elderly relative.

Changes in employment and finance. Although gender differences associated with employment exist throughout the working life, some are definite to the middle years. The expenses of sending their children to university frequently cited as a reason of increase in women's hours of paid employment. For many women, this creates an extra burden as they also continue to have key responsibility for maintaining the home. However, women may have both positive and negative experiences concerning paid work. Having spent time at home and brining up children, women may view paid work as a new challenge. It often provides an opportunity to pursue a career, and may increase self-esteem or independence

Although work can offer new opportunities, increasing the number of hours spent in paid employment may create added stress, especially as women are still expected or feel the need to continue having primary responsibility for looking after the family and home. The other major employment change that women often face during midlife is early retirement. This may be taken voluntarily to meet increasing demands with elderly relatives or may occur because of redundancy. Making adjustments to retirement can however sometimes be difficult. While both men and women may experience changes in self-image associated with retirement, for women this occurs amidst a variety of other changes both social and biological.

Changing relationships with children. Relationships between parents and children change as children leave from home for further education or employment. However, this transition may not be problem-free, for parents have less control over their children's actions. In addition, children who are taking examinations or those having relationship difficulties often require emotional support. When children leave home, women experience a mixture of emotions. Some are thankful for their increasing independence, giving the parents more time to spend together. The findings

of the study by Bossard and Boll (2008) also supported that menopause is the period of crises for women as they have to adjust with the independence of their children. Other found it quite difficult to deal with the changes brought by their children leaving home. Although many women mention missing their children once they have left home, they generally adjust to the situation fairly quickly, often finding that there are advantages as well as disadvantages. Whilst much has been made of what is often termed, the 'empty nest syndrome', the majority of women adjusts very well to the changes brought about when children leave home. Where there are a number of role-changes, however, women may find it takes longer to adjust.

Death of family or friends. In addition to losing elderly relatives, women often have to face up to the death of friends and family members of a similar age to them. The loss of a loved one can be emotionally distressing in itself, especially when the person is of a similar age. It can have an additional effect of increasing the awareness of a person's own mortality. The feeling of loneliness after members of the family die can be particularly difficult to deal with during the middle years when a number of deaths may occur within a short time. Many women will have two parents and parents-in-law will be reaching the end of their lifetimes at a similar time.

Such a sense of loneliness, brought about by the death of friends and family members, often occurs at the same time that women are making adjustments to children leaving home and the move towards retirement, or indeed a return to paid employment. While these changes may be manageable in isolation, women may find them more stressful when they occur in short space of time.

Change in outlook on life. It is difficult to pinpoint what is it that brings many women to change their outlook on life during the middle years. Studies revealed that

around half of menopausal women re-evaluated their life as a result of the menopause. It is unlikely to be just one factor that makes women rethink their position but, rather, a combination of a number of factors. At some point, however, during middle years, women seem to take stock of their lives. For many women children often leave home around the time of the menopause and this often brings about a change in role for women. This can be an important factor in bringing about a changed outlook in life, especially for women who have remained at home to look after the family and home. However, the impact of children leaving home on a woman's outlook on life varies, with some women seeing it as a time for new challenges, while others are struggling to find fulfillment in life.

For many women, reaching the age of 50 years provokes a re-evaluation of life. While they often see the age of 50 as a landmark for old age, on the whole there is a sense of inevitability with ageing and therefore, it is not generally viewed negatively. Instead, when reaching the age of 50, there is a tendency to consider the half-way landmark in life, and the way in which the rest of life is spent, therefore, needs some careful thought. Reaching the age of 50 years and realizing that so much life has been spent already was disturbing for some women. This, however, does not generally last for very long and adjustments to being a person in their fifties are soon made.

In summary, women report menopause is a stage in their life where they feel the need to take stock and re-evaluate where they are going and what they are doing. Although this is probably something that we all do to some extent throughout our lives, it seems a more prominent feature of middle age. At this time, in addition to the menopause where biological changes are experienced, women have a number of other social changes. They reach the age of 50 years, they often have changes in social roles

such as caring for elderly relatives or returning to paid employment, and they are faced with an increased illness and possibly death of friends and relatives. All these factors can contribute to what is probably aptly termed ‘the change in life’, where women may find themselves re-assessing the past and planning for their future. Although women can find this a time of unsettlement, this really lasts for long and usually results in a positive outlook for the future.

Present study focused women in menopausal stages (pre, peri and post) where the physical changes are affecting the psychological and social aspect of their lives. The said changes lead to the changes in daily-life activities, especially the general out. Physical changes in this stage are usually accompanied by psychological and social difficulties. Present study included psychological well-being as an important variable and aimed to find its link with changes in menopausal stages.

Psychological Well-being

“Well-being” was first used the field of health. The World Health Organization (WHO) defined health as a positive state of physical, mental, and social well-being, not merely the absence of disease or infirmity (WHO, 2006).

Well-being is a state of physical health and psychological wellness that permits for optimum functioning in a dynamic environment. This state implicates the capability to balance personal and work life, and is also associated with physical, psychological, social, and spiritual health. Every person experiences well-being in different ways and each individual uncovers his/her own strengths to achieve it (Blalock & Blalock, 1999).

Psychological well-being has been one of the major variables in present study. Psychological constructs can be best understood by studying different conceptual models.

Conceptual models of psychological well-being. Many theories of psychological well-being have been proposed, these theories can be categorized into three major paradigms including; ***Need and goal satisfaction*** this paradigm centers on the idea that the reduction of tensions leads to happiness. They argue that individual attain psychological well-being when they move towards an ideal state or accomplish a valued goal. Secondly, ***Process or Activity***, Shelden, Ryan and Reis (1996) found that people were happiest on days when they engaged in activities for intrinsic reason. Similarly, Csikszentimihalyi (1975), Cantor and Blanton (1996), and Harlow and Cantor (1996) emphasized the importance of active participation in life tasks. When individuals are approaching their goals or are engaged in interesting activities, they experience psychological well-being. Third as ***Genetic and Personality Predisposition*** and according to this paradigm, there is an element of stability in people's level of psychological well-being that cannot be explained by the stability in the conditions of people's lives. These theories argued that psychological well-being is strongly influenced by stable personality and genetic dispositions (Synder & Lopez, 2002). There are three major types of models used to describe the concept of psychological well-being which are as follows.

Two domain model of well-being. Bradburn (1969) presented two domain model of well-being. The model explained two types of affect; Positive Affect (PA) and Negative Affect (NA). This model termed these affects in orthogonal dimensions. Each affect has unique correlates and each contributes to well-being. For example NA is found to relate to unpleasant events (Warr, Barter, & Brownbridge, 1983) and

health complaints (Watson, Clark, & Carey, 1988), while PA is found to relate to pleasant events.

Diener and colleagues conducted a series of studies on well-being (Diener, 1984; Diener & Larson, 1993; Diener, Larson, Levine, & Emmons, 1985). They presented a theoretical model of well-being. This model filled the gap of knowledge between past controversies which emerged as a result of Bradburn's model (Diener, et al., (1984) never used the word 'model' but it has been inferred from their findings).

However, Diener et al. (1984) clarified that positive and negative affect are components of well-being and they are not independent in some events of life. Each type of affect clearly suppresses the others. Both types of affect are not independent even in terms of their frequency of occurrence. Obviously, the more a person feels positive or negative effect, the less the person will feel the other. Feelings of happiness (positive affect) clearly mean suppression of sadness (negative affect) at the time of experience.

A multidimensional model. It is the most recent model of psychological well-being is presented by Ryff and Keyes (1995). They found that psychological well-being encompasses six distinct dimensions of wellness including: Self-acceptance, Purpose in life, Personal Growth, Positive relations, Environmental mastery, and Autonomy. Ryff and Keyes (1995) claimed that this model explains the structure of psychological well-being in a more meaningful way than it was explained through early approaches. They said that this model is superior to two domain model (Bradburn, 1969) and the single factor model, which emerged through life satisfaction research (e. g., Sauer & Warland, 1982), grand quality of life research (Heady, Kelley, & Wearing, 1993). The conclusion drawn by Ryff and Keyes is that psychological

well-being is a multifaceted construct which encompasses positive self-regard, mastery of the surrounding environment, quality relations with others, continued growth, development, purposeful living, and the capacity for self-determination. The components of Ryff's model (1995) of psychological well-being are described as follows:

Autonomy. It is the sense of self-determination as considerable emphasis in literature with reference to psychological well-being on such qualities as self-determination, independence, and regulation of behavior from within. Self-actualizers are described as showing autonomous functioning. The fully functioning individual is also described as having an internal locus of evaluation, where by one doesn't look towards others for approval, but evaluates oneself by personal standards, individuation is seen to involve a deliverance from convention, in which the person no longer clings to the collective fears, beliefs, and the law of masses. The process of turning inward in the later years is also seen by life span developmental theorist to give the person a sense of freedom format the norms governing everyday life.

Environmental mastery. The individual's ability to choose or create environments suitable to his or her psychic conditions is defined as characteristics of mental health. Maturity is seen to require participation in a significant sphere of activity outside of self. Life span development is also described as requiring the ability to manipulate and control complex environments. These theories emphasize one's ability to advance in the world and change it through physical or mental activities. Successful aging also emphasizes the extent to which the individual takes advantage of opportunity. These combined perspectives suggest that participation in and mastery of environment is important ingredients of an integrated framework of positive psychological functioning.

Personal growth. Optimal psychological functioning requires not only that one achieve the prior characteristics, but also that one continue to develop one's potential, to grow and expand as a person. The need to actualize oneself and realize to experience is a key characteristic of a fully functioning person. Such an individual is continually developing and becoming, rather than achieving a fixed state.

Positive relation with others. Many of the preceding perspective of psychological wellbeing emphasize the important of warm, trusting interpersonal relations. The ability to love is viewed as the central component of mental health. Self actualizers are described as having strong feelings of empathy and affection for all human beings and as being capable of great love, feelings and more complete identification with others. Adult development stage theories also emphasize the achievement of close union with others and guidance and direction of others thus the important of positive relations with others is repeatedly stressed in these conceptions of psychological wellbeing.

Purpose in life. Mental health is defined to include beliefs that give one the feeling there is purpose in and meaning to life. The definition of maturity also emphasizes a clear comprehension of life's purpose, a sense of directedness, and intentionality. The life span developmental theories refer to a variety of changing purpose or goals in later life. Thus, one who functions positively has goals, intentions and a sense of direction, all of which contribute to feeling that life is meaningful.

Self-acceptance. This is defined as the central feature of mental as well as characteristics of self-actualization, optimal functioning and maturity. Life span theories also emphasize acceptance of self and one's part life. Thus holding positive

attitude towards oneself emerges as central characteristics of positive psychological functioning.

The conclusion drawn by Ryff and Keyes is that well-being is a multifaceted construct including positive self-regard, mastery of the external environment, quality inter-personal relations, continued growth and development, purposeful living, and the capacity of self-determination. Ryff and Keyes also developed Ryff Scale of Psychological Well-being (RSPWB) which is going to be used in present research.

General emotional state of the person also affects the daily life activities. A closer look at the cognitions of a normal person reveals that it is the tendency of mind to evaluate events, emotions and find the causes of everything to understand the daily life events. This also helps them to repeat the pleasant event and avoid unpleasant ones. Casual model explain this phenomenon of psychological well-being.

Causal models of psychological well-being. Casual models of well-being are differentiated in terms of bottom-up versus top-down approaches to happiness (Brief, Butcher, George, & Link, 1993).

Bottom-up model. This model suggests that happiness is derived from summation of pleasurable and unpleasurable moments or experiences. It is the evaluation of well-being in domains including marriage, work, and family. This evaluation helps people in developing an overall sense of subjective well-being (Brenner & Bertell, 1983; Bryant & Marquez, 1986; Haring, Okun, & Stock, 1984; Okun, Olding, & Cohn, 1990; Wood, Rhodes, & Whelan, 1989). In other words, satisfaction and happiness are results from having many specific moments of happiness in life. A basic tenet of this position is that experience is written on the blank slate of our minds. Philosophically, this model is the Lockean notion that

nothing is in the mind except what was first in the senses (Brief et al., 1993). In the bottom-up view, objective life circumstances might be the primary predictors of one's level of overall happiness.

Top-down model. The top-down view, by way of contrast, assumes that people have a predisposition to interpret life experiences in either positive or negative ways, and this predisposition in turn influence one's evaluation of satisfaction in specific domains. Experience is not so much objectively good or bad but rather is interpreted that way. Philosophically, this model is *Kantain,* in that. Kant (1958) holds the view that the mind actively interprets and organizes the sensory experiences. Such knowledge is pure as well as empirical. The mind accepts incoming sensation along with filtration and selection of only those sensations that are congruent with one's belief and attitudes. From a top-down perspective, our subjective interpretation of events should majorly influence well-being as compared to objective circumstances. Costa, McCare, and Norris (1981) mentioned that "despite circumstances, some individuals seem to be happy, whereas in such situations most people are unhappy".

Emergence of these models initiated the research work to obtain the evidence about real causes of happiness. The top-down model explains the well-being in a better way. Whereas, many others like Maddy, Bartone, and Puccetti (1987) confirmed the bottom-up hypothesis. Many others did not give the preference to one model over the other, but they tried to integrate both the approaches (e.g., Brief et al., 1993; Diener, et al., 1984; Maddy, et al., 1987; Wilson, 1967).

Integrated model. Integrated model proposes that global features of personality and an individual's objective life events influence the way in which the person interprets the circumstances of his or her life, and these interpretations, in turn

directly influence subjective well-being. Feist, Bonder, Jacobs, Miles, and Tan (1995) conducted a longitudinal study over four month period (after one month each) with 160 subjects in order to compare top-down and bottom-up models of well-being. Latent variables of well-being were physical health, daily hassles, world assumptions, and constructive thinking. Results showed the application of both bottom-up and top-down models, and proved that personality as well as objective life events influence the way of one's perception.

Apart from well-being women also feel negative feelings towards themselves during the menopausal transition. The changes in their lives affect their productivity as member of family and as part of work environment in case of working women. The negative impact may lead to low opinion about one's own abilities and performance.

Change of life can be a term used to refer to all the changes (both biological and social) that occur during middle years and that the term 'menopause' be used to describe the biological changes. While the physical and life changes are not necessarily related, they may have an effect on each other. Thus a woman might be less able to cope with symptoms such as night sweats, which often impair sleep, when she also has to deal with travelling long distances to support elderly relatives. Likewise, an ageing appearance may be more difficult to come to terms with when the loss of friends and family members serve as reminders of a woman's own mortality (Ballard, 2003).

Psychological Well-Being and Menopause. Well-being is a salient issue for midlife women as they respond to the bio-psycho-social changes associated with the menopausal transition (MT). The variation in women's well-being across MT is not clear. The majority of studies of MT were cross-sectional, and even when data were

collected from the same individuals over time, subsequent analyses were often stage specific. In a longitudinal study on Australian women's health during MT, change in well-being (measured as the difference between positive and negative mood scores) was related to symptoms, other life events, feelings for partner, and exercise; there was no significant direct association of well-being with hormonal status (Dennerstein et al., 2007).

There are many other transitions faced by the women in their middle age along with menopausal transitions. These include changes in marital status and parental roles, which may be at least as salient as and often more salient to women's well-being than factors related to the MT alone. Along with this there are important personal resources which also contribute to the management of such transitions. These personal resources include mastery and social support.

Findings of research conducted by Harlow and colleagues reported that hot flushes, night sweats, sleep disturbances, urinary frequency, vaginal dryness, poor memory, anxiety and depression are major reported symptoms affecting quality of life (Joffee, Soares, & Cohen, 2003).

Mastery is the mental and emotional capacity to perform skills and behaviors needed to manage new situations and environments (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). Women with a sense of mastery create environment compatible with their physical, psychological, and social needs (Keyes & Ryff, 1999). A research was conducted by Curhan, et al. 2014 and colleagues stated that the supportive social relationships were repeatedly found to be foundational to well-being by respondents in a national survey of well-being at midlife, buffering the disruption caused by transition (Turner & Marino, 1994).

In a sample of middle-aged women, Dennerstein, Smith, and Morse (as cited in Avis et al., 2004) found that well-being in general was related to self-rated health status, symptoms, stress, living with a partner, exercising once a week, vasomotor symptoms, a history of premenstrual complaints, smoking, and attitudes towards aging and menopause. While not specially studying middle-aged women, research on social indicators has shown that some of the factors associated with subjective well-being or QoL in general populations include marital status, age, stressful life events, stress, social support, depression, health, and internal control (Abbey & Andrews, 1986; Tran, Wright, & Chatters,1991).

Nicol-Smith (1996) reported that duration, severity and impact of menopausal symptoms vary tremendously from person to person and population to population but menopausal symptoms can profoundly affect personal and social functioning. It has also been highlighted that psychological and emotional problems cannot be attributed to menopausal transition.

Many studies have investigated anxiety and depression during the menopausal transition. However, there is little understanding of positive aspects of well-being among menopausal women. A study conducted by Deeks and McCabe (2004) reported two studies about purpose in life, self-acceptance and social role. In Study One found that the effects of age group and menopausal group could not be separated: All women felt they would be more positive about these well-being measures in the future than they had been in the past and at present. Study Two found that women who were in peri-menopausal and postmenopausal stages did not feel as positive about their role/s in life as premenopausal women, regardless of their age. The results suggested that the menopause may indicate that women's role/purpose in life is

changing. It is important psychosocial aspects of women's lives are incorporated in most of the studies of menopause.

In the study by Sammel et al. (2003) the major predictors of weight gain among menopausal women were quality of life and other psychological factors including depressed mood and anxiety. One might speculate some causality between these factors; did weight gain lead to decline in quality of life.

Another study was conducted to measure changes in physical and mental health in groups of women defined by menopausal status. This was longitudinal study with Australian Women aged 45–50 years in 1996. Results revealed that mean scores for five of the eight dimensions were highest (indicating better state of health or well-being) in pre-menopausal women. There were declines (that is, worsening health) in the dimensions in most groups of women. Declines were largest in physical functioning and physical role limitation in women who remained peri-menopausal role. Physical aspects of general health and well-being decline during the menopausal transition. Sensitive measures and careful analysis are needed to understand about the causes of worsening of well-being for peri-menopausal women.

Psychological well-being dealt with the psychological health of human beings and this health affect the evaluation of one's own self. If a person is in a good psychological health then he/she would have been enjoying life to the optimum and also fulfilling the assigned responsibilities. This leads to the positive evaluation of one's own self. When psychological health is compromised then it leads a chain reaction and impact reaches one's own psychological evaluation. Present study included self-concept as a major variable and intends to relate with the menopausal experiences.

Self-Concept

Self-concept and self-identity is the mental and conceptual understanding and persistent regard that one holds for his/her own existence. The combination of attributes, abilities, behaviors, attitudes, and values that people believe define them different from everyone else is their self-concept. Self-concept goes beyond the physical entity bounded by a person's skin; it is a psychological construct in which the concepts of "me" and "not me" are defined. These distinctions emerge gradually and change continuously from early childhood through adulthood. As a result, children's view of themselves becomes more differentiated and more complex as they mature (Kostelink, Whiren, Soduman, Stern, & Gregory, 2002).

The literal meaning of the term self-concept refers to the ideas and views about oneself. The simplest definition can be all the possible answers to the question, who am I? According to Hamachek (1992), self-concept refers to that particular cluster of ideas and attitudes about one's own self at any given moment. Another way of understanding self-concept is to view it as the organized cognitive structure of person's own self as individual derived from the sum of all his/her experiences. Self-concept then is one's own mental image of one's own, a collection of beliefs about the kind of person we are.

For Mead (1934) self-concept emerged directly from the behavior of others towards the individual and indirectly from physical and mental attributes of the individual himself. According to Rosenberg (1965) self-concept is the sum total of individual and feelings about him/herself as an object. Self-concept is the whole set of attitudes, opinions, and cognitions that a person has of himself. Rogers (1961) defines self-concept as an organized configuration of perceptions of the self which are

admissible to one's consciousness, of one 'characteristics, and abilities; the percepts and concepts of the self in relation to others and to the environment. Rogers was optimistic about human potential and believed that the search for self is ongoing. Jung (1959) conceptualizes "self that activity strives for oneness, harmony, and wholeness." Self serves as a motivating force, and one tries to actualize the self which depends on the accuracy in the perception of one's ability.

Though theorists discussed self-concept in the past but it has been considered as a major focus in the recent times. There are few theories explaining this phenomenon as further research and exploration is needed in this regard. The existing theories are briefed here.

Theoretical background of self-concept. There have been numerous approaches to a theoretical exposition of the nature and development of self-concept. Early in the history of American psychology James (1980) accorded this topic an important place when the study of self was pursued by the introspection (Atkinson, 1930).

Most of the perspectives in psychology explain self-concept with reference to self, as self remains the core issue in psychological paradigm. Most of the theories documented the importance of self-concept. Self is described as that aspect of the person which carries out psychic, mental, or psychological acts; as the individual is revealed to his own observations; and as the organization of personal activity oriented with reference to a complex object called "the me". Three aspects may be involved, *self-as-subject*, or what the person think of himself, *self-as-object*, or what others think of the person, and *self-as-person* or doing; involving such activities as manipulating, perceiving, and thinking.

Self-concept may or may not be close approximation of reality, and the self-concepts are always in the process of becoming, particularly during childhood, when they are undergoing the maximum change. Self-Concept theories emphasize identity constructed through interaction with others. Pragmatic theories emphasize social process of interacting within a community. A dramatistic view describes the role performances that people enact to create an identity. Postmodern views of self how a relational perspective of self is created as a person participates in various relational communities.

Psychoanalytic view. Freud (1926) conceived the personality in terms of both mental and instinctual dynamics. He has given the ideas of structures in early 1930s. His early theory postulated these psychic systems: the conscious, preconscious, and the unconscious. Freud gave structural hypothesis stating that mental processes were organized in terms of their functions. He described the origin id, the ego and the super ego, and analyzed their inner relations. The id is the 'dark inaccessible part of personality'. It is the 'core of the being', the primitive and relentlessly demanding, and wholly unconscious portion of the psychic; the self as dynamic agency or ego. The most important function of the ego and one that id neglects is self-perception. Although the ego structures cannot be destroyed, they can be disorganized.

According to Adler (1930), each individual is unique being, in thinking, feeling, speaking, and acting. Even two individuals do the same things; will not be the same because of their "creative self". Adler also considered environment and heredity as important factors. The creative power combines the innate potentialities and environmental influences into a movement towards overcoming obstacles. The child is born with a free creative self. It is subjective, dynamic, unified, personal, and

unique style of life. Moreover, the creative self is the main determinant of personality because it utilizes the individual's heredity and environment.

Jung (1933) was also one of the first to conceptualize "self" that actively strives for oneness. Jung (1959) further says that the self serves as a motivating force, which is dormant from birth, but appears in the middle age. One tries to actualize the self, which depends on the accuracy in the perception of one's abilities.

Erikson (1958) defined self-concept as conscious, cognitive, and evaluative of the person's own thoughts and opinions about themselves. It has been called the individual's "self-hypothesized identity". He refers to it the individual's "ego identity', or the individual's self-perceived, consistent individuality. It begins with an awareness of uniqueness, that individuals are distinct, separate from others (Erikson, 1959).

Erickson had given psychosocial stages of development and explained the phenomena as midlife crisis. Menopause is a biological as well as a psychosocial phenomenon faced by midlife women.

Trait perspective. Murray (1938) developed a theory in which he emphasized the central organizing and governing process of self, whose function is to integrate the conflicting forces to which the person is exposed to satisfy the person's needs, and plan for the attaining person's goals. According to Murray when a need is aroused individual is in a state of tension. Gradually, an individual grows up, he learns to attend to the objects and to perform actions that in the past have seemed to reduce tension. A need is a construct that stands for "*a force in the brain region"* that organizes various processes such as perception, thinking, and action so, as to change an existing and unsatisfying condition. A need can be provoked by internal forces but more often it is stimulated by environmental factors.

Typically a need is accompanied by specific feelings, or emotion and it has particular way of expressing itself in seeking resolution. According to Murray (1938), there are twenty needs, which are significant and interrelated to one another. Importance and satisfaction of those needs leads to the development of personality and concept of self in an individual.

Allport (1950) emphasized that personality is not a finished product but a transitive process. It has some stable features, but at the same time it is undergoing change. He emphasized that the basic problem of psychology is to understand the patterned uniqueness of each individual. Allport coined the word 'proprium' which he defined as *"all aspects of personality that make for inward unity"*. Propium is the self or ego that has a core of personal identity and is developing in time.

For Allport, the proprium represents the positive, creative, growth-seeking, and forward-moving quality of human nature. So, self can be described in terms of proprium, which is a short hand expression for the set of personality related matters that gives organization to personality and accounts for uniqueness.

Allport (1961) identified seven functions and structures of proprium. The first he called "the sense of bodily self" which is composed of sensation arising within the body. The second is "sense of self-identity" in which child recognizes himself as a distinct and constant point of reference.

Sociological perspective. In social paradigm, Cooley (1961) was one of the earliest social theorists, who addressed the concept of "self". According to Cooley, the social milieu from which a person comes contributes heavily to how a person views himself. On the basis of person's view, Cooley's theory states that self is concerned primarily with how the self grows as a consequence of interpersonal interaction. Here, posited the concept of "the looking glass self". Cooley (1961)

believes that self is an important aspect of our personality and is the reflection we receive from the minds of others. That reflection makes us to think in both dimensions positive (we can do) and negative (we can't do), which tarnishes our self-image. Cooley further suggests that our behaviors are under the influence of our social order. Our self-esteem, self-confidence, and hopes are chiefly founded upon the opinions of others. Simply people's feelings about themselves are highly sensitive to how they think that how they are being regarded by other people.

Mead (1934) described the self-concept as emerging directly from the behavior of others toward the individual and indirectly from physical and mental attributes of the individual himself. According to Mead, self is an object of awareness rather than a system of processes as we see others responding to us. Mead's self is socially formed self, which grows in a social setting where there is a social communication. Mead, further, suggests that people can have, as many selves as there are number of social groups in which they participate. For instance, a person may have a family self, which reflects the values and attitudes experienced by his family' a school self, which represents the expectations, attitudes, experienced by his teachers and fellow students and many other selves. Self-concept is an interpretation of our experiences (menopause is one of the important experiences which can change the interpretation of their selves), it concerns how we are the same and how we differ from others, and it results in our seeing ourselves as distinct from other people. Because the self-construct is formed out of comparisons between others, and us, and much of our social life is controlled by it.

Self-concept theory. Personality theorists have attempted to explain individual's self-concept. The basic concept explained by such theorists is the perception of one's own self or one's own ego. A person usually measures him/herself

as confident, happy, social, reliable, and careful. Person measures his/her characteristics with those of his/her ideal self. The self-concept theory suggests that an individual's self-image of the ideal self-determines behavior.

Rogers (1961) was one of the first to write about self-concept and how it develops. Fulfillment of self means that one is basically positive, open to the experiences, truthful of his or her own thoughts or feelings, self-evaluative rather than at the many of others, approval, and willing to be a process than a product. Rogers was optimistic about human potential and believed that the search for self is ongoing. The self-concept presumably is a particularly a human manifestation. To understand how it comes into being, we must consider two additional off shoots of the actualizing tendency in the human being; the need for positive regard and the need for gaining approval or disapproval. Both are considered secondary or learned needs, commonly developed in early infancy that represents specialized expressions of the overall actualizing tendency, the approval of others and frustration at receiving disapproval. The need for positive self-regard is a more internalized version of this. In other words, it refers to personal satisfaction at approving and dissatisfaction at disapproving of oneself. In the process of gaining approval and disapproval from others, person develops a conscious sense of which they are, called a self-concept.

Self-perception theory. Bem (1972) has offered self-perception theory. She argued that many of our attitudes are based simply on our perceptions of our own behavior and circumstances in which the behavior occurs. Bem's self-perception theory suggests that people's expressions of attitude are top of the head phenomenon rather casual, verbal statements. People have no great state in their attitudes; rather they seem simply to be trying to cooperate with a curious question by giving a plausible answer without strong conviction of feelings. So they readily change these

superficial answers. The self-perception process should be most likely to occur when people's own attitudes are vague and ambiguous. Self-perception theory works for individual who do not possess well defined prior attitudes might not be available as the individual has relatively few prior experiences with regard to issues or it might be because the person has no immediate sensory data relevant to the issue.

Enhancing self-concept is a vital goal in itself and an important mediating variable that impacts on a variety of desirable outcomes in a variety of settings. Rogers (1961) was also one of the first to conceptualize 'self' that actively strives for oneness and unity. Striving towards that oneness, harmony and wholeness is the ultimate goal of life. He believed that to achieve unity and wholeness, the individual must become increasingly aware of the wisdom available in his or her personal and collective unconscious and must learn to live in harmony with it.

Cattell and Gorsuch (1973) have tried to explore self and its definition. They discriminated between the experienced self usually explored through introspection, the cognitive self-conceptual thought an individual has of him/herself and the structural or acting self- as observed by others. They pointed out that the self is involved in controlling and coordination of all the functions of personality. They also discussed that self can be observed in the behavior of an individual, his/her emotional stability, competitiveness, independence of judgment, acceptance of reality, good morals and so on. This pattern well represents the psycho-analytic ego and can be understood as the acting coordinating self. In addition, other motivation and temperaments are part of the self and reflect "me" in the manner, style, and mood through which one achieves his goals.

Components of self-concept. According to Hamachek (1992) self-concept is always subjective. One person sees himself as too short; another sees himself as very

friendly; still another views herself as an emotional person; yet another describes herself as having above-average intelligence. Self-concept involves at least four separate and unique but interrelated components (1) physical self-concept (2) social self-concept (3) emotional self-concept (4) intellectual self-concept. So far our self-concept in one area may influence our self-concept in other area (Frank & Miller, 1994).

Positive self-concept. Individuals with positive self-concept will aspire to leadership, are willing to receive constructive criticism, and are willing to risk more often (Turner as cited in Batool, 2004). The person perceives himself as capable and important and is therefore able to perform at a normal or superior level. A strong sense of identity or certainty is self-attributes promote a sense of control over future outcomes thus generating positive effect and confidence in self. A healthy self-concept is one that helps an individual to develop a true picture of his or her abilities, wants, desires, and values gives awareness where one needs to grow and develop. Factors like maternal relationships and identification (Moretti as cited in Batool, 2004).

Negative self-concept. According to Kaplan (1984), people with poor or negative self-concept usually generalize their failure in one facet of their life to their total self and so feel discouraged, avoid leadership roles, criticism and risk taking. According to Harper (as cited in Batool, 2004) those with negative self-concept frequently have an external locus of control, a belief that they are at the mercy of fact or luck or others than their own efforts. Franken (1994) states “there is a growing body of research which indicates that it is possible to change the self-concept. Self-concept is not something that people can and will but rather it depends on the process

of self-reflection, people come to view themselves in a new, more powerful way of viewing the self that people can develop possible selves" (p.443).

Often an individual with a lost sense of self is filled with misdirected anger towards himself or herself. Those with a low self-image also tend to have less motivation for learning and work, and generally poorer emotional and psychological health and well-being. They are easily frustrated, blame others for their short comings, avoid difficult situations so as not fail and are dependent on others to tell them how they are doing. In relationships and families it is manifested in the form of dependence (Gough & Heilbrun, 1983). Healthy behaviors are altered because of the unhealthy behavior of dependence. These individual uses those around them to validate and make sense of their world. They feel awkward in social situations and try to be as unnoticeable as possible. They often appear clumsy and uncomfortable. They do not feel confidence in their social skills to make contact with others. They are filled with a sense of hopelessness and a feeling no one could ever love them. As a result of this hopelessness social interaction decreases and the need to please others increases (Rosenberg, 1978).

Structure and development of self-concept. Research in social psychology (Wald, as cited in Gage & Berliner, 1992) conceptualizes self-concept as a multifaceted phenomenon composed of asset of images, scheme, and prototypes. There has been a similar movement in sociology where the self is defined in terms of multiple identities. Identities include personal characteristics, features and experience as well as roles and social statuses. In both streams of research authors define the self-concept in terms of various self-representations. Their work indicates that some self-representations are more important than others. Some are representations of present perception of self-versus desired perception of self, some are core conceptions or

salient identities while others are more peripheral; and some are relatively stable (Sullivan, 1953) while others are dynamic.

Self-concept is composed of four interrelated self-perceptions; the ideal self, one's self esteem, physical self, and a set of social identities. Each of these elements plays a crucial role in understanding how the self-concept relates to energizing, directing, and sustaining organizational behavior. Each of these self-representations will be described and their interrelationships discussed.

The perceived self. Most models and descriptions of the self-involve elements of self-perceptions; however, most are unclear as to what aspects of the self the individual holds perceptions of. According to Jones (1980) self consists of material, social and spiritual self. One's own body, family and possessions are perceived to be the material self. Other people's opinion and image of one's self constitutes social self and emotions, desires and feelings of a person is considered to be spiritual self. Kihlstrom and Cantor (1983) suggest that individuals know about their traits, values, attribution patterns, experiences, actions and thoughts. They also perceive their physical appearance, attributes and other dispositions. The theorists conceptualized that self-concept is developed not in isolation but in the context of social and personal identities also including the traits and attributions (Gergen, 1971).

Perception of attributes by an individual can be explained in terms of level and strength. Level refers to the degree of perception of possessions, whereas strength refers to Individual's own judgment about his trait, competency and value. These dimensions ultimately define the high and low self-esteem of an individual (Seligman, 1996).

Development of perceived self. Self-perceptions are products of environmental interaction. Self-perceptions are developed through attitude formation, attitude change, and self-attribution (Franken, 1994). The relationship between social feedback and the perceived self is embedded in the process of attribution. In trying to understand a particular person, people make causal attributions of his/her observed behavior. (Kelley, 1971). These attributions become the basis for self-perceptions. These attributions are communicated directly or indirectly to the person.

Direct communication involves written or oral evaluations, praise reprimand or recognition. For example, direct feedback can be about a trait (you're too kind) a competency (you're a generous person). Attributions are also communicated indirectly using different methods. A project or task can be evaluated in such a way that the related individual feels the responsibility for the outcome. This is an example of indirect social feedback. Other types of indirect communication are inclusion or non-inclusion of a particular person in the group depending on his/her activities, inability to follow the orders or suggestions of group members. Acceptance of member in the group by group members does not always be obvious through direct verbal feedback but there are other ways of communicating the acceptance or rejection like non-verbal cues.

Basic assumptions regarding self-concept. Success and failures experienced by people in various areas of their lives are found to be significantly associated with their opinion about themselves and their social relationships. It is also becoming clear that self-concept has at least three major qualities (1) it is learned (2) it is organized and (3) it is dynamic.

Self-concept is learned. Self-concept is not present inherited or something present at the time of birth. It emerges gradually in the early years of life and is evolved by the perceived experience, most importantly experiences with the significant others (Hamacheck, 1992). According to Hamacheck (1992), the fact that self-concept is learned has some important implications, for instance,

1. Self-concept is not instinctive and therefore it has the capacity to evolve socially through experiences and is also related to development and actualization.
2. Self-concept changes due to previous experiences and self-perceptions. It changes with the change in the other people's opinion about a person.
3. Person perceives different aspects of their personality at different times and there is also difference in the clarity of perception at different times. Counselors therefore use inner focusing as an important tool
4. If a person experience something opposite to their previous experience then the new experience can be a threat to his/her self-concept. Usually there is a strongly held self-concept which motivates as well as protects a person psychologically but more are these inconsistencies, there is a chance that they may lead to emotional problems.
5. Polar thoughts and extremism in cognitions of a person often leads to negative interpretations of one's self. These dichotomous thoughts include dividing things in terms of opposites, over generalizing and so forth.

***Self-concept is organized*.** Most research findings concluded that self-concept is generally stable and characterized by orderliness and harmony (Gough, Lazzari, & Fioravanti, 1978). There are infinite perceptions regarding one's personal existence and each perception is amalgamated with all the other perceptions forming a complex.

It is generally stable and organized quality of self-concept that gives consistency to the personality (Gough et al., 1978). This organized quality of self-concept has corollaries.

1. Self-concept needs consistency, stability, and tends to resist change. If self-concept changes abruptly then the individual would likely tries to regain consistency.
2. The resistance of a belief is dependent on its importance in the personality. If the concept is of central importance for the person then it is likely to strongly resist any change.
3. The core of self-concept is the doer self often termed as "I" and it is different from the object self often termed as "me". It helps the person to reflect on past events analyze present perceptions and shape future experience.
4. Basic self-perceptions are usually very stable and they resist change. Self-concept is similar to the popular phrase "Rome was not built in a day" and neither is self-concept.
5. Perception of success and failure influence self-concept. Failure in a highly regarded area lowers evaluations in all other areas as well. Success in a prized area raises evaluations in other seemingly unrelated areas.

Self-Concept is Dynamic. Self-concept has the capacity to evolve in various circumstances. It is imagined as a continuously active system not only shapes the ways a person views oneself, others, and the world but is also serves to direct action and enables each person to take a consistent stance in life. Self-concept cannot be viewed as the cause of any behavior but actually it is gyrocompass of human

personality as it is responsible for the consistency in personality and direction for behavior. The dynamics of self-concept also carries corollaries.

1. The world and things are not perceived in isolation but they are perceived to be related to each other and also related to self-concept.
2. Development of self-concept is a continuous process. Usually a healthy personality continues to include new ideas into the self-concept and expel the old ideas which are outdated or inconsistent with the present self-concept.
3. Mostly self-concept tries to maintain the equilibrium and consistency of self-concept despite the helpful or hurtful aspects of it.
4. In most cases self-concept is considered of prime importance and physical body has the secondary importance. There are examples of sacrificing of physical comfort for emotional satisfaction
5. Self-concept continuously guards itself against loss of self-esteem for it is this loss that produces feelings of anxiety.
6. If self-concept has to constantly defend itself from threats and failures, growth opportunities for self-concept are limited.

Factors related to self-concept affecting menopause. Within western societies, the menopause tends to be associated with ageing. This image appears to have been shaped by a number of factors. For example, there are a number of biological changes, such as a dry skin, brittle nails, changing fat distribution, and softer breasts, which occur when the level of estrogen (female reproductive hormone) fall. In addition, women reach the menopause on average, at around the age of 50, which is often seen as a milestone age. The menopause also represents a change in a woman's ability to reproduce, and this is often associated with getting older. Unfortunately, within western societies, there is also a tendency to view ageing

negatively. For many women, therefore the menopause is approached with concerns about ageing and a loss of value within society (Ballard, 2003).

Most women notice changes in their physical appearance over their lifetime, but these changes are often more pronounced during the middle years. Many women find that they catch an unexpected glimpse of themselves in the mirror and find their mother's face staring back in reflection. At first, this may be a bit alarming. Although such a mirrored image is often initially disturbing, it is generally considered to be an inevitable part of aging. Indeed, most of the women perceive the changing looks as part and parcel of life and something that was going to happen whatever they did. They often remarked that looking older was simply something that you had to come to terms with. In addition to looking older themselves, women often pointed out that their husbands; partner or relative was also ageing. This is sometimes allowed women to see them as ageing as well, when compared to others of a similar age. As the pressure on women to preserve their youthful looks can be generated from other people. This is largely because there is a tendency, within western societies, to promote youthful women in positive light and older women in a negative light. In other countries, such as China and Japan, where higher status is rewarded to women as they get older, the menopause is associated with fewer emotional symptoms than it is in Western societies.

Thus in countries such as Britain and USA, both the film and the advertising industries not only focus on youthful, glamorous images of women, but also encourage women to participate in age-resisting practices. A glance at the shelves of any high-street chemist shop will reveal that the number of anti-wrinkle creams for women far outweighs the number available for men. Although majority of the women accepts their ageing body image, but for a few women this is usually an area of

concern. However, despite the focus on maintaining youthful looks within western societies, most women expressed a greater concern about the possible changes in the body function, rather than in body image. They spoke about their concerns about not being able to care for themselves when they get older. Such images of physical deterioration are often influenced by women's experiences of caring for elderly relatives (Ballard, 2003).

In addition to observing physical deterioration in elderly relatives, women may experience a number of subtle changes in their own health, many of which they recognize as marking the start of future disablement. The need for reading glasses, being unable to run for a bus, increased tiredness, or a general feeling that the body is slowing down, can be reminders of an ageing body. Although there are biological reasons linked to women's changing body image over the time of menopause but these physical changes are influenced by social changes. The low value that older women have in Western societies as well as exposure to elderly relatives who require care, both contribute to the idea that going through the menopause represents stage in getting old (Ballard, 2003).

These theories and researches incorporate person's view about all the aspects of his/her life. Present research also aims to study physical self, family self and academic self as a predictors of physical and psychological menopausal symptoms.

Self-concept and menopause. Perception of self is considered to be an important psychological factor playing role in the developmental process. During the menopause stage women face many changes, but perception of their selves and the relationship of this self-perception and self-concept are still elusive. Bertero (2003) found that women during menopause perceive social, psychological, physical,

devaluation and loss of personal value. Physical self-perception is of vital concern in menopause symptoms (Bloch., 2002) and Elavsky 2005).

Shu, Luh, Li, and Lu (2007) found in their survey about self-concept and menopause amongst middle age women that 92% of women's experienced overall normal self-concept, while physical self-concept, psychological self-concept, and academic/work attainment self-concept was found higher in highly educated women compared to lower educated women. The findings also revealed that for premenopausal women, physical self-concept, personal self-concept, and academic/work attainment self-concept were the remarkable predictors for menopause symptoms (both psychological and physical). The outcome of this survey suggested that for premenopausal women, only physical self-concept may considerably predict psychological and physiological symptoms.

Pre-, peri-, and postmenopausal women in their forties, late forties and early fifties reported emotional disturbances and these emotional disturbances leads to negative thoughts about self. Various researches reported the such emotional disturbances; Bromberger, et al., 2003; Rasgon, Shelton & Halbreich, 2005; Vesco, Haney, Humphrey & Nelson, 2007) revealed that women in perimenopausal stage reported depressive symptoms as compared to women in pre and postmenopausal stage. Along with other risk factors vasomotor symptoms (Avis, Crawford, & McKinlay, 1997; Dennerstein et al., 1993 Hassa, Tanir, Yildirim, Oge, & Mutlu, 2005; Nedstrand et al 1996), hot flushes (Schmidt, Haq & Rubinow, 2004) and negative life events such as divorce, empty nest syndrome, and death of a significant other (Boulet et al 1994) significantly lead to the development of depressive symptoms among women in perimenopausal stage.

Women in their midlife experience low self-concept which is related to menopausal symptoms including nocturnal hot flushes, nausea, headaches, body aches and pains, weakness, visual problems, vaginal discharge, irritability, muscle stiffness and/or incontinence (Brown, Gallicchio, Flaws, & Tracy, 2008).

Neugarten and Kraines (1964) reported that women in menopausal stages reported the psychological pressure of loss of reproductive ability along with the changes in family. Another study reported that women experiencing menopausal symptoms along with physiological changes also face social transition with increased levels of stress that may require additional coping mechanisms and consequently change in the perception of self (Wise, Otto, Soars, & Cohen, 2003). The influence of menopausal symptoms can have significant influence on daily, social and sexual life of postmenopausal women (Hassa, et al., 2005).

Relationships are related to the positive self-concept and the change in relationships effects self-concept. In middle age it is hard to generalize the meaning of relationships. It embraces a greater multiplicity of life paths than ever before. One 45-year old may be happily married and raising children; other may be contemplating marriage or, on the brink of divorce. Most individuals in midlife who are married voice considerable satisfaction with being married (Santrock, 2006).

Psychological discomfort and physical signs are stimulated by the sub-domain of self-concept to variable extent. Generally, the progressive self-concept will predict them from the physiological symptoms, mental distress and physical apprehension (Shu et al., 2007). Poorer physical self-concept is also a notable predictor of decreased QoL (Kyrios, Nankervis, Reddy, & Sorbello, 2006).

As explained by different researches women in their menopausal stages reported distress and emotional problems. Such problems affect their own psychological health in one way and their social relationships in another way. Relationship with spouse is considered to be the most significant in anyone's life. Changes in physical and psychological health of women affect their relationship with their spouses. It is for this reason that present study included marital satisfaction as another major variable.

Marital Satisfaction

Research findings suggest that relationships are always noteworthy for women, and the features of their married relations modulate their life experiences. Strong supportive relations might assist midlife women in defending against the stress induced by stressful life events whereas undermine relationships harmfully influence women's perceived strain, menopausal symptomology, and marital satisfaction (Fielder & Kurpius, 2010).

While studying women's lives, condition of married relationship has arisen as an essential circumstantial factor compelling to be weighing up. Various studies reported that it is not actuality to be married but physiological and psychological health of spouse are positively or destructively affected by the status of this relation (Fielder & Kurpius, 2010). In a study by Gove, , & Briggs-Style, Hughes, 1990, it was reported that unsatisfied marital life was observed to be more harmful to one's psychological well-being than living alone, separated, or widowed.

It was studied that marital quality with satisfaction to menopausal symptomology, menopausal symptom increased by poor marital satisfaction, marital annoyance and resentment. It is also remarkable that the sexual relationship was

associated to the involvement of symptomology, sexual distress supplemented to symptomology. This is frequently reported that by reduction of the reproductive hormonal levels through peri-, and post menopause resulted adverse effect on sexual functionality (Abernethy, 1997).

Marital satisfaction has been explained through different models.

Theoretical models of marital satisfaction. Theorists and researchers have explained marital satisfactions, factor contributing and hampering marital satisfaction. Some of the models are explained here.

Social exchange model. Social exchange theories of marriage explain the marital relationship as an economy of reciprocal exchange of needed and valued commodities, such as companionship, sex, sharing of household labor, care giving nurturance and opportunities for giving care and nurturance to another person. These theories of marriage are used for explaining or predicting many consistencies within and across martial relationships. Social exchange theories have allowed researchers to consider many variables. They can potentially account for a variety of marital outcomes by distinguishing between marital satisfaction and marital stability. The theoretical application of the social exchange paradigm to martial relationships has focused on marital satisfaction or quality and stability (Lewis & Spanier, as cited in Udry, Deven, & Coleman, 1982).

Thiabault and Kelley (as cited in Levinger, Senn, & Jorgensen, 1970) discussed social relationships based on an exchange of desirable reinforcement and considered this factor as the motivator for the initiating and sustaining of social relationships. Sagar (1976) explained marriage as a dyadic relationship system dependent upon both conscious and unconscious expectations. These expectations

function as contract, spoken or unspoken, to which the partners are bound. The survival and quality of marital relationship is dependent upon these aforementioned factors.

Researchers working on social exchange perspective have identified several characteristics that differentiate distress from non-distressed marriages. Among those are: (a) greater perceived inequality, (b) low rates of pleasing and higher rates of displeasing behavior, (c) greater contingent reciprocity of negative behaviors (reactivity), and (d) strong relationships between displeasing behavior and daily satisfaction-all true of distressed and compared to non-distressed marriage (e.g., Davidson, 1984; Davidson, Balswich, & Halverson, 1983; Jacobson, Waldron, & Moor as cited in Skowran, & Friedlander, 1998; Levenson, & Gottoman, 2002; Margolin & Wampold, as cited in Cousins & Vincent, 1983).

Personal views of relationships contribute towards self-concept and social exchange model explained the changes in relationships and these changes will influence self-concept. This is one of the reasons that present research aims to find out mediating effect of marital satisfaction in relationship between self-concept and menopausal symptoms.

Role expectation models. Expectations play vital role in the maintenance of any interpersonal relationship. It is generally believed that marital satisfaction depends largely on the ability of the marital partner to define and enact maturely satisfying marital roles. The basic assumption of this model is that marital happiness seems to be congruent before the role expectation of one spouse and the role performance of the other spouse than to any specific pattern of roles (Lewis & Spanier, as cited in Udry, et al., 1983). It is basically concerned with perception of

actions and activities of others according to one's own frame of liking and disliking, and his own role desirability and expectations. This theory states that when an individual indulges in those activities which are according to the expectation of his fellow, the activities performed by him are considered acceptable, and those which are contradictory to already existing system are dejected or gain less approval, or sometimes strongly disliked.

Nye and McLanghlin (as cited in Bahr, Chappel, & Leigh, 1983) have developed role competence theory of marital satisfaction that is based on the notion that 'greater the role competence of a role player (as reported by his or her spouse), the greater the marital satisfaction of the role enactor's spouse'. In other words husband or wife is satisfied to the extent that he or she feels the spouse is satisfying certain role expectations.

Rollins and Galligan, (as cited in Twenge, Campbell, & Foster, 2003) argue that role expectations may be more significant predictors of marital quality than family life cycle stages. They say that adding children does necessarily decrease marital quality if role expectations are not clear and reasonable.

Social learning model. Social learning theory (Gottman, as cited in Adams & Laursen, 2001; Jacobson & Margolin, as cited in Christensen, 2000) like exchange theory, posit that satisfaction is direct expression of the extent to which partners behave in ways that produce feelings of pleasure rather than displeasure for themselves and their mates. This theory suggests that partner's satisfaction is reflected in the way they treat each other, with more satisfied spouses tending to express more warmly and less hostility than spouses who are less satisfied.

The roots of this model lies in Thibaut and Kelley's social exchange theory (as cited in Levinger et al 1970) but it has evolved over the last 25 years to encompass not only the behavioral economics of the original interdependence model but also cognitive, meditation, and affective components (Baucom & Epstein, 1990).

Nye (1982) gave a model after utilizing the social exchange paradigm of Thibaut and Kelley (as cited in Levinger et al 1970) which is based on the idea that the degree to marital satisfaction experienced in dyad is reflected in the evaluative outcomes available to the interactions.

Evaluative outcomes are the result of the reward minus costs in the marriage weighed against what individual feel they deserve. Concomitantly, marital stability is determined by the degree of positive affect toward spouses (satisfaction), the unattractiveness of alternatives to marriage, and the constraints against the dissolution of the marriage.

These models explain different facets of marital satisfaction. As mentioned above marital satisfaction and stability is not dependent on one the married partner but rather it is dependent on actions and reactions of both partners and their attitude towards each other and marriage as a life-long commitment.

Marital satisfaction and menopause. Social support is always an important contributor to the positive outcomes in various significant roles in its smooth transition and support from spouse will be most important for women. In various researches, marital satisfaction is found to be associated with smooth menopausal transition in women. As midlife is phase of menopausal transition in female lives, therefore social support plays a significant role.

Among these female-specific ‘windows of vulnerability’, the menopausal transition constitutes a complex example: this transition is marked by progressive, dynamic changes in sex hormones and reproductive function. At the same time, these changes overlap with the aging process per se, and with modifications in metabolism, sexuality, lifestyle behaviors and overall health (Santoro & Perry, 2009).

Cifcili, Akman, Demirkol, Unalan, & Vermeire, (2009) conducted a qualitative research to find out the menopausal experiences of women. Results indicated that family conflicts, especially problems with their partners are significant experiences of women in the menopausal transition. "Emotional instability or irritability" is perceived to be important reason for such conflicts. The women reported their over sensitivity and irritability is responsible mostly for the family conflicts they are facing. The participants also reported their need for support at this crucial transitional stage of their lives. Lack of family support is reported to have worsened their situation. The participants expressed their wish about their family members to be more tolerant of their irritability. They also reported loss of sexual desire and considered it as a serious handicap in the marital relationship. Some of the participants reported that despite loss of sexual interest they are trying to continue their sex life with their husbands.

Another study revealed that marital unhappiness does not reach the critical stage of separation, desertion or divorce but women report sexual dissatisfaction in forties, late forties and early fifties. This sexual and emotional disturbance is mostly attributed to menopause (Bossard & Boll, 2008).

Kolod (2009) reported her observations, grounded on a small number of patients and friends which were established by psychological investigation that

weakening of sex drive is one of the most common and annoying problems of menopausal women. The empirical evidences corresponding common problems with sex at menopause, but they fluctuate from psychoanalytic literatures in recommending therapeutic as well as psychological treatments.

In another study based on 324 women between age of 40 to 60 years, it was noticed that due to increased levels of follicle stimulating hormone frequency of sexual interactions decreased considerably and that an increase in anxiety and depression that often accompany menopause affected sexual life in a negative manner (Danaci et al. 2003), " (p. 30). In another research by Mishra and Kuh (2006) established on 1,525 women of 47 to 54 years, sex related complications were reported in 95% of the postmenopausal women for which health specialists recommend them (a) to think about direct treatments for vaginal desiccation, (b) to classify somatic signs of complications with intercourse, (c) to consider psychological issues for falloff in sex life, and (d) to ponder the probable role of intimate partners.

Dennerstein, Alexander, and Kotz (2003) led the Melbourne Women's Midlife Health Project, which is a prospective, observational study of a community-based sample of Australian-born women aged 45–55 years at baseline. There were eight annual assessments using self-report questionnaires and blood sampling for hormone levels. The authors write, "sexual problems are among the most frequently presented health concerns of women attending the menopause clinics" (p. 64). During early to late menopause period, the proportion of women with scores demonstrating sexual dysfunction increased from 42% to 88%. Dennerstein, Lehert, and Berger (2005) observed that prior function and relationship factors are more important than hormonal determinants of sexual function of women in midlife" (p. 80).

Decreased sexual attention at menopause was reported to be modulated by psychological factors like piled up annoyance to one's partner and distanced sexual distress. Menopause is frequently a spell when a woman takes stock of her life and thinks what she desires to retain and what she needs to modify. While considering standard of her marriage, she may come to know that pleasure with the sexual feature of her association has been weakening for certain time. As soon as sexual drive decreases at the onset of menopause, the entire concept of a sexual relation with her partner may have become oppressive and complications in a relationship might keep them separated for years because the woman remain indulged with children and in projecting her career (Mitchell, 2002).

Conclusions based on the psychological researches on menopause pointed out those complications with sexual drive are amongst the maximum disorders reported in menopause clinics. More significant finding of these studies was to give equal importance to psychological issues like marital status, aggression and hopelessness along physiological effects such as vaginal desiccation and reduced levels of sex hormones to treat menopausal symptomology.

Menopause onset usually takes place when the children are going to leave home and that is felt as vacuity by the couple. This emptiness can revitalize complications in the marital relationship that fetch things ahead. This is the time when the couples either disperse or they struggle to solve the problems. Consequently, menopause can overlap with an intersection where marital relationships either terminate or proceed. Present research is also aims to find out that how menopausal transition effect the marital satisfaction among pre-, peri-, and postmenopausal.

Various theories have been mentioned to explain the variables of present research (e.g., psychological well-being, self-concept, marital satisfaction and menopausal symptoms), because there is no single theory that explaining all the variables chosen for the current research. Different theories are overlapping and incorporating the different aspects of the variables. Therefore, integrative approach is used to explain the variables of the present research.

Menopause and demographic variables

Menopausal symptoms are found to be related to certain demographic variables. Educational level, employment status and economic condition are the significant demographic variables in this respect.

Jokinen et al., (2003) believes that higher level of education in women would have less number of menopausal symptoms. Lower level of education in women could lead to psychological changes, which would be basis for menopausal symptoms (Blumel, Schumacher, Weider, & Brahler, 2002).

Findings of the employment status comparisons with regards to the menopausal symptoms indicate that working women experience less menopausal symptoms. Psychological symptoms e.g., anxiety, depression, irritability, and loss of interest in most things are frequently experienced by non-working women than working women. The reason might have been that multiple roles increase self-confidence and feeling of self-worth and expand the arrangements of satisfaction and social support. These finding are also in accordance with the earlier researches (e.g., Orgulo, Kucuk, &, Aksu, 2011; Sarace, Oztekin, & Celebi, 2011).The non-working women also experience more somatic symptoms e.g., muscle or joint problems, headache, and breathing difficulties, and vasomotor symptoms e.g., hot flushes,

sweating at night than working women.. This might be that working women are more likely to care themselves and make changes to their diet and lifestyle (walking, exercise). These results are also in line with those of (e.g., Orgulo et al., 2011; Kakkar et al., 2007).

Research evidences suggest that with increasing age sexual desire decreases, particularly when women are in their late 40s and 50s (Howon, Gath, & Day, 1994; Osborn et al., 1988). Non-working women are more likely to have urinary problems and dryness of vagina. The reason might be that working women take more care of their personal hygiene. Being mobile and economically independent, rendering women in better position to deal with urinary and vaginal dryness problems (Orgulo et al., 2011). Studies suggest that working women experience less menopausal symptoms than non-working women and also indicate that employment status has a positive effect on menopausal symptoms (Mathews & Bromberger, 1994; Cochrane & Stopes, 1981).

Economic condition has also been found as an important variable in studies of menopause. Gerber (2001) found that women with good economic status experience lesser menopausal symptoms or would bear them better. It seems that better economic status results from higher education and better job. So, these would be effective factors to reduce symptoms and changes of menopause (Fahami, Beygi, Zahraei, & Arman, 2007).

Rationale of the Present Study

Menopause is contemplated to be a significant phase in woman's life. It is a transition period for her and influences significantly her psychological and social aspects of her personality. The hormonal changes in the body are found to be strongly

associated with minor psychological problems like mood swings and so forth to severe issues like losing control on expression of emotions and so forth.

Researches in medical field divided the menopausal period into three stages premenopausal, perimenopausal, and postmenopausal. The hormonal and other physical changes start in premenopausal stage and continue till postmenopausal period. Menopause usually occurs between ages 45-54 years (Jassim & Al-Shboul, 2008). However, it is not uncommon to see women experience early menopause that occurs at or before 45 years of age (Shuster, Rhodes, Gostout, Grossardt, & Rocca, 2010), and well beyond the age of 50 years. So, in the present research the age range of the selected participants is from 40-60 years.

There are physical and psychological changes that are associated with the onset of menopause. These changes affect the daily life activities of women and also change her attitude towards herself and others around her. According to Diener (1984) '…well-being is concerned with how and why people experience their lives in positive ways, including both cognitive judgments and affective reactions (p.542). Ryff (1989) reported that well-being is a multidimensional construct that not only includes a range of contributing psychological well-being factors, but changes throughout the life-span, and should be considered from a developmental perspective.

There are previous studies of menopause and well-being and these investigations have been limited to measures of happiness (Dennerstein, 1996) and health related factors (Groenveld, Barensten, Dokter, & Drogendijk, 1993) rather than a more multidimensional psychosocial approach that incorporates a range of quality of life factors. In order to explore the possibility of positive psychological consequences of the menopause the present study is devised to further understand

factors of well-being (e.g., purpose in life, self-acceptance, relations with others, autonomy, etc.) and negative consequences of menopause on marital satisfaction and self-concept. Present study aims at comparing these two variables in pre-, peri-, and postmenopausal women of Pakistan.

Interpersonal relationships are important for women and help in maintaining a positive image of themselves in their own eyes. Along with the physical and psychological changes during menopause women experience sexual dissatisfaction as well. It is mostly attributed to the hormonal changes in body but mostly leads to marital issues (Abernethy, 1997).

Marital relationship characterized by strong support may help to buffer midlife women against the stress resulting from stressful life events while relationships fought with conflict may adversely impact women perceived stress, menopausal symptomology, and marital satisfaction (Fielder & Kurpius, 2010). Present study aims to compare the level of marital satisfaction among pre-, peri- and postmenopausal women.

There are clear evidences of physical changes in the body during menopause which reduces the ability of women in performing their daily life activities. It leads to dissatisfaction with one's own self. The related psychological changes in women also contribute to change in the self-concept of women going through menopausal stages. The findings suggest that self-concept is an important factor for mid-life women to adjust to their menopause and sometimes self-concept influence physiological symptoms and psychological distress in varying degrees. In general, the positive self-concept will prevent the psychological distress and physical distress and physical

symptoms (Shu et al., 2007). Self-concept is also an important variable studied in present study to find out its relationship with menopausal symptoms.

Furthermore, there are several other populations (e.g., cancer patients, infertile women) have been under consideration regarding psychological well-being (Maryam, 2002; Naheed, 1997; & Saima, 2003), self-concept (Tahir, 1994), and marital satisfaction (Abida, 1994; Shahid, 2010; &Tallat, 2008). All the foregoing observations suggest that the issues of psychological well-being, marital satisfaction, and self-concept also need to be examined among menopausal women as well in Pakistan.

Present research aims to compare all three statuses of menopausal women i.e. pre-, peri-, and postmenopausal on psychological well-being, self-concept, and marital satisfaction and their relationships, while other researches (e.g., Nisar et al 2008) done in Pakistan had only considered postmenopausal women. In present study premenopausal women and perimenopausal women are also included.

On the basis of existing literature menopausal symptoms, psychological well-being, self-concept and marital satisfaction are identified as important factors. So, present research aims at exploring these interrelationships of menopausal symptoms, psychological well-being, self-concept and marital satisfaction among midlife women of Pakistan. Therefore, focus groups discussions were conducted, It was aimed that midlife women would be asked about their perception related to the relationship of menopausal symptoms, psychological well-being, self-concept, and marital satisfaction. The results of focus group supported the research objectives.

Previous researches focused on either one or two phases of menopause but present research aims to study all the three stages (pre-, peri-, and postmenopausal).

Furthermore, it also aims to study psychological well-being, self-concept, and marital satisfaction and their relationship with physical and psychological menopausal symptoms among pre-, peri-, and postmenopausal women.

In the light of research evidences mentioned in previous paragraphs, present study aims to explore the prediction of menopausal symptoms by self-concept, marital satisfaction and psychological well-being. As the previous researches (Deeks & Mccabe, 2004; Kolod, 2009; Schmidt, 2005) showed significant relationship of present study variables (menopausal symptoms, psychological well-being, self-concept, and marital satisfaction) therefore, present study also aims to study mediating effect of marital satisfaction on the relationship of psychological well-being and menopausal symptoms and on the relationship between self-concept and menopausal symptoms in pre, peri and postmenopausal groups. The strong relationship evidences (Fielder & Kurpius, 2010; Groenveld et al., 1993; Shu et al., 2007) are also used as a basis for exploration of mediating relationship of present study variables. The study aims to find the mediating effect of psychological well-being and marital satisfaction on relationship of self-concept and menopausal symptoms in pre, peri and postmenopausal groups.

Certain demographic variables are also found to have strong association with menopausal symptoms (Orgulo et al., 2011; Blumel, et al 2002; Mathews & Bromberger, 1994). Educational status, employment status and economic condition are studied and found to have significant relationship with menopausal symptoms (Gerber, 2001). Present study also aims to examine the role of women's person and demographic characteristics (education, employment status and economic conditions) in experiencing menopausal symptoms among pre, peri and postmenopausal groups.

Given these various contributions, we conducted the current study to understand the menopause, and related symptoms and their impact on psychological well-being, self-concept, and marital satisfaction which are not well explored among pre-, peri-, and postmenopausal women of Pakistan.

Furthermore, present research also aimed to examine the interrelationships of the research variables which are not studied in Pakistan for example, mediating effect of marital satisfaction on relationship of self-concept and menopausal symptoms and mediating effect of psychological well-being on relationship of self-concept and menopausal symptoms.

Present research can be considered as an effort to develop awareness about the less focused topic like menopause, which is considered as forbidden to talk about in Pakistani culture due to which most of the time women having health concerns suffer a lot because, in Pakistan there is a myth that menopause is a natural process without any health concerns while in Western cultures such issues are openly discussed and help is provided to women suffering from physical and psychological symptoms of menopause. Research evidences (Cefeili, et al 2009; Santoro & Perry, 2009) indicated that menopause reduces marital satisfaction. Women in Western cultures seek counseling for marital issues when they are going through menopause whereas, in Pakistan marital therapy and counseling is not very common. In Western cultures young girls are educated about menopause and related health concerns at school level. So, this research may contribute to a better understanding of the menopause and its relationship with certain psychological variables like psychological well-being, self-concept, and marital satisfaction among Pakistani women.

Chapter-II

Research Design

Beginning in line with the existing literature review the current research aims to study the phenomena of menopause along with certain psychological variables i.e., psychological well-being, self-concept, and marital satisfaction among women of pre-, peri-, and postmenopausal stages.

The present research consisted of four phases. The details are as follows.

Phase I: It comprised of Focus Group Discussions with pre, peri, and postmenopausal women. Six focus groups were carried out to know opinions, experiences, and attitudes towards psychological and physical symptoms of menopause. Two focus groups were conducted with each group of premenopausal, perimenopausal, and postmenopausal women respectively.

The objectives of phase I were:

1. To find opinions of pre-, peri-, and postmenopausal women about experience psychological and physical symptoms of menopause.
2. To get information related to psychological well-being, self-concept, and marital satisfaction among pre-, peri-, and postmenopaual women.
3. To find the impact of physical and psychological menopausal symptoms on psychological well-being, self-concept, and marital satisfaction among pre-, peri-, and postmenopausal women.

Phase II: It consisted of translation and cross-language validation of two scales i-e Greene Climacteric Symptoms Scale (GCSS) and Tennessee Self-Concept Scale-2 (TSCS-2). These two instruments were translated into national language of

Pakistan (Urdu) to make them more understandable and comprehendible for the target population.

The main objectives of this part of research were:

1. Translation of Tennessee Self-Concept Scale (TSCS-2), and Greene Climacteric Symptoms Scale (GCSS) into Urdu language to be used in next studies of the present research.
2. To determine the reliability and validity of the instruments.

This part of research consisted of the following steps.

Step I: Forward Translation

Step II: Expert Panel or Committee Approach

Step III: Back Translation

Step IV: Cross Language Validation

Phase III: Comprised of Pilot Study to determine the psychometric properties of instruments and preliminary analysis of collected data.

The specific objectives of the pilot study were:

1. To establish the psychometric properties of the instruments on a small group.
2. To identify the associated relationship among Psychological Well-being, Self-concept, Marital Satisfaction, and Menopausal Symptoms.

Phase IV: Consisted of main study which was conducted to achieve the objectives and test the hypotheses of present research. On the basis of literature review following hypotheses are formulated.

1. The peri-and postmenopausal women will perceive less psychological well-being than premenopausal women.
2. Peri-, and postmenopausal women will have less positive self-concept than premenopausal women.
3. Premenopausal women will have more marital satisfaction than peri-, and postmenopausal women.
4. Physical self-concept, Family self-concept, and academic attainment self-concept predicts psychological and physical menopausal symptoms among pre, peri and postmenopausal women.
5. Marital satisfaction and psychological well-being mediates the relationship between self-concept and menopausal symptoms.
6. Working women will experience less menopausal symptoms than non-working women.
7. Women with higher educational level will experience less menopausal symptoms than those women with lower educational levels.
8. Women belong to lower income families will experience more menopausal symptoms than higher income families.

One-Way ANOVA, Multiple regression, Mediation, and Two-Way ANOVA analyses were done to address different hypotheses.

Chapter-III

Phase I: Focus Group Discussions

Phase I of the present research comprised of the focus groups as previous researches (Avis et al., 1993; Kaufert et al., 1992; Nisar et al., 2012; Rahman et al., 2011) gave different findings related to menopausal symptoms and their intensity in different cultures. Subsequently there was difference in extent of impact of such symptoms in lives of menopausal women. Focus groups were conducted to investigate the opinions, and experiences regarding menopausal symptoms of pre-, peri-, and postmenopausal women from Pakistani culture.

Objectives. Focus groups were conducted to explore the knowledge, attitudes and experiences related to menopause among pre, peri and postmenopausal Pakistani women in an indigenous content.

The objectives were:

1. To explore the phenomenson of menopause in Pakistani culture.
2. To explore the experiences regarding menopausal symptoms of Pre, Peri and Postmenopausal women in Pakistan
3. To find out how menopausal symptoms affect Psychological Well-Being, Self-Concept, and Marital Satisfaction of women in Pre, Peri and Postmenopausal stages.

Sample. Six Focus groups were conducted with pre-, peri and postmenopausal women to explore the phenomena of menopause among women in Pakistani culture. The specific objective was to get an account from a sample about menopause and its impact on psychological well-being, self-concept, and marital satisfaction among

middle-aged women. The results provided the basis for further exploration of menopause and its relationship to self-concept, psychological well-being, and marital satisfaction.

First and second group consisted of premenopausal women. 10 housewives were in first group and 10 working women in second group.

Third and fourth group consisted of perimenopausal women. 7 housewives were in third group and 7 working women were in fourth group.

Fifth and sixth group consisted of postmenopausal women. 7 housewives were in fifth group and 7 working women were in sixth group.

Participants in each group shared some common characteristics. Women in all groups were 40-60 years old (*M* = 47.88, *SD* = 7. 36). The women had varied educational level from matric to M.Phil. Three focus groups were conducted with housewives and other three with working women. All the women were Muslim. All participants were married having at least one child.

Procedure. Six focus group discussions were conducted. Two focus groups were conducted with each group of pre-, peri-, and postmenopausal women, respectively. Focus groups were conducted because it provides a platform for a carefully planned discussion that was designed to obtain perceptions, feelings, subjective phenomenology, opinions and ideas of women regarding the concerned topic. It is also a quick, easy, practical way to have an overview about the topic with target population.

Before starting each focus group a brief introduction of the facilitator and participants was done to develop a rapport with participants. During the discussion it

was carefully monitored that every participant should take part in discussion. Participants were asked permission to record the discussion although they were told that their recording will be used only for the purpose of research but due to the hesitation from one or two participants in each group, recording could not be done. Important notes were taken by the trained helper and researcher herself in detail. At the end participants were thanked for their quality time and cooperation. Each session of focus groups took almost one hour

After each focus group the notes of researcher and facilitator were reviewed and rearranged. All the information from participants was compiled by the researcher and facilitator. Some details were added which were not in written form but recalled while the post focus group discussion of researcher and facilitator. The responses of participants were discussed and notes were prepared for analysis. The analysis included the tabulation of statements by different participants of the groups. It helped in giving an overall view of the extent of effects related to menopause.

Focus group guide. Focus group guide was prepared by the researcher. In the first step of the study a focus group guide was prepared with the help of existing literature and subject experts on the topic. The focus group guide had brief statements and probing questions regarding objectives of the focus group. The sequence of topics and questions in the guideline were from general to specific. The questions were related to the knowledge of menopause, experienced symptoms, and changes in life-style, behavior, attitude of the participants, marital satisfaction, well-being and self-concept of respective group.

There was a slight difference in questions of three groups i.e. pre (See Appendix-I & II), peri (see Appendix-III & IV)

کیاماہواری میں بے قاعدگی کی وجہ سے خود میں کوئی تبدیلی محسوس کی؟

(Do you perceive any change in yourself due to irregularity in menstrual flow?)

and post (see Appendix-V & VI).

کیاماہواری کے ختم ہونے سے آ نے خود میں کوئی تبدیلی محسوس کی؟

(Do you perceive any change in yourself due to cessation of menstrual flow?)

Focus group guide for premenopausal group contained questions were focused on knowledge of menopause and initial symptoms.

The focus group guide for perimenopausal group had questions contained some comparison questions of previous knowledge and current experience. While most of the questions concentrated on their current experiences and their severity.

The focus group guide of postmenopausal group also contained some comparison questions similar to the questions of pre-menopausal group. The questions for this group focused on their previous as well as current experiences and concerned about the changes in their life-style that has taken place due to menopause. The topic guide was revised after every focus group (see Appendix -I-VI). The details of each focus group are as follows.

Focus group 1. This focus group aimed at collection information related to menopause from housewives in pre-menopausal stage.

Sample. The first focus group was conducted with 10 pre-menopausal women. They were housewives from Rawalpindi and Islamabad Cities. Their age range was from 35 to 46 years, with mean age of 40 years. The educational qualification for all the participants was ranged from matriculation to graduation. All the participants were approached individually. Some of the participants expressed happiness on reaching the stage of menopause and other participants had unpleasant feelings towards menopause.

Starting from the introduction of the topic and general orientation of the study, questions were asked following the guideline. Different aspects were discussed in the focus group covering the important objectives of the study (see Appendix -I). The session took almost one hour.

Results. Data collected from focus group discussions was reviewed and identified responses were reviewed for content analyses. The responses were tabulated in form of frequencies. Results were compiled in descending order of their frequencies. Frequencies depict the prevalence of ideas, symptoms, and psychological effects of menopausal symptoms among pre-, peri-, and postmenopausal women. The greater frequencies provide validating evidences related to presence of study variables among participants. Whereas, the lesser frequencies show less validating evidences related to presence of various aspects of study variables.

Following information was gained by the first focus group and is presented in the form of frequencies.

1. Women said that they will feel relief after cessation of menstruation (f=9).
2. They reported worry about pre-menopausal symptoms (f=8).
3. Women have information about menopause (f=8).

4. Women reported muscular pains and fatigue (f=7).
5. They also reported no changes in their sex drive (f=7).
6. Women have some myths regarding menstruation like avoid putting hands in cold water, not to take medicines for pain, and not to take bath (f=7).
7. Women felt the changes in their activities and emotions are due to normal aging process which men and women goes through at this age (f=7).
8. They reported relatively less interest in personal grooming (f=7).
9. Most of the women of this age group have negative attitude and feelings about menstruation (f=6).
10. They consider pre-menopausal changes as a hindrance in their daily routine and activities (f=6).
11. Women reported that they feel that at times they are unable to control their emotions (f=6).
12. Women reported that they got information about menopause from elder sisters or mothers (f=6).
13. They also reported that before menopause they were able to do a lot of activities daily as compared to the present situation where physically they exhaust easily and postpone many activities. (f=5).
14. Women were worried about the care of their children as they heard about the stories of women who had terrible menopausal experiences (f=5).
15. Women reported low self-worth especially when they are unable to do activities (f=4).
16. Women were worried about the unavoidable physical changes in the body (f=4).
17. Some women reported weight gain (f=4).

18. Women got information about menopause from friends only (f=3).

19. They reported minor health issues of blood pressure and diabetes (f=3).

20. Woman reported that she will feel less feminine and incomplete after menopause (f=1).

21. Woman reported that before menopause she always felt good about guests and serving them but now it is getting tough for her (f=1).

22. Woman reported that she felt terrible about her fatigue as she has small children and needs more attention (f=1).

Focus group 2. It aimed at collection of information related to menopause from working women in pre-menopausal stage in order to develop understanding about menopause among Pakistani women.

Sample. The second focus group was comprised of 10 premenopausal women. They all were lecturers in Govt. Degree College for Women, Zafar-ul-Haq Road, Rawalpindi. Their age range was 37 to 45 years with mean age of 41 years. Their educational qualification was from Masters to M. Phil in different disciplines. They were approached individually. After taking their consent they were included in the focus group. It also took an hour to finish the focus group (see Appendix -II). At the end of the discussion the participants were thanked for their cooperation.

Results. Following information was obtained from the second focus group.

1. Women in this focus group agreed that girls should be briefed regarding menstruation before time by their mothers (f=10).

2. Women reported that they are worried about their gradually deteriorating output at workplace as well as at home due to menopause (f=9).

3. They had no information or briefed by their mothers about the menstruation or menarche in their adolescence (f=8).

4. Women in this focus group were well educated so they had enough knowledge regarding menopause. They thought that around the age of 50 they will experience menopause, and they can experience some menopausal symptoms like weight gain, depression, dull life, lack of energy, or may be end of sexual relationships (f=8).

5. They reported that they feel anger towards themselves when they are unable to manage activities and their physical requirements and consequently feel low about themselves (f=8).

6. Women knew about menopause (f=8) and most of them got that information from colleagues (f=5) or library books (f=3).

7. Women reported no changes in their sex drive (f=7).

8. Women reported that they get tired easily and they have to postpone tasks (f=7).

9. Women reported that they were already told by their class fellows and elder sisters (f=6).

10. Women were worried about anticipated changes in their married life and their husband's reaction about menopause (f=6).

11. they also reported some physical and psychological symptoms due to the menarche like depression, irritation, anger, isolation, and physical pain (f=5).

12. Women said that sometimes they are unable to balance between job and home (f=5).

13. Women reported that they are gradually losing interest in dressing and grooming (f=5).

14. They reported that they feel irritation more often and sometimes they argue with colleagues (f=4).

15. Women expressed their worry and concern about their deteriorating health (f=2).

16. Women reported sleep problems (f=2).

17. They also reported health issues like joint pains, headache, etc. (f=2).

18. Another woman mistook menstruation as blood cancer (f=1).

Focus group 3. This focus group aimed at collection information related to menopause from housewives in perimenopausal stage.

Sample. The third focus group was conducted with the 7 peri-menopausal women. Their age range was from 44 to 51 years (*M* = 48 years). They were all house wives from Rawalpindi and Islamabad. The educational qualification of the participants ranged from matriculation to graduation. All the participants were briefed about the topic and objectives of the study (see Appendix -III).

Following information was obtained from the third focus group.

1. Perimenopausal women suggested that awareness of menopause and related symptoms is important for younger women (f=7).

2. Women in this group reported symptoms of irritation, depression, headache, and hot flushes (f=6).

3. Women reported that they had knowledge about menopause and they got that from other elder women and age fellows (f=6).

4. They felt happy when they menstruate after skips (f=6).

5. Fatigue and time management issues in household work were also reported by them (f=5).

6. Women considered that their sacrifices have no worth in the eyes of their children and husband (f=5).

7. Women reported that they have been gaining weight since the start of menopausal symptoms (f=5).

8. Women reported that they feel worthless at home and experience lack of attention from their family members (f=4).

9. Women reported that they thought there would be no drastic changes in their daily-life activities after menopause but their experiences were different (f=4).

10. Women reported bizarre imaginations and fantasies, mostly related to lack of recognition of their efforts and hard work for their family members (f=4).

11. Women reported less affection for husband and reduced sexual drive (f=4).

12. They felt reduced decision making power and psychological confusion in daily life matters which were easily dealt in their past lives (f=4).

13. Women expressed their hopelessness for future as they think that their physical and psychological symptoms would aggravate with age and their sufferings would increase (f=4).

14. Women reported weight problems (f=4).

15. Feelings of worthlessness was also reported by the women (f=3).

16. They did not recognize their psychological symptoms as menopausal e.g., they relate depression to the death of significant others (f=3).

17. They also reported psychological symptoms like memory loss, time management problems, over-sensitivity, crying spells, depression (f=3).

18. Women reported problems in tolerating the different behaviors of colleagues and felt lack of control at times (f=3).

19. Women reported general disappointment and lack of interest in life. They felt lack of motivation in daily activities (f=3).

20. Women also reported a feeling of freedom due to menstruation skips (f=3).

21. Women reported that they didn’t experience any menopausal symptoms (f=2).

22. Women reported that they started reading about menopause when they themselves experienced initial symptoms to understand and manage the symptoms (f=2).

23. Women reported that their children are complaining about their changed behavior and unnecessary irritability (f=2).

24. Women reported difficulty in falling sleep at night (f=2).

25. Women reported that they do not share with anyone as they feel others did not listen to them carefully. When they feel extreme sadness they used to cry a lot (f=2).

26. Woman reported that she felt pathetic and said that she was experiencing, hot flushes, itching, profuse sweating, and crawling sensation for last 6 years but few months ago she recognized them to be related to menopause after reading about it in a book (f=1).

27. A women reported emotional outbursts and feeling of guilt afterwards. She said she apologize to family members the next day as she used to say harsh words to them (f=1).

Focus group 4. The fourth focus group was comprised of 8 perimenopausal working women, from Rawalpindi and Islamabad. Two were senior nurses of CDA hospital in Islamabad. Six were teaching in different private schools of Rawalpindi and Islamabad. Their age range was from 45-50 years. Their educational qualification

was ranged from B.Sc to Masters. They were asked questions related to their phase and its impact on their lives (see Appendix -IV).

Results. Following information was obtained from the fourth focus groups.

1. Women reported that they felt happiness when they menstruate after skips (f=6).

2. Most frequently experienced symptoms were irritation, depression, headache, quick and strong heart beats, hot flushes, night sweats, and tiredness (f=6).

3. Women in this group were of the view that by the end of the age of 45 years, women would experience shortened menstrual cycle of 18-21 days duration (f=6).

4. They felt reduced decision making power and psychological confusion in daily life matters which were easily dealt in their past lives (f=4).

5. Women reported that they thought there would be no drastic changes in their daily-life activities after menopause but their experiences were different (f=4).

6. They reported less affection for husband and reduced sexual drive (f=4).

7. Women reported bizarre imaginations and fantasies, mostly related to lack of recognition of their efforts and hard work for their family members (f=4).

8. Women express their worry related to weight gain as that would their physical health and psychological confidence (f=4).

9. Women have been experiencing increase in number of menstruation days and heavy flow after menstruation skips for 2-3 months (f=4).

10. Women reported psychological symptoms like memory loss, time management problems, over-sensitivity, crying spells, depression (f=3).

11. Women reported problems in tolerating the different behaviors of colleagues and felt lack of control at times (f=3).

12. They also reported a feeling of freedom after menstruation skips (f=3).

13. Women did not recognize their psychological symptoms as menopausal e.g., they relate depression to the death of significant others (f=3).

14. They also reported feeling of worthlessness (f=3).

15. They reported that their children are complaining about their changed behavior and unnecessary irritability (f=2).

16. Women also reported that menstruation stops altogether (f=2).

17. Women reported that they didn't experience any menopausal symptoms (f=2).

18. A woman described their symptoms as being severe (f=1).

Focus group 5. This focus group aimed at collection information related to menopause from housewives in postmenopausal stage.

Sample. The fifth focus group was conducted with the 7 post-menopausal women. Their age range was from 50 to 60 years (*M* = 55). They all were house wives from Rawalpindi and Islamabad. The educational qualification of the participants ranged from matriculation to graduation. All the participants were briefed about the topic and objectives of the study. There were many questions asked to the participants about covering the objectives of the focus group (see Appendix -V).

Following information was obtained from the fifth focus group.

1. Women in this group reported irritable mood, mood swings, crying spells, distress, and sadness (f=6).

2. They reported experiencing a gradual onset of the menopause (f=5).

3. Participants in this group felt freedom after menopause as they can attend events and functions without worry (f=5).

4. Women reported that being knowledgeable about menopause did not help them in experiencing the actual phenomenon (f=5).

5. Women reported reduced sexual drive and lack of attraction towards husband (f=5).

6. Women reported lack of interest in their own health and grooming (f=5).

7. Participants also reported that they are unable to do the routine household and get tired earlier than usual. They had to get help from other persons in family or arranged for housemaid (f=5).

8. Women reported their symptoms as being severe (f=5).

9. They reported reduced sexual activity and sex drive (f=5).

10. Women also reported weight gain (f=5).

11. Few attributed it to reduced physical activity (f=3).

12. They also reported that they share their physical and emotional problems with their daughters (f=5); few reported sharing of problems with husband (f=2).

13. Participants reported that they have started feeling themselves to be unattractive and old (f=4).

14. Women didn't recognize the symptoms as menopausal (f=4).

15. Lack of attention from their husbands and children was reported (f=4).

16. Sleep disturbances were also reported by the participants (f=3).

17. They reported that they felt freedom in religious activities after menopause especially in the month of Ramadan (f=2).

18. Women said that other women can be helped by giving knowledge before menopause (f=2).

19. Sudden cessation of menstruation was also reported by a woman (f=1).

20. A woman reported that sometimes she wishes to die at times especially when she couldn't figure out about the causes of her emotional problems (f=1).

Focus group 6. This focus group aimed at collection information related to menopause from working women in post-menopausal stage.

Sample. The sixth focus group was conducted with the 7 postmenopausal women. Their age range was 35 and from 50 to 60 years with mean age of 56.4. They all were working women of different public and private institutes from Rawalpindi and Islamabad. The educational qualification of the participants was ranged from graduation to masters. All the participants were briefed about the topic and objectives of the study. Numerous questions were prepared and most of them were improvised after listening to the responses (see Appendix -VI).

Results. Following information was obtained from the sixth focus group.

1. Women reported that due to persistent feeling of tiredness they had to arrange for part time or full time housemaids (f=6).
2. Participants were observed that they feel freedom from menstruation and fear of pregnancy after complete cessation of menstruation (f=6).
3. They also reported experiencing a gradual onset of the menopause (f=5).
4. Women didn't recognize the psychological symptoms as menopausal (f=5).
5. When looking back the past few years, women were able to recall experiencing symptoms, for which they could not identify the cause (f=5).
6. Symptoms like mood swings, crying spells, distress, sadness, feeling of worthlessness and poor attention from others were also reported by them (f=5).
7. Despite knowing the psychological symptoms they were unable to control them (f=4).
8. Lack of attention from their husbands and children was also reported (f=4).

9. Hopelessness for future due to the poor physical health was also expressed by them (f=4).
10. They also felt freedom in social activities after menopause (f=3).
11. Women also reported lack of interest in their own health and grooming (f=3).
12. Weight problems and related concerns were also reported (f=3).
13. They have started feeling themselves to be physically unattractive (f=3).
14. Women reported reduced attraction towards husband (f=2).
15. Women felt lethargic and lack of motivation in life (f=2).
16. They reported insomnia (f=3).
17. Others reported hypersomnia (f=2).
18. Sudden cessation of menstruation was also reported by women in this group (f=2).
19. Women reported their symptoms as being severe (f=2).
20. Lack of control on expression of emotions was another problem reported by the women (f=1).
21. A woman with age of 35 experienced premature menopause, and felt severe depression and other psychological and physical symptoms (f=1).
22. A woman reported reduced sexual activity and sex drive (f=1).

Discussion. Six focus groups were conducted for the above mentioned purpose with women from pre, peri and postmenopausal stages. From each stage one focus group was conducted with housewives and other with working women. Most of the results of focus groups with housewives and working women of premenopausal stage revealed similar results. But there was slight difference in the intensity of reported symptoms and problems.

The research evidences suggested different findings related to menopause. A study conducted by Kaufert, Gilbert and Tate (1992) reported that 85% of Caucasian populations reported vasomotor symptoms and they also reported other physical and emotional symptoms. The researchers also reported that the percentage of women varies within the country. Studies of Asian countries reported lowest rates. Research findings of Japan and Thailand reported 6% and 12% respectively, and studies in Africa reported 30%-80% rate (Avis, Kaufert, Lock, McKinley & Vass, 1993). Some Pakistani and Bangladeshi researchers reported vasomotor, somatic and psychological symptoms of menopause among women of respective countries (Nisar et al., 2012; Rahman et al., 2011). In the light of these research findings, focus group was conducted in present study to have a baseline data of menopause and its impact on psychological well-being, self-concept and marital satisfaction. Present study aimed to collect data from focus groups and review the findings accordingly before conducting the main study.

Previous researches indicated that non-working women (housewives) experience more somatic symptoms e.g., muscle or joint problems, headache, and breathing difficulties. Non-working women also experience vasomotor symptoms e.g., hot flushes, sweating at night than working women than working women (Orgulo et al., 2011; Mathews & Bromberger, 1994). Therefore, working women and housewives were invited in separate focus groups. Most of the results of focus groups with housewives and working women of premenopausal stage revealed similar results. But there were difference in the intensity of reported symptoms and problems.

These finding are also in accordance with the earlier researches (e.g., Orgulo et al., 2011; Mathews & Bromberger, 1994).The non-working women also experience more somatic symptoms e.g., muscle or joint problems, headache, and breathing

difficulties, and vasomotor symptoms e.g., hot flushes, sweating at night than working women.

First two focus groups were conducted with housewives and working women in premenopausal stage, respectively. The results suggested that women of this stage were experiencing initial symptoms of menopause. The results indicate that women in premenopausal group have concerns about their productivity as a member of family. They have slight physical and psychological menopausal symptoms. The results are in accord with the previous studies including the study conducted by Jong, Shun, Shiang, Kai & Lung 2001; Lori, Erica, William & Richard (2003).

Third and fourth focus groups were conducted with housewives and working women of perimenopausal stage. Fifth and sixth focus groups were conducted with housewives and working women of post-menopausal stage. The women in these groups reported severe psychological and physical symptoms as compared to the women in premenopausal stage. Some women in last four groups (perimenopausal and postmenopausal groups) reported reduced libido and sexual activities. Moreover, they also reported less affection towards husbands. Research evidences suggest that sex drive and sexual activities decline in premenopausal stage and it continue its decline in peri-, and postmenopausal stages (Greendale & Arriola, 2001).

Some women in various groups (pre-, peri-, and postmenopausal) attributed the deteriorating physical changes to other reasons (health problems like blood pressure, diabetes, etc.) rather than menopause and this is also suggested in the research conducted by Porter, Penny, Russell, and Russell (1996). They reported that in their study, as much as 35% to 45% of premenopausal women also reported similar symptoms (joint and muscular discomfort, physical and mental exhaustion, anxiety,

depressing mood, irritability), this could be explained since most of the somatic or psychological symptoms experienced by these middle age women are not exclusively as a result of changes due to menopause alone, it's could also resulted from other physical, psychological, or health related problems which is related to aging in these group of women which can represent as menopausal like symptoms. In present study few women in each group reported similar severity of symptoms and they can be explained by medical problems other than menopause. Even some women also expressed their perceived connection of health related problems with their aging process.

Few women reported sudden cessation of menstrual cycle, whereas most of the women reported gradual cessation and reported related medical problems as well. Other research evidences suggest that only small percentage of women experience sudden cessations. A study conducted by Kaufert et al. (1992) reported that majority of women experience menstrual changes years before their final period. Only an estimated 10% report an abrupt cessation. Heavy flow is common among women in the Manitoba study, and this heavy flow led to medical consultation by about 25% of women.

Women reported many physical and psychological symptoms which were affecting their daily life activities. The most commonly reported are vasomotor symptoms (hot flushes and night sweats) sleeping disturbances, changes in libido, mood changes and fatigue. The prevalence of many of these symptoms varies from early to late menopause. According to Obermeyer (2000), vasomotor symptoms, though they are not unique to menopause, are by far the most commonly reported. Women who were prone to physical and emotional symptoms, also reported vasomotor symptoms. These symptoms varied to large extent amongst women of

different countries. Another study by Avis et al. (2004) reported association of above mentioned factors with marital satisfaction.

The results of focus groups suggested psychological problems like sad mood, crying spells, anxiety, low self-esteem, low confidence, lack of interest in personal grooming and low self-worth. Apart from these findings some women reported weight gain in menopausal stages (peri- and post). According to Sammel et al. (2003), in menopausal women the expected key factors accountable for weight gain were psychological issues as well as depressed mood, anxiety and quality of life. There might be considered some conflict between these factors; was weight gain responsible to turn down quality of life.

Most of the women in focus groups reported low self-worth due to their reduced ability in performing activities as member of family and part of workplace. Some women reported that they feel lack of attention from their husband and children. Working women reported lack of attention to the importance of their activities at workplace. A study conducted by Lachowsky (2002) reported that women experience loss of personal value, and perceive physical, psychological and social devaluation.

Some women in focus groups reported their fears related to aging and losing their physical attraction. Fisher (1995) stated that physical alterations, whether from illness or the normal aging processes were integrated into the self-concept. While other women reported experience of freedom and positive feeling like they can keep their sanctity and offer their prayers without fear of having periods. They are also happy for keeping fasts regularly during “Ramazan”. Some women reported that they feel themselves “Pak” because menstruation causes “napaki”.

These findings explain the difference of perception about menopause in Pakistani culture than Western cultures. In eastern cultures, aging leads to gaining more respect in the society and other social benefits.

In conclusion, there were few physical and psychological symptoms in premenopausal stage as compared to peri- and postmenopausal stages. Due to the declining health of women in menopausal stages (pre, peri and post) they reported feelings of less positive self-concept and low marital satisfaction. Results of focus group discussions revealed that menopausal symptoms can be associated with the consequent changes in psychological well-being, self-concept and marital satisfaction. The findings of focus group are the basis for further exploration of the aforementioned phenomenon using standardized instruments.

The conclusion of focus group led to selection, translation and validation of instruments of self-concept and menopausal symptoms, which will be translated and validated as standardized instruments for measurement of other variables like psychological well-being and marital satisfaction were available in native language i.e. Urdu.

Chapter-IV

Phase II: Translation, and Cross Language Validation of the Instruments

For the measurement of self-concept, Tennessee Self-Concept Scale (Fitts & Warren, 2003), was translated after getting the permission from the Western Psychological Services (see Appendix-XVII), and for the measurement of menopausal symptoms Green Climacteric Symptoms Scale (Greene, 1998) was selected. The Ryff Scale of Psychological Well-being (Ryff, 1989) and Marital Satisfaction Scale (Olson, & Fowers, 1989) were available in Urdu version therefore the instruments were translated and cross-validated for language. Brief descriptions of these instruments are as follows.

Tennessee Self-Concept Scale (TSCS-2; [Fitts & Warren, 2003]). Self-Concept of the participants was measured by TSCS-2 (see Appendix-VII). It is a multidimensional measure of self-concept, with a 5-point response scheme (1- strongly disagree; 5- strongly agree) and 74 items. It covers six dimensions including Physical Self (PHY), Moral-Ethical self (MOR), Personal Self (PER), Family Self (FAM), Social Self (SOC), and Academic Attainment/ Work Self (AAS). Test-retest reliability for PHY is .79, for MOR is .77, for PER is .73, for FAM is .80, for SOC is .70, and for ACA is .76.

Tennessee Self-Concept subscales are described as follows.

1. ***Physical self-concept (PHY):*** The PHY score presents the individual's view of his or her body, state of health, physical appearance, skills, and sexuality. Individuals are likely to use information about their appearance or their health status in a self-enhancing way.

2. ***Moral Self-Concept (MOR):*** This scale describes the self from a moral-ethical perspective, examining moral worth, feelings of being a 'good' or 'bad' person, and satisfaction with one's religion or lack of it.
3. ***Personal Self-Concept (PER):*** It measures the individual's feeling of personal value, sense of capability as a person, and self-evaluation of the personality apart from the body or relationships to others.
4. ***Family Self-Concept (FAM):*** This scale measures the individual's feelings of adequacy, worth and value as a family member. It also reveals that how the individual perceive his/herself in relation to his or her immediate circle of acquaintances.
5. ***Social Self-Concept (SOC):*** It measures how individuals perceive themselves in relations to others. It also reveals the more general way the individual's sense of capability and worth in social communication with other people.
6. ***Academic/Work Self-Concept (ACA):*** It measures that how people perceive themselves in school and work settings, and how they believe they are seen by others in those settings.

Green Climacteric Symptoms Scale [GCSS; (Green, 1998)]. To measure the experience related to menopausal symptoms GCSS was used (see Appendix-X). GCSS includes 21 items, having a 4-point Likert type scale response scheme (0 not at all, 1 a little, 2 quite a bit, and 3 extremely). GCSS is consisted of 3 subscales psychological symptoms (items 1-11), Somatic scale (items 12 to 18), and Vasomotor scale (items 9 to 20). Item 21 is a probe for Sexual Dysfunction. High scores on scale show high experience of symptoms related to menopause and low scores show less

experience of symptoms. Test-retest reliability of Psychological scale is .87, for Somatic (physical) Scale is .84, and for Vasomotor Scale is .83.

The translation and validation of instrument involved three steps i.e. forward translation, back translation, and cross language validity. The details of these steps are as under.

Step 1: forward translation. In order to attain greater confidence for creating parallel Urdu translated versions of instruments present study was sampled each sphere for forward translation. Six bilingual experts were approached for forward translation of TSCS-2 and GCSS. Two translators were English Language experts (M. Phil in English). Two bilingual experts were students of psychology studying M.Phil and Ph.D level in university (having a knowledge of both source and target language), and two bilinguals had done their masters in Urdu and advanced diploma in English. They were requested to translate the original scales. Each of the bilingual translated the items independently. These translators fit in the criteria as described by Brislin (1980) who believed that translation should: (1) have a clear understanding of the original language, (2) have a high probability of finding a readily available target language equivalent so that he/she does not have to use unfamiliar term, and (3) able to produce target language items readily understandable by the eventual set of respondents who are the part of the pilot and main study.

Committee Approach. Next an expert panel was approached by the researcher. The goal in this step was to identify and resolve the inadequate expressions, concepts of the translation. An expert panel of 3-5 individuals is usually considered appropriate. For present study committee approach was done with 4 participants including the two lecturers of psychology, the supervisor of the study, and the researcher herself, as the researcher was not the part of the translation phase. In

this phase committee members critically analyzed each statement of every scale and selected the one, which conveyed the best meaning. Committee members also evaluated the translated items with reference to their context, grammar, and wording.

Step II: back translation. In step II the translated version mutually agreed upon by the panel, was back translated into the source language as a check on initial translation and to identify the points of equivalence or difference between the two versions. The instrument translated through double procedure show higher reliabilities than those that are translated from source to target language only (see Appendix-IX, XII) (Berkannovic, 1980).

For this phase again six bilingual experts were approached who were not exposed to the original English items of scales, were provided with Urdu translation of scales that have been obtained in step 1. They have to translate the items into English. Out of six bilinguals three were lecturer in English, having six years teaching experience. Three were students of psychology at M.Phil and Ph.D level.

The back translation of the Urdu version and original scales were examined by the same committee. The committee observed that the back translation matched to a great extent with the original scales. Finally, the Urdu translated items arranged in the item order given in the original scales.

Step III. cross language validation. In this step validation process involved a comparison of Urdu translated version with original English version of the scales. So, the following procedure was carried out to assess the quality of Urdu translation and determine the empirical equivalence of the target script against the original versions.

Sample. The English and Urdu versions of scales were administered on the sample of 30 pre-, peri-, and post-menopausal women (10 from each menopausal status). Their age range was 40-59 years. Their educational levels varied from

graduation to masters. All the participants had studied Urdu and English languages as a part of their courses in different grades.

Procedure. Accordingly, the scales were administered twice to two groups of bilingual Pakistani women in Urdu-Urdu, and Urdu-English sequences. The administration of the tests carried out in groups including 15 in each group.

Participants were randomly assigned to the two conditions: Urdu test and retest; Urdu test and English retest. These groups were made to control the experiences of learning effect that may take place due to the administration of Urdu and English tests on two weeks apart.

Results. In order to determine cross-language validity and test-retest reliability of the scales, correlation coefficient between the scores of two administrations has been carried out. Second administration was done after fifteen days of first administration.

Table 1

Retest reliabilities of Urdu and English versions of TSCS-2, and GCSS (N = 30)

Scales	*r*
Tennessee Self-concept Scale (Urdu-Urdu)	.69**
Tennessee Self-concept Scale (Urdu-English)	.64**
Greene Climacteric symptoms scale (Urdu-Urdu)	.98**
Greene Climacteric symptoms scale (Urdu-English)	.84**

**$p < .01$

Table 1 shows that two groups (Urdu-Urdu retest, Urdu-English retest) correlations for all scales are significant. The reliability coefficients of TSCS for Urdu-Urdu is .69 ($p<.01$) and for TSCS Urdu-English is .64 ($p<.01$). The results are consistent with the findings of original TSCS-2 test retest reliability coefficients ranged from .47 to .82

Discussion. Pakistani psychologists are interested to adapt and translate the new and well researched instruments so that these can be applied to local population with confidence. Although in the present study, independent back translation and committee approach was done but it was important to establish the cross-language validity of the instruments.

If scores on an instrument in test–retest administration are strongly related to each other then it indicates the stability of the construct measured by the instrument and also strong test-retest reliability. In the present study TSCS-2 and GCSS have been translated and it was important to establish test-retest reliability before using the instruments in the main study. To see the empirical equivalence, both the versions were administered to the subjects of bilingual in Urdu-Urdu, and Urdu-English sequence. However, the correlations of Urdu-English tests are significant but low as compared to the Urdu-Urdu tests. That can explained considering the low correlations of these two groups. Apparently it seems that Pakistani women were not familiar with these words as they are not in common terminologies used by Pakistani population. These problems have also been tackled in the Urdu version.

The scales have been translated and, the cross language validation analyses reveal that the correlations of Urdu-Urdu, and Urdu-English tests, are satisfactory. Greene Climacteric symptoms scale yielded test-retest reliability coefficient for Urdu-Urdu .98 (p<.01) and for Urdu-English .84 (p<.01) which is highly satisfactory. The test-retest reliability of the scale was .87 (Greene, 1990) consistent with present study findings. The satisfactory range of values indicates the stability of the scales over time, as well as cross-language validity of the Urdu and English versions. Although, the correlations of Urdu-English retest are significant, the reason may be the practice effect of the same language administration. Overall, these results indicate the strong

evidence of cross language validity or empirical equivalence or original and translated versions of scales, and shows that both the tests are conceptually similar.

The TSCS-2, GCSS have been translated and the cross language validity of these instruments has been establishing that the correlations of Urdu-Urdu and Urdu-English tests which are satisfactory. Then the instruments were ready for the pilot study.

Chapter-V

Phase III: Pilot Study

The pilot study was planned to achieve the following objectives on a small group.

1. To establish psychometric properties of the Ryff Scale of Psychological Well-Being (Ryff, 1989), translated by Ansari, (2010), Tennessee Self-Concept Scale, (TSCS-2) developed by Fitts and Warren (2003), Greene Climacteric Symptoms Scale (Greene, 1998), and Marital Satisfaction Scale (Olson & Fowers, 1989) translated by Iqbal, (2010).
2. To find relationship between variables (menopausal symptoms, Psychological Well-Being, Self-Concept and Marital Satisfaction) among women in pre-, peri-, and postmenopausal stages.

Sample

Sample of pilot study comprised of 60 women (20 for each menopausal status) with age range of 36-59 years. Participants of the pilot study were from Rawalpindi and Islamabad. Their menopausal status was classified as pre-, peri-, and postmenopausal on the basis of symptoms given in their self-report (see Appendix-XIV. Participants were married with at least one child. Minimum education level of participants was matric (10th Grade). The age range of premenopausal women was 36-48 years (M = 43.90, SD = 4.40). Perimenopausal women's age was 38-52 years (M = 43.35, SD = 3.54). Women in postmenopausal group were with age range of 44-59 years (M=53.20, SD=2.91). All the women were assigned to either premenopausal status, perimenopausal status, or postmenopausal status by using a common method of menopause classification that is a length of time since last menstrual period (Deeks & McCabe). Premenopausal = no noticeable change in flow or frequency of

menstruation over at least 12 months; Perimenopausal = changes in menstrual frequency and flow in previous 12 months associated with menopause; Postmenopausal = no menstrual flow for 12 months or more. All the participants had achieved natural menopause, without any intervening cause such as pregnancy, lactation, exogenous hormone use, dietary deficiencies, or surgical removal of the uterus or ovaries.

Instruments

Four Instruments were used in the present study, GCSS [(Greene, 1998) see Appendix-XI)], TSCS-2 [(Fitts & Warren, 2003) see Apendix VIII)], Urdu version of the Ryff scale of psychological well-being (Ansari, 2010), and Urdu version (see Appendix-XVI) of marital satisfaction (Iqbal, 2010).

The Ryff Scale of Psychological Well-being Urdu-version [RSPWB; (Ansari, 2010)]. The Ryff scale of Psychological Well-being (RSPWB) 54-item, is theoretically-grounded self-report instrument that focuses on measuring six dimensions of psychological well-being: self-acceptance, personal growth, purpose in life, positive relations with others, environmental mastery, and autonomy (Ryff, 1989) (see Appendix-XV). Each dimensional scale contains 9 items equally split between positive and negative items. Items are scored on a 6-point scale ranging from strongly agree to strongly disagree. Internal consistency (alpha) for six subscales ranges from (0.82 to 0.90). A shorter version of Ryff Scale of Psychological Well-Being (RSPWB) comprised 54 items developed by Ryff and Keys (1995) was used in present research. This Scale comprised of six dimensions of wellness. These dimensions are self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. This scale encompasses

six dimensions of wellness and generates separate score for each dimension as well as a total score was calculated to determine individual's level of psychological well-being. High scores on this scale indicate high psychological well-being and vice a versa.

1. ***Environmental Mastery.*** This subscale measures the sense of mastery and competence in managing everyday environment. High scores on this dimension indicate individual having the environment, controls complex array of external activities, and makes effective use of surrounding opportunities, able to choose or create contexts suitable to personal needs and values. On the other side the low score indicate that individuals have difficulty in managing everyday life affairs, feel unable to change or improve surrounding context, unaware of surrounding opportunities, and lack in sense of control over external world. This subscale consists of 9 items.
2. ***Positive Relations with Others.*** This subscale measures trusting relationships with others. High scores explaining individual's tendency to warm, satisfying, trusting relationships with others; concerned about the welfare of others, capable of strong empathy, affection, and intimacy. Low score on this dimension indicates that individual has a few close, trusting relationships with others, finds it difficult to be warm, open and feels isolated and frustrated in interpersonal relationships. This subscale consists of 9 items.
3. ***Personal Growth.*** It measures the personal development among individuals. The high score showed that individual has a feeling of continued development; sees self as growing, is open to new experiences, has sense of realizing his or her potential and is changing in ways that reflect more self-knowledge and effectiveness. Whereas, the low scores indicate that individual has a sense of

personal stagnation, lacks sense of improvement, feels bored, and feels unable to develop new attitudes or behaviors. This subscale consists of 9 items.

4. ***Self-Acceptance.*** This subscale measures individual's attitude towards oneself. High score explaining a positive attitude toward the self acknowledges and accepts multiple aspects of self, including good and bad qualities. While the person scoring low generally feels dissatisfied with self, and is troubled about certain personal qualities and wishes to be different than what he or she is. This subscale consists of 9 items.
5. ***Purpose in life.*** This subscale measures individual's sense of directedness in life. The person scores high on this subscale has goals in life and a sense of directedness. He or she holds beliefs that give life purpose. While a low scorer lacks a sense of meaning and directedness in life and has no outlook or belief that gives life a meaning. This subscale consists of 9 items.
6. ***Autonomy.*** It measures individual's independence and self-determination. High scores on this subscale indicates individual as self-determining and independent, able to resist social pressures and act in certain ways, regulates behavior from within and evaluate self by personal standards. The low score indicates that individual is concerned about the expectations and evaluations of others, relies on judgments of others to make important decisions and conforms to social pressures. This subscale consists of 9 items.

The scale is best conceived to measure well-being as a multidimensional construct made up of life attitude (Ryff, 1989). This is a widely used measure to assess the wellness of individuals across cultures (Ansari, 2010; Kafka & Kozma, 2002).

Marital Satisfaction Scale (MSS; [Olsen, 1989]). Marital satisfaction scale is the subscale of Enrich Couple Scale (Olsen & Fowers, 1989) (see Annex-XVI). It was used to measure the marital satisfaction. MSS includes 10 items, with a 5-poits Likert type scale response scheme (1, strongly disagree; 5, strongly agree). Test–retest reliability for MSS is (.91).

Enrich Marital Satisfaction Scale originally developed by Olson and Fowers (1989) translated by Iqbal, 2010), and Greene Climacteric Symptoms Scale (GCSS; [Greene, 1998] were also used in the pilot study (details are present in chapter III).

Demographic information sheet. Demographic information related to level of education, monthly family income, marital status, age, profession, No. of children, menopausal status, was collected (see Appendix- XIV).

Procedure

The data was collected from different areas of Rawalpindi and Islamabad. Participants were briefed about the purpose of the present study; their consent (see Appendix-XIII) was taken for participation in the study. Before administering the scales they were assured that all the information provided by them would be kept confidential and were used only for the research purpose. Participants were requested to give their responses honestly and accurately. They were also asked to give responses on all the items of the scales. After collecting the data statistical analysis was done by using SPSS 18 version.

Results

Alpha reliabilities and Item total correlations were calculated to find the validity and internal consistency of the scales, and to see the relationship between

psychological well-being, self-concept, menopausal symptoms, and marital satisfaction inter scale correlations were done.

Reliability Estimates of Instruments. For the determination of the reliability of all the variables, Ryff Scale of Psychological Well-Being (RSPWB), Tennessee Self-Concept Scale (TSCS-2), Green Climacteric Symptoms Scale (GCSS), and Enrich Marital Satisfaction Scale (EMSS), Cronbach Alpha Coefficients have been calculated.

Table 2

Alpha Reliability Coefficients of total an subscales of the Ryff Scale of Psychological Well-Being, the Tennessee Self-Concept Scale -2,the Green Climacteric Symptoms Scale, and the Marital Satisfaction Scale (N = 60)

Variables	No of Items	*a*	*M*	*SD*	*Kurtosis*	*Skew*
Psychological well-Being scale	54	.75	167.70	17.84	-1.060	-.714
Environmental Mastery	9	.91	34.53	7.26	-.299	-,713
Positive Relations with others	9	.85	36.92	5.80	.197	-1.29
Personal Growth	9	.82	31.73	5.62	.155	-1.05
Self-Acceptance	9	.88	36.45	6.86	-.046	-.507
Autonomy	9	.76	35.48	4.56	.083	-.926
Purpose in Life	9	.64	34.40	4.39	.549	-.122
Tennessee Self-Concept Scale	74	.94	24.90	12.98	-.437	-.437
Physical self	14	.90	47.21	7.77	-.169	-.445
Moral Self	12	.68	43.60	4.28	-.301	.323
Family Self	12	.75	40.77	4.67	-.499	-.376
Social Self	12	.83	43.18	4.92	-.092	-.885
Academic Attainment Self	12	.86	38.02	6.78	-.589	-.619
Personal Self	12	.86	44.88	6.15	-.398	-.379
Greene Climacteric Symptoms Scale	21	.96	2.24	13.7	-.825	.618
Psychological Symptoms	11	.95	12.75	8.33	.693	-.829
Somatic Symptoms	7	.84	5.95	4.27	.596	-1.02
Vasomotor Symptoms*	2	.77	2.62	1.70	.661	-.272
Enrich Marital Satisfaction Scale	10	.91	34.87	7.42	-.413	-.245

* Spearman Brown *r* was used for reliability analysis of Two-item scale

Table 2 represents the alpha reliability of the total and subscales of RSPWB, TSCS-2, GCSS, and MSS. These coefficients of six subscales of RSPWB ranged from .64 (Purpose in Life), to .88 (Self-Acceptance), and .96 for RSPWB, indicate

that the items of these subscales are internally consistent. The coefficients of six subscales of TSCS-2-Urdu ranged from .68 (Moral self), to .90 (Physical self), and .95 for total TSCS-2-Urdu, indicate that the items of these subscales are internally consistent. The alpha reliability of the total and subscales of Green Climacteric Scale (GCSS) are ranged from .59 (Vasomotor symptoms), to .95 (Psychological symptoms), and .96 for total GCSS-Urdu, indicate that the items of these subscales are internally consistent. The alpha reliability of MSS is .91. Furthermore, the Table 6 also showed the mean and standard deviation of all variables. The skewness and kurtosis values explain the normal distribution of data.

Item-Total Correlations of the Ryff Psychological Well-Being Scale-Urdu. Item-total correlations were carried out to find out the internal consistency and construct validity of the subscales of psychological well-being inventory Urdu version.

Table 3

Item total correlations of subscales of the Ryff Scale of Psychological Well-Being (N=60)

Environmental Master		Positive Relations		Personal Growth		Self-Acceptance		Autonomy		Purpose in Life	
Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*
1	.76**	1	.72**	1	.59**	1	.68**	1	.70**	1	.53**
2	.83**	2	.65**	2	.69**	2	.70**	2	.50**	2	.68**
3	.67**	3	.54**	3	.84**	3	.79**	3	.49**	3	.56**
4	.83**	4	.58**	4	.81**	4	.67**	4	.73**	4	.53**
5	.79**	5	.66**	5	.71**	5	.79**	5	.63**	5	.52**
6	.85**	6	.88**	6	.61**	6	.80**	6	.68**	6	.71**
7	.88**	7	.74**	7	.69**	7	.38**	7	.47**	7	.59**
8	.71**	8	.59**	8	.45**	8	.74**	8	.37**	8	.53**
9	.76**	9	.78**	9	.41**	9	.81**	9	.76**	9	.41**

**$p<.01$

Table 3 shows the item total correlations of all the six subscales of psychological well-being inventory-Urdu version, which indicates that all the subscales have significant positive item-total correlations at $p < .01$ and correlation coefficients range from .67 to .88 for Environmental Mastery, .54 to .88 for Positive Relations, .41 to .84 for Personal Growth, .38 to .81 for Self-Acceptance, .37 to .76 for Autonomy, and .41 to .71 for Purpose in Life. The significant correlation coefficients of item total of subscales suggest satisfactory internal consistency and construct validity.

Item-Total Correlations of the Tennessee Self-Concept Scale-2-Urdu-version. Item-total correlations were carried out to find out the internal consistency and stability of TSCS-2 Urdu version.

Table 4

Item total correlations of subscales of the Tennessee Self-Concept Scale-2 (N=60)

Physical		Moral		Personal		Family		Social		Academic	
Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*
1	.63**	1	.69**	1	.76**	1	.61**	1	.58**	1	.34**
2	.61**	2	.42**	2	.60**	2	.37**	2	.77**	2	.59**
3	.70**	3	.68**	3	.62**	3	.77**	3	.68**	3	.59**
4	.53**	4	.48**	4	.75**	4	.71**	4	.60**	4	.82**
5	.80**	5	.62**	5	.9**	5	.66**	5	.72**	5	.38**
6	.79**	6	.64**	6	.82**	6	.42**	6	.76**	6	.67**
7	.50**	7	.38**	7	.55**	7	.49**	7	.66**	7	.68**
8	.53**	8	.58**	8	.38**	8	.69**	8	.37**	8	.87**
9	.78**	9	.42**	9	.59**	9	.37**	9	.49**	9	.76**
10	.75**	10	.75**	10	.65**	10	.65**	10	.74**	10	.80**
11	.76**	11	.64**	11	.69**	11	.54**	11	.82**	11	.54**
12	.53**	12	.65**	12	.66**	12	.58**	12	.60**	12	.62**
13	.77**										
14	.68**										

**$p<.01$

Table 4 shows that all the items have positive significant correlation with the total score of the subscales of TSCS-2. This suggests that all the subscales have significant positive correlations with their respective domains.

Item-total correlations of all items of six subscales are significant at p >.01 and correlation ranges from .53 to .80 for Physical, .38 to .69 for Moral, .38 to .82 for Personal, .37 to .77 for Family, .37 to .82 for Social, and .34 to .87 for Academic attainment. The significant correlation coefficients of item total of subscales suggest satisfactory internal consistency and construct validity.

Item-Total Correlations of the Green Climacteric Symptoms Scale. Item-total correlations were carried out to find out the internal consistency and stability of GCSS.

Table 5

Item total correlations of subscales of the Green Climacteric Symptoms Scale (N=60)

Psychological		Somatic		Vasomotor	
Item No	*r*	Item No	*r*	Item No	*r*
1	.84**	1	.55**	1	.90**
2	.72**	2	.57**	2	.95**
3	.86**	3	.81**		
4	.86**	4	.79**		
5	.79**	5	.70**		
6	.87**	6	.69**		
7	.85**	7	.90**		
8	.92**				
9	.89**				
10	.84**				
11	.65**				

$^{**}p < .01$

Table 5 shows the item total correlations of subscale of Green Climacteric scale-Urdu version, which indicates that all the items have significant positive correlations with their respective domains. Item-total correlations of all items of all subscales of

GCSS are significant at *p* >.01 and correlations ranges from.65 to .92 for psychological, .55 to .90 for Somatic, and .90 to .95 for vasomotor. The significant correlation coefficients of item total of subscales suggest satisfactory internal consistency and construct validity.

Item-Total Correlations of the ENRICH Marital Satisfaction Scale. Item-total correlations were carried out to find out the internal consistency and stability of Enrich Marital satisfaction Scale Urdu version.

Table 6

Item total correlations of subscales of ENRICH Marital Satisfaction Scale (N=60)

Item No	*r*
1	.84**
2	.86**
3	.91**
4	.79**
5	.82**
6	.60**
7	.78**
8	.42**
9	.85**
10	.64**

$^{**}p < .01$

Table 6 shows the item total correlations of the Marital Satisfaction Scale (MSS) which indicates that all the items have significant positive correlations with their respective domain. Item-total correlations of all items of MSS are significant at P >.01 and correlation ranges from 41 to .91. The significant correlation coefficients of item total of subscales suggest satisfactory internal consistency and construct validity.

Inter-scale Correlations. The inter scales correlation coefficients of all the scales with each other and with total have also been calculated (see Table 7).

Table 7

Inter scales correlations of RSPWB, TSCS-2, GCSS, and MSS (N =60)

Measures	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV	XVI	XVII
I Environmental Mastery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
II Positive Relations	.88**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
III Personal Growth	.79**	.79**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV Self-Acceptance	.89**	.81**	.82**	-	-	-	-	-	-	-	-	-	-	-	-	-	-
V Autonomy	.73**	.72**	.76**	.82**	-	-	-	-	-	-	-	-	-	-	-	-	-
VI Purpose in Life	.45**	.53**	.65**	.58**	.58**	-	-	-	-	-	-	-	-	-	-	-	-
VII Physical	.32*	.35**	.23**	.47**	.54**	42**	-	-	-	-	-	-	-	-	-	-	-
VIII Moral	.30*	.21*	.23**	.41**	.50**	.34**	.63**	-	-	-	-	-	-	-	-	-	-
IX Family	.38**	.38**	.30*	.48**	.57**	.38**	.71**	.70**	-	-	-	-	-	-	-	-	-
X Academic	.43**	.41**	.28*	.51**	.59**	.45**	.83**	.70**	.68**	-	-	-	-	-	-	-	-
XI Personal	.47**	.47**	.42**	.60**	.64**	.48**	.81**	.78**	.83**	.74**	-	-	-	-	-	-	-
XII Social	.60**	.56**	.38**	.69**	.68**	.50**	.81**	.67**	.73**	.79**	.82**	-	-	-	-	-	-
XIII Psychological	-.39**	-.39**	-.33*	-.50**	-.57**	-.56**	-.85**	-.64**	-.63**	-.87**	-.80**	-.77**	-	-	-	-	-
XIV Somatic	-.42**	-.41**	-.45**	-.49**	-.57**	-.55**	-.74**	-.57**	-.55**	-.77**	.73**	-.67**	.91**	-	-	-	-
XV Vasomotor	-.29**	-.36**	-.33**	-.32**	-.38**	-.42**	-.55**	-.18*	-.26**	-.51**	-.43**	-.43**	.67**	.70**	-	-	-
XVI Sex	-.36**	-.40**	-.17*	-.43**	-.41**	-.27**	-.71**	-.30**	-.43**	-.70**	-.58**	-.64**	.68**	.92**	.46**	-	-
XVII Marital Satisfaction Scale	.50**	.47**	.39**	.65**	.66**	.50**	.79**	.64**	.68**	.82**	.77**	.84**	-.77**	-.71**	-.38**	-.72**	-

$^*p<.05$, $^{**}p<.01$

Table 7 shows that there are significant positive correlation among Ryff Scale of Psychological Well-being (EM, PR, PG, SA, AT, and PL), Self-Concept (PHY, MOR, FAM, ACD, PER, and SOC), and Marital Satisfaction scales. Green Climacteric Symptoms Scale has significant negative correlation with other scales. It indicated that those respondent who experience high level of psychological well-being, self-concept and marital satisfaction experience low level of menopausal symptoms.

Discussion

The main objectives of the pilot study were pre-testing of scales on a small group and to establish the psychometric properties of the all four scales Ryff Scale of Psychological Well-Being (RSPWB), Tennessee Self-Concept Scale-2 (TSCS-2), and Green Climacteric Symptoms Scale (GCSS), and Marital Satisfaction Scale (MSS). Alpha reliability coefficients, Item total correlation, and inter scales correlations were computed to find out the internal consistency and construct validity of three scales.

The findings of reliability coefficients of TSCS-2 are consistent with the findings of previous research indicated reliability coefficients in range from .73 to .95 (Kraebber, & Greenan, 2012). These findings show that all the items of all the measures are internally consistent and sufficiently reliable. However alpha coefficients .64 for purpose in life the subscale of RSPWB, .68 for MOR of TSCS-2, and .59 for VAS of GCSS are somewhat low, it may be due to the small sample size, and these coefficients may be improved by taking a large sample size in main study of the present research.

The item-total correlation analysis of RSPWB-Urdu version indicates that all the items of all the subscales have shown high positive correlations with total scores.

All the items have significant positive correlation (see Table 3). On TSCS-2 (Urdu version) all the items of all the subscales have significant positive correlations with total scores (see Table 4). Positive significant correlations indicate that all the items are measuring the same construct like the scale as a total.

All the items of subscales of GCSS-Urdu have also shown significant positive correlations with total scores (see Table 4). Item total correlations of MSS-Urdu have also shown significant positive correlations with total scores (see Table 5). Thus, indicating consistency of items with the total of the scale. The significant item-total correlations calculated from the data collected from Pakistan suggest that the instruments can be used to measure these constructs in our culture.

The internal consistency was further determined by inter scales correlation of all scales (see Table 7). There is positive correlation between RSPWB, TSCS-2, and MSS. It indicates that participants with high psychological well-being also have positive self-concept and high marital satisfaction. Moreover, participants with positive self-concept found to have high marital satisfaction. Whereas, the scores on RSPWB, TSCS-2 and are MMS found to have negative correlation coefficients with GCSS (see Table 7). It indicates that those respondents who experience more menopausal symptoms have low levels of psychological well-being. This finding is consistent with the previous research evidences (for instance Deeks & McCabe, 2004) where many researchers have found that the menopausal symptoms among women hinder in quality of life including daily life activities and other responsibilities.

Another result of pilot study indicated negative relationship between menopausal symptoms and self-concept (see Table 7). Researchers have found the

similar relationship in other researches (e.g., Bromberger et. al., 2003; Shu et. al., 2007 and so forth).

Inter-scale correlations of pilot study shows that women having more menopausal symptoms experience lesser marital satisfaction (see Table 7). Previous research by Cifcili et al. (2009) found that emotional instability of the women caused by high frequency of symptoms led to marital conflicts and subsequently marital dissatisfaction.

The findings of pilot study provided support for the reliability and validity for all four instruments. Therefore findings of the pilot study supported the use of instruments in the main study and testing of the hypotheses.

Chapter-VI

Phase IV: Main Study

Findings of focus groups and pilot study paved the way for main study. Phase IV consisted of main study aimed to find the severity of menopausal symptoms among pre, peri- and postmenopausal women. It was also aimed to study the relationship of marital satisfaction, psychological well-being, and self-concept among pre, peri-, and postmenopausal women.

Objectives

The objectives of the study are as follows:

1. To compare the psychological well-being, marital satisfaction and self-concept of pre-, peri-, and postmenopausal women.
2. To compare the perceived self-concept and its relationship with menopausal symptoms among pre-, peri-, and postmenopausal women.
3. To find out the relationship between psychological well-being, self-concept, marital satisfaction and menopausal symptoms among pre-, peri-, and postmenopausal women.
4. To study the experience of menopausal symptoms along with the demographic variables i.e., education, occupation, and monthly income of the family.
5. To study the prediction of menopausal symptoms by self-concept.
6. To study mediating role of psychological well-being and marital satisfaction on relationship between self-concept and menopausal symptoms among pre, peri- and postmenopausal groups.

Hypotheses of the study

On the basis of existing literature the variables like psychological well-being, self-concept and marital satisfaction, are identified as important factors for menopausal experience and hypotheses (see p. 77) were formulated to test these factors were further confirmed by the findings of focus group discussions (see Chap II).

Operational Definitions

Menopausal symptoms. Greene (1998) categorized menopausal symptoms in four categories which are somatic, psychological, vasomotor symptoms and sexual symptoms.

Somatic symptoms. Somatic symptoms include symptoms like feeling dizzy, pressure or tightness in head or body, parts of body feeling numb or tingling, headache, muscle and joint pains, loss of feeling in hand and feet, and breathing difficulty (Greene,1998). High Score on the items related to somatic symptoms show more experience of these symptoms.

Vasomotor symtoms. Vasomotor symptoms are hot flushes and night sweats (Green, 1998). High Score on the items related to vasomotor symptoms show more experience of these symptoms.

Sexual symptoms. Sexual symptoms are related to loss of libido among women in menopausal groups (Greene, 1998). High Score on the item related to sexual symptom show high experience of these symptoms.

Psychological well-being. Ryff and Keyes (1995) is that well-being is a multifaceted construct including positive self-regard, mastery of the external

environment, quality inter-personal relations, continued growth and development, purposeful living, and the capacity of self-determination.

Environmental Mastery. It is the sense of mastery and competence in managing everyday environment (Ryff & Keyes, 1995). High scores on this dimension indicate individual having the environment, controls complex array of external activities, and makes effective use of surrounding opportunities, able to choose or create contexts suitable to personal needs and values. On the other side the low score indicate that individuals have difficulty in managing everyday life affairs, feel unable to change or improve surrounding context, unaware of surrounding opportunities, and lack in sense of control over external world.

Positive relations with others. It is related to trusting relationships with others (Ryff & Keyes, 1995). High scores explaining individual's tendency to warm, satisfying, trusting relationships with others; concerned about the welfare of others, capable of strong empathy, affection, and intimacy. Low score on this dimension indicates that individual has a few close, trusting relationships with others, finds it difficult to be warm, open and feels isolated and frustrated in interpersonal relationships.

Personal growth. It is related to the personal development among individuals (Ryff & Keyes, 1995). The high score showed that individual has a feeling of continued development; sees self as growing, is open to new experiences, has sense of realizing his or her potential and is changing in ways that reflect more self-knowledge and effectiveness. Whereas, the low scores indicate that individual has a sense of personal stagnation, lacks sense of improvement, feels bored, and feels unable to develop new attitudes or behaviors.

Self-acceptance. It measures the individual's attitude towards oneself (Ryff & Keyes, 1995). High score explaining a positive attitude toward the self, acknowledges and accepts multiple aspects of self, including good and bad qualities. While the person scoring low generally feels dissatisfied with self, and is troubled about certain personal qualities and wishes to be different than what he or she is.

Purpose in life. It refers to person goals in life and a sense of directedness (Ryff & Keyes, 1995). High score shows beliefs that give life purpose. While a low scorer lacks a sense of meaning and directedness in life and has no outlook or belief that gives life a meaning.

Autonomy. It refers to individual's self-determination and independence, ablity to resist social pressures and action in certain ways, regulation of behavior from within and evaluate self by personal standards (Ryff & Keyes, 1995). The low score indicates that individual is concerned about the expectations and evaluations of others, relies on judgments of others to make important decisions and conforms to social pressures.

Self-concept. Self-concept and self-identity is the mental and conceptual understanding and persistent regard that one holds for his/her own existence (Fitts & Warren, 2003).

Physical self-concept. It is the individual's view of his or her body, state of health, physical appearance, skills, and sexuality. Individuals are likely to use information about their appearance or their health status in a self-enhancing way.

Moral Self-Concept. It describes the self from a moral-ethical perspective, examining moral worth, feelings of being a 'good' or 'bad' person, and satisfaction with one's religion or lack of it.

Personal Self-Concept. It is the individual's sense of personal worth, feeling of adequacy as a person, and self-evaluation of the personality apart from the body or relationships to others.

Family Self-Concept. It is the individual's feelings of adequacy, worth and value as a family member. It also reflects the individual's perception of self in relation to his or her immediate circle of associates.

Social Self-Concept. It measures how individuals perceive themselves in relations to others. It reflects the more general way the individual's sense of adequacy and worth in social interaction with other people.

Academic/Work Self-Concept. It measures that how people perceive themselves in school and work settings, and how they believe they are seen by others in those settings.

Marital Satisfaction. It is defined as quality and interaction of the spouses within the marriage that positively and negatively influences the physical and mental health of spouses (Fielder & Kurpius, 2010).

Sample

Sample of main study comprised of 348 women (116 for each menopausal status) with age range of 35-60 years. Their menopausal status was classified as pre-, peri-, and postmenopausal. All the women were assigned to either premenopausal status, perimenopausal status, or postmenopausal status by using a common method of menopause classification that is a length of time since last menstrual period (Deeks & McCabe, 2004). Premenopausal = no noticeable change in flow or frequency of menstruation over at least 12 months; Perimenopausal = changes in menstrual frequency and flow in previous 12 months associated with menopause; Postmenopausal = no menstrual flow for 12 months or more (see Appendix-XIV). All

the participants had achieved natural menopause, without any intervening cause such as pregnancy, lactation, exogenous hormone use, dietary deficiencies, or surgical removal of the uterus or ovaries, and presence of medical conditions like diabetes, hypertension, cardiac disease, and thyroid disorders. The age range of premenopausal women was 36-46 years (M = 40.83, SD = 3.09). Perimenopausal women's age was 39-55 years (M = 47.78, SD = 4.89). Women in postmenopausal group were with age range of 44-57 years (M = 50.92, SD=3.25). On the basis of education level women were divided into two groups lower education level [matric and intermediate (n=200)], and higher education level [graduation and above (n=148)].Minimum education of the participants was matriculation and maximum education was masters and above. They were all married working (n=157) and non-working (n=191) women and with at least one child (to rule out the factor being childless). Furthermore, women were divided into three groups on the basis of their monthly income (group one; PKR: 20000-39000 (n=115), group two; PKR: 40000-59000 (n=146), and group three; PKR: 60000 & above (n= 87).

Instruments

Following instruments have been used in the main study of this research.

1. The Ryff Scale of Psychological Well-being Urdu-version (Ansari, 2010) (details are given in Chapter V, p.106).
2. The Tennessee Self-Concept Scale (TSCS-2) originally developed by Fitts and Warren, (2003) (details are given in Chapter IV, p. 98).
3. The ENRICH Marital Satisfaction Scale originally developed by Olsen (1989), and translated by Iqbal (2010) (details are given in Chapter V, p. 105).

4. The Greene Climacteric Symptoms Scale (GCSS) developed by Greene, (1990) was used. (Details of these instruments have been written earlier in Chapter IV, p.99).

Procedure

The data was collected from the women of different areas of Rawalpindi and Islamabad. The women were contacted in their institutions and homes and were informed briefly about the purpose of the present study, and their consent was taken for participation in the study. Before administering the scales they were assured that all the information provided by them would be kept confidential and were used only for the research purpose. Participants were requested verbally about how to respond to various items in each questionnaire. They were also requested to read each item carefully and respond as honestly as possible by selecting the option that is closest to their personal experiences. They were requested to give responses on all the items of the scales. The average time to complete the questionnaires was 25-30 minutes. They were also asked to give response on all the items of the scales. After collecting the data statistical analysis was done by using SPSS 19 version.

Results

In order to meet the objectives of the study and to test the formulated hypotheses, a series of statistical analyses were carried out. At preliminary level the data was explored to identify the outliers and to get descriptive statistics. The means, standard deviations, alpha reliability estimates, item total correlations, inter scales correlations, one-way ANOVA, Regression, moderation, mediation, and two-way ANOVA were carried out. For this purpose, Statistical Package for Social Sciences (SPSS 19) was used. Following are the results of the study.

Psychometric Properties. For the determination of reliability of Ryff Scale of Psychological Well-Being (RSPWB), Tennessee Self-Concept Scale (TSCS-2), Green Climacteric Symptoms Scale (GCSS), and Marital Satisfaction Scale (MSS), Cronbach alpha coefficients have been calculated.

Table 8

Alpha Reliability Coefficients of the total and subscales of the Ryff Scale of Psychological Well-Being, the Tennessee Self-Concept Scale -2,the Green Climacteric Symptoms Scale, and the Marital Satisfaction Scale (N = 348)

Variables	No of Items	*a*	*M*	*SD*	*Kurtosis*	*Skew*
Psychological Well-being Scale	54	.96	208.40	31.1	-1.020	.106
Environmental Mastery	9	.91	33.95	6.81	-.560	.364
Positive Relations with others	9	.86	36.28	5.56	-1.29	.201
Personal Growth	9	.85	31.71	5.62	-1.05	.182
Self-Acceptance	9	.89	36.20	6.79	-.514	-.041
Autonomy	9	.72	35.24	4.33	-.941	.136
Purpose in Life	9	.77	34.33	4.31	-.215	.619
Tennessee Self-Concept Scale						
Physical self	14	.91	46.70	7.71	-.552	-.152
Moral Self	12	.70	43.27	4.27	-.244	-.266
Family Self	12	.76	40.58	4.58	-.510	-.471
Social Self	12	.84	34.56	6.58	-.734	-.433
Academic Attainment Self	12	.87	44.59	6.20	-.459	-.321
Personal Self	12	.89	42.86	4.93	-.958	-.041
Greene Climacteric Symptoms Scale	21	.96	2.24	13.79	-.825	.618
Psychological Symptoms	11	.90	12.59	6.63	.405	.850
Somatic Symptoms	7	.75	7.92	3.62	-.547	.365
Vasomotor Symptoms*	2	.76	1.72	1.29	.217	.580
Marital Satisfaction Scale	10	.92	34.43	7.51	-427.	.378

*Spearman Brown *r* was used for reliability analysis of Two-item scale

Table 8 represents the alpha reliability coefficients of the scales (RSPWB, TSCS-2, GCSS, and MSS) used in the study. These coefficients of six subscales of RSPWB have considerably high reliability coefficients ranged from .72 (Autonomy), to .91 (Environmental Mastery), and .97 for the Ryff Scale of Psychological Well Being, indicate that the items of these subscales are internally consistent. The coefficients of six subscales of Tennessee Self Concept Scale-2-Urdu found to have

reliability coefficients ranged from .76 (Family Self), to .91 (Physical self), and .96 for total Tennessee self-concept scale-2-Urdu, indicate that the items of these subscales are internally consistent. The alpha reliability of the total and subscales of Green Climacteric Symptoms Scale (GCSS) ranged from .75 (Somatic Symptoms), to .90 (Psychological symptoms), and .93 for total Green Climacteric Symptoms Scale-Urdu, indicate that the items of these subscales are internally consistent. The alpha reliability of MSS is .92. Table 5 also reveals the skewness and kurtosis values falling within acceptable ranges.

Item Total Correlations of the Ryff Scale of Psychological Well-Being-Urdu. Item-total correlations were carried out to find out the internal consistency and construct validity of the subscales of the Ryff Scale of Psychological Well-Being-Urdu.

Table 9

Item total correlations of subscales of the Ryff Scale of Psychological Well-Being (N=348)

Environment Mastery		Positive Relation		Personal Growth		Self-Acceptance		Autonomy		Purpose in Life	
Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*
1	.59**	1	.71**	1	.61**	1	.67**	1	.69**	1	.47**
2	.81**	2	.63**	2	.70**	2	.69**	2	.45**	2	.70**
3	.66**	3	.53**	3	.85**	3	.79**	3	.52**	3	.57**
4	.79**	4	.61**	4	.81**	4	.68**	4	.73**	4	.68**
5	.80**	5	.69**	5	.75**	5	.79**	5	.62**	5	.59**
6	.84**	6	.89**	6	.60**	6	.86**	6	.70**	6	.77**
7	.90**	7	.75**	7	.69**	7	.37**	7	.46**	7	.66**
8	.69**	8	.60**	8	.44**	8	.75**	8	.41**	8	.67**
9	.78**	9	.79**	9	.40**	9	.87**	9	.77**	9	.33**

**$p<.01$

Table 9 show the item total correlations of all the six subscales of the Ryff Scale of Psychological Well-Being-Urdu version, which indicates that all the items of subscales have significant positive correlations with subscale total. These results reveal that there is internal consistency among all the items of each subscale.

Item Total Correlations of the Tennessee Self-Concept Scale-2. Item-total correlations were carried out to find out the internal consistency and construct validity of the subscales of Tennessee Self-Concept Scale-2.

Table 10

Item total correlations of subscales of the Tennessee Self-Concept Scale-2 (N=348)

Physical		Moral		Personal		Family		Social		Academic/Work	
Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*	Item No	*r*
1	.60**	1	.68**	1	.78**	1	.64**	1	.62**	1	.34**
2	.61**	2	.17**	2	.56**	2	.39*	2	.78**	2	.61**
3	.77**	3	.69**	3	.63**	3	.79**	3	.71**	3	.61**
4	.52**	4	.47**	4	.76**	4	.72**	4	.59**	4	.83**
5	.84**	5	.47**	5	.78**	5	.67**	5	.71**	5	.38**
6	.76**	6	.65**	6	.83**	6	.46*	6	.77**	6	.70**
7	.49**	7	.17**	7	.56**	7	.52**	7	.67**	7	.65**
8	.35**	8	.60**	8	.43**	8	.71**	8	.28**	8	.88**
9	.77**	9	.25**	9	60**	9	.28**	9	.48**	9	.74**
10	.75**	10	.76**	10	.68**	10	.29**	10	.73**	10	.87**
11	.77**	11	.64**	11	.71**	11	.67**	11	.81**	11	.57**
12	.56**	12	.65**	12	.67**	12	.53**	12	.62**	12	.70**
13	.76**										
14	.67**										

**$p<.01$

Table 10 shows the item total correlations of TSCS-2 (Urdu version), which indicates that all items of six subscales have significant positive correlations with their subscales total. This suggests internally consistency of all the items of six subscales of TSCS-2.

Item Total Correlations of the Green Climacteric Scale. Item-total correlations were calculated to find out the internal consistency and construct validity of the subscales of Greene Climacteric Symptoms Scale Urdu version.

Table 11

Item total correlations of subscales of the Green Climacteric Symptoms Scale (N=348)

Psychological		Somatic		Vasomotor	
Item No	*r*	Item No	*r*	Item No	*r*
1	.77**	1	.44**	1	.88**
2	.65**	2	.48**	2	.93**
3	.73**	3	.65**		
4	.74**	4	.75**		
5	.72**	5	.74**		
6	.83**	6	.58**		
7	.82**	7	.80**		
8	.77**				
9	.69**				
10	.56**				
11	.59**				

$^{**}p < .01$

Table 11 shows the item total correlations of subscales of Green Climacteric symptoms scale-Urdu version, which indicates that all the items have significant positive correlations with their respective subscale total. These results also suggest that all the items are internally consistent with total scores.

Item Total Correlations of Enrich Marital Satisfaction Scale. Item-total correlations were calculated to find out the internal consistency and construct validity of the Enrich Marital Satisfaction Scale Urdu version.

Table 12

Item total correlations of subscales of ENRICH Marital Satisfaction Scale (N=348)

Item No	*r*
1	.86**
2	.87**
3	.91**
4	.79**
5	.83**
6	.62**
7	.79**
8	.43**
9	.86**
10	.65**

**$p < .01$

Table 12 shows the item total correlations of the Marital Satisfaction Scale which indicates that all the items have significant positive correlations with the scale total. Results also indicate that all the items are internally consistent.

Inter Scale Correlation. Inter scale correlation coefficients of all the scales (used in the present study) with each other and with total have also been calculated (see Table 13).

Table 13

Inter scales correlations of RSPWB, TSCS-2, GCSS, and MSS (N =348)

Measures	1	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV	XVI	XVII
1.Environmental Mastery																	
2.Positive Relations	.86**																
3. Personal Growth	.76**	.78**															
4. Self-Acceptance	.89**	.80**	.81**														
5.Autonomy	.72**	.73**	.77**	.80**													
6. Purpose in Life	.53**	.63**	.71**	.70**	.66**												
7. Physical	.36**	.40**	.27**	.51**	.57**	49**											
8. Moral	.33**	.27**	.27**	.45**	.52**	.41**	.65**										
9. Family	.37**	.40**	.29**	.50**	.56**	.42**	.72**	.72**									
10.Academic/work	.45**	.44**	.31**	.55**	.61**	.52**	.83**	.70**	.68**								
11. Personal	.49**	.48**	.44**	.63**	.65**	.55**	.81**	.80**	.83**	.72**							
12. Social	.61**	.59**	.39**	.70**	.68**	.58**	.82**	.69**	.74**	.80**	.83**						
13. Psychological	-.36**	-.40**	-.38**	-.46**	-.49**	-.54**	-.66**	-.46**	-.41**	-.65**	-.52**	-.53**					
14. Somatic	-.34**	-.36**	-.39**	-.42**	-.48**	-.48**	-.59**	-.47**	-.41**	-.65**	.56**	-.49**	.82**				
15. Vasomotor	-.22**	-.30**	-.33**	-.39**	-.34**	-.38**	-.44**	-.17**	-.17**	-.41**	-.30**	-.30**	.58**	.68**			
16. SEX	-.36**	-.43**	-.26**	-.38**	-.35**	-.28**	-.49**	-.19**	-.27**	-.54**	-.37**	-.44**	.57**	.56**	.37**		
17. Marital Satisfaction	.50**	.47**	.40**	.61**	.66**	.56**	.80**	.66**	.69**	.85**	.78**	.83**	-.53**	-.55**	-.30**	-.57**	

**$p<.01$

Table 13 shows that there are significant positive correlation among Psychological Well-being (Environmental Mastery, Positive Relations, Personal Growth, Self-Acceptance, Autonomy, Purpose in Life), Self-Concept (Physical, Moral, Family, Academic, Personal and Social), and Marital Satisfaction Scale. Green Climacteric Symptoms Scale has significant negative correlation with other scales. It indicated that those respondents who experienced high level of psychological well-being, self-concept and marital satisfaction experienced low level of menopausal symptoms.

Premenopausal, perimenopausal and postmenopausal group-wise differences on psychological well-being. It was hypothesized that peri-and postmenopausal women will perceive low level of psychological well-being than premenopausal women.

In order to see the difference among three groups of pre-, peri-, and postmenopausal women, the means, standard deviations, and F-values, and post hoc test on total and six subscales of the Ryff Scale of Psychological Well-Being were computed. The results are shown in Tables 14 to 21.

Table 14

Means, Standard Deviations, and F Values for the Ryff Scale of Psychological Well-Being for pre-, peri-, and postmenopausal groups (N = 348)

Scales	Premenopausal (n = 116)			Perimenopausal (n = 116)			Postmenopausal (n = 116)				
		95% CI			95% CI			95% CI			
	M (SD)	*LL*	*UL*	*M (SD)*	*LL*	*UL*	*M (SD)*	*LL*	*UL*	*F*	*p*
Environmental Mastery	34.36(2.49)	33.90	34.82	26.16(3.87)	25.45	26.83	30.54(5.83)	29.47	31.61	106.21	.00
Positive Relations	40.55(2.49)	40.08	41.02	31.20(3.87)	31.12	32.15	32.27(5.82)	34.17	36.38	139.07	.00
Personal Growth	37.63(2.88)	37.09	38.16	27.17(2.96)	26.62	27.71	30.35(3.93)	29.63	31.08	307.62	.00
Self-Acceptance	40.93(3.93)	40.21	41.68	30.51(4.84)	29.63	31.41	36.63(6.11)	35.56	37.75	124.89	.00
Autonomy	43.69(3.89)	42.97	44.40	36.32(3.64)	35.65	36.99	39.53(4.16)	38.76	40.29	106.21	.00
Purpose in Life	37.12(4.25)	36.34	37.90	32.03(2.94)	31.44	32.57	33.71(3.36)	33.09	34.32	61.62	.00
Psychological Well-Being	234.28(15.92)	231.36	237.21	183.84(16.28)	180.85	186.84	206.03 (25.16)	201.41	210.66	193.65	.00

Between Groups *df* = 2; Within Groups *df* =345; Total *df* = 347

Note = CI =Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

$^{**}p<.01$

Table 14 shows that there is significant difference among pre-, peri-, and postmenopausal women on total and all six subscales (Environment Mastery, Positive Relation, Personal Growth, Self-Acceptance, Autonomy, and Purpose in Life) of Psychological Well-Being Inventory. The premenopausal group has high mean scores which indicate that premenopausal women have more psychological well-being than perimenopausal and postmenopausal women.

Table 15

Tukey's Honesty Significant Difference (HSD) Post Hoc Test for the Environmental Mastery subscale of the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	8.19*	.56	.000	6.87	9.52
	Postmenopausal	3.82*	.56	.001	2.49	5.14
Perimenopausal	Premenopausal	-8.19*	.56	.000	-9.52	-6.87
	Postmenopausal	-4.38*	.56	.000	-5.70	-3.05
Postmenopausal	Premenopausal	-3.82*	.56	.001	-5.14	-2.49
	Perimenopausal	4.38*	.56	.000	3.05	5.70

*p< .05, **p<.01

Table 15 shows the post hoc test differences between pre-, peri-, and postmenopausal groups. The post hoc test comparisons indicate the significant difference between the environmental mastery of pre-, peri-, and postmenopausal women. The significant difference on the Environment mastery reveals that premenopausal women are more competent in managing every day affairs than perimenopausal and postmenopausal women.

Table 16

Tukey's Honesty Significant Difference (HSD) Post Hoc Test for the Positive Relations subscale of the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	8.90*	.537	.000	7.65	10.18
	Postmenopausal	5.27*	.537	.000	4.01	6.54
Perimenopausal	Premenopausal	-8.91*	.537	.000	-10.18	-7.65
	Postmenopausal	-3.64*	.537	.003	-4.90	-2.37
Postmenopausal	Premenopausal	-5.27*	.537	.000	-6.54	-4.01
	Perimenopausal	3.64	.537	.003	2.37	4.90

*$p < .05$

Table 16 shows the comparison between all three groups on the positive relations with others subscale of the Ryff Scale Psychological Well-being. The significant difference ($p<.05$) on positive relations with others reveals that premenopausal women have close, trusting relationships with others and peri-menopausal and postmenopausal women experience less positive relations with others.

Table 17

Tukey's Honesty Significant Difference (HSD) Post Hoc Test for the Personal Growth subscale of the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	10.45*	.43	.000	9.44	11.47
	Postmenopausal	7.27*	.43	.000	6.26	8.29
Perimenopausal	Premenopausal	-10.46*	.43	.000	-11.47	-9.44
	Postmenopausal	-3.18*	.43	.011	-4.19	-2.16
Postmenopausal	Premenopausal	-7.27*	.43	.000	-8.29	-6.26
	Perimenopausal	-3.18*	.43	.011	2.16	4.19

*$p < .05$

The results shown in Table 17 revealed the comparison between all three groups on the Personal Growth subscale of the Ryff Scale Psychological well-being. Significant high scores ($p<.05$) on personal growth indicate that premenopausal women have feeling of continued growth, open to new experiences, and reflect more

self-effectiveness than other two groups of women. Furthermore, results indicate that perimenopausal have less sense of personal growth as compared with the premenopausal and postmenopausal women (p<.05).

Table 18

Tukey's Honesty Significant Difference (HSD) Post Hoc Test for the Self-Acceptance subscale of the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	10.41*	.66	.000	8.85	11.97
	Postmenopausal	4.36*	.66	.022	2.74	5.86
Perimenopausal	Premenopausal	-10.41*	.66	.000	-11.97	-8.85
	Postmenopausal	-6.11*	.66	.000	-7.67	-4.55
Postmenopausal	Premenopausal	-4.30	.66	.022	-5.86	-2.74
	Perimenopausal	6.11	.66	.000	4.55	7.67

*p< .05

Table 18 shows that there are significant differences (p<.05) among pre-, peri-, and postmenopausal groups on the self-acceptance subscale of the Ryff Scale of Psychological Well-Being. Significant high scores (p<.05) on self-acceptance indicate that premenopausal women have more positive evaluation of themselves than perimenopausal and postmenopausal women and perimenopausal women have less positive evaluation of themselves and are unable to develop new attitudes or behaviors than pre-, and postmenopausal women.

Table 19

Tukey's Honesty Significant Difference (HSD) Post Hoc Test for the Autonomy subscale of the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	7.37*	.51	.000	6.17	8.56
	Postmenopausal	4.16*	.51	.005	2.96	5.37
Perimenopausal	Premenopausal	-7.37*	.51	.000	-8.58	-6.17
	Postmenopausal	-3.21*	.51	.028	-4.41	-2.00
Postmenopausal	Premenopausal	-4.16*	.51	.005	-5.37	-2.96
	Perimenopausal	3.21*	.51	.028	2.00	4.41

*$p < .05$

Table 19 shows the significant difference ($p<.05$) among pre-, peri-, and postmenopausal women on Autonomy subscale of the Ryff Scale of Psychological Well-Being. The significant difference ($p<.05$) on autonomy subscale reveals that premenopausal women, are more self-determinant & independent, and are less concerned about the expectations and evaluations of others, and able to resist social pressures to act and think, and evaluate themselves by personal standards than peri-, and postmenopausal women.

Table 20

Tukey's Honesty Significant Difference (HSD) Post Hoc Test for the Purpose in Life subscale of the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	5.09*	.47	.001	3.90	6.18
	Postmenopausal	3.41*	.47	.010	2.31	4.1
Perimenopausal	Premenopausal	-5.09*	.47	.001	-6.18	-3.90
	Postmenopausal	-1.67*	.47	.000	-2.77	-.57
Postmenopausal	Premenopausal	3.41*	.47	.010	-4.51	-2.31
	Perimenopausal	1.67*	.47	.000	.57	2.77

*$p < .05$

Table 20 shows the significant difference ($p<.05$) among pre-, peri-, and postmenopausal women on the Purpose in Life subscale of the RSPWB. The significant difference on purpose in life reveals that premenopausal women, have more sense of meaning and purpose in life than peri-, and postmenopausal women. As

compared to the pre-, and postmenopausal women perimenopausal women lacks a sense of meaning and purpose in life.

Table 21

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on the Ryff Scale of Psychological Well-Being (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	50.44*	2.57	.000	44.38	56.49
	Postmenopausal	28.25*	2.57	.000	22.19	34.31
Perimenopausal	Premenopausal	-50.44*	2.57	.000	-56.49	-44.38
	Postmenopausal	-22.19*	2.57	.001	-28.24	-16.13
Postmenopausal	Premenopausal	-28.25*	2.57	.006	-34.31	-22.19
	Perimenopausal	22.19*	2.57	.001	16.13	28.25

*$p < .05$

Table 21 shows the post hoc test results that indicate the significant difference ($p<.05$) among pre-, peri-, and postmenopausal women on the Ryff Scale of Psychological Well-Being. Premenopausal group has high mean scores on Total of RSPWB. These significant differences ($p<.05$) reveal that premenopausal women have more sense of wellness than perimenopausal and postmenopausal women and women belong to the perimenopausal group have less scores on psychological wellness as compared to the women of other two groups.

The analytical comparison revealed from the results shown in Tables 14 to 21, that the premenopausal women have high mean scores on the Ryff scale of psychological well-being and its subscales than perimenopausal and postmenopausal women experience low level of Psychological Well-Being as compared to the premenopausal women.

These differences among the three groups are consistent with hypothesis of present study that is “the peri-, and postmenopausal women will perceive less psychological well-being than premenopausal women”.

Premenopausal, perimenopausal and postmenopausal group-wise differences on self-concept. It was hypothesized that perimenopausal women will perceive self-concept less positively than pre-, and postmenopausal women.

In order to test this hypothesis, difference among three groups of pre-, peri-, and postmenopausal women in terms of means, standard deviations, F-values, and post hoc test on total and six subscales of Tennessee Self-Concept Scale-2 (TSCS-2) were computed. The results are shown in Tables 22 to 28.

Table 22

Means, Standard Deviations, and F values for pre-, peri-, and postmenopausal groups on Tennessee Self-Concept Scale-2 and its subscales (N = 348)

Scales	Premenopausal (n = 116)			Perimenopausal (n = 116)			Postmenopausal (n = 116)				
		95% CI			95% CI			95% CI			
	M (SD)	*LL*	*UL*	*M (SD)*	*LL*	*UL*	*M (SD)*	*LL*	*UL*	*F*	*P*
Physical self	49.58(8.85)	47.95	51.21	44.91 (7.19)	4359	46.24	45.62(6.01)	44.51	46.73	13.21	.000
Moral self	44.06 (4.07)	43.31	44.81	43.25 (4.24)	41.50	42.99	43.50 (4.51)	44.34	37.00	5.61	.055
Personal self	47.16(6.44)	45.97	48.35	43.19 (4.19)	42.42	43.96	43.42(6.84)	42.16	43.96	16.34	.000
Family self	41.51 (5.35)	40.52	42.49	40.23 (3.42)	39.60	40.86	39.99 (5.04)	39.06	40.92	3.51	.031
Social self	44.46 (5.10)	43.52	45.40	41.06 (3.12)	40.48	41.63	43.06 (5.60)	42.02	44.09	15.15	.028
Academic/ Work	36.44(6.90)	35.16	37.71	32.37 (6.04)	31.25	33.48	34.86 (6.15)	33.72	35.99	11.98	.011
Total TSCS-2	259.58(33.50)	253.42	265.75	240.62(23.54)	236.29	244.95	247.19(30.1)	241.66	252.73	1250	.001

Between Groups df = 2; Within Groups df = 345; Total df = 347

Note = CI =Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

Table 22 shows that there are significant differences (*p*<.05) among pre-, peri-, and postmenopausal women on all the subscales of Tennessee self-Concept Scale-2 except Moral. The significant difference (*p*<.05) on total Tennessee self-Concept Scale-2 shows that premenopausal women have more positive view of themselves than peri-, and postmenopausal women.

Table 23

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Physical subscale of the Tennessee self-Concept Scale-2 (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	4.66*	.97	.000	2.36	6.96
	Postmenopausal	3.96*	.97	.000	1.65	6.26
Perimenopausal	Premenopausal	-4.66*	.97	.000	-6.96	-2.36
	Postmenopausal	-.71	.97	.750	-3.01	1.59
Postmenopausal	Premenopausal	-3.96*	.97	.000	-6.26	-1.65
	Perimenopausal	.71	.97	.750	-1.59	3.01

$^*p < .05$

Table 23 indicates the post hoc comparisons which indicate that there are significant differences (*p*<.05) among pre-, peri-, and postmenopausal women on Physical self-concept subscale. The significant result (*p*<.05) reveals that premenopausal women view their physical appearance and health status more positively than peri-, and postmenopausal women.

Table 24

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Personal subscale of the Tennessee self-Concept Scale-2 (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	3.97*	.78	.000	2.14	5.81
	Postmenopausal	3.74*	.78	.000	1.90	5.57
Perimenopausal	Premenopausal	-3.97*	.78	.000	-5.80	-2,14
	Postmenopausal	-.23	.78	.952	-2.07	1.60
Postmenopausal	Premenopausal	-3.74*	.78	.000	-5.58	-1.90
	Perimenopausal	.23	.78	.952	-1.60	2.06

$^*p < .05$

Table 24 shows that there are significant differences among pre-, peri-, and postmenopausal groups on Personal (PER) subscale of TSCS-2. The high score on Personal subscale reveals that premenopausal women reflect good sense of personal worth, and self-evaluation of their personalities than perimenopausal and postmenopausal women. In other words perimenopausal women have less positive evaluation of themselves as compared to the premenopausal and postmenopausal groups.

Table 25

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Family subscale of TSCS-2 (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*p*	*LL*	*UL*
Premenopausal	Perimenopausal	1.28	.62	.097	-.17	2.72
	Postmenopausal	1.52*	.62	.038	.07	2.97
Perimenopausal	Premenopausal	-1.28	.62	.097	-2.72	.17
	Postmenopausal	.24	.62	.919	-1.21	1.69
Postmenopausal	Premenopausal	-1.52*	.62	.038	-2.97	-.07
	Perimenopausal	-.24	.62	.919	-1.69	1.21

*$p < .05$

Table 25 shows that there are significant differences ($p<.05$) among pre-, peri-, and postmenopausal women on Family (FAM) subscale of Tennessee self-Concept Scale-2. The high scores on Family subscale reveals that premenopausal women have more supportive and nurturing families as compared to the peri- and postmenopausal women.

Table 26

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Academic subscale of TSCS-2 (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	4.07*	.84	.000	2.09	6.04
	Postmenopausal	1.58	.84	.145	-.39	3.55
Perimenopausal	Premenopausal	-4.07*	.84	.000	-6.04	-2.09
	Postmenopausal	-2.49*	.84	.009	-4.46	-.52
Postmenopausal	Premenopausal	-1.58	.84	.145	-3.55	.39
	Perimenopausal	2.49*	.84	.009	.52	4.46

*$p < .05$

Table 26 shows that there are significant differences ($p<.05$) among pre-, peri-, and postmenopausal women on Academic (ACA) subscale of TSCS-2. The high scores on ACA indicate that premenopausal women are more confident and competent in learning and work situations as compared to the peri-, and postmenopausal women. In other words, perimenopausal women perceive themselves less confident and competent when approaching new tasks than pre and postmenopausal women.

Table 27

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Social subscale of TSCS-2 (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	3.41*	.62	.000	1.94	4.87
	Postmenopausal	1.41	.62	.063	-.059	2.87
Perimenopausal	Premenopausal	-3.41*	.62	.000	-4.87	-1.94
	Postmenopausal	-2.00*	.62	.004	-3.46	-.54
Postmenopausal	Premenopausal	-1.41	.62	.063	-2.87	.058
	Perimenopausal	2.00*	.62	.004	-.054	3.46

*$p < .05$

Table 27 shows that there are significant differences ($p<.05$) among pre-, peri-, and postmenopausal women on Social (SOC) subscale of TSCS-2. The high scores ($p<.05$) on Social subscale indicates that premenopausal women are viewed by both themselves and others as being friendly and social than peri-, and postmenopausal

women. Low mean scores ($p<.05$) of peri-, and postmenopausal indicate the social awkwardness and lack of social skills.

Table 28

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Total TSCS-2 (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	18.97*	3.85	.000	9.89	28.03
	Postmenopausal	12.39*	3.85	.004	3.32	21.46
Perimenopausal	Premenopausal	-18.97*	3.85	.000	-28.03	-9.89
	Postmenopausal	-6.58	3.85	.204	-15.64	2.49
Postmenopausal	Premenopausal	-12.39*	3.85	.004	-21.46	-3.32
	Perimenopausal	6.58	3.85	.204	-2.49	15.64

*$p< .05$

The results shown in Table 28 indicates the significant differences ($p<.05$) among pre-, peri-, and postmenopausal women on Tennessee Self Concept Scale-2. The significant difference ($p<.05$) reveals that premenopausal women have more positive aspects and view themselves more competent than other two groups of peri-, and postmenopausal women.

The analytical comparison revealed from the results shown Tables 15 to 21, the premenopausal women have high mean scores ($p<.05$) on Tennessee self-Concept Scale-2. The low scores of perimenopausal women reveals that the self-concept of perimenopausal women usually does not reflect a good fit between their abilities and their goals and they may less likely to say positive things about themselves.

These differences support our hypotheses that "perimenopausal women will perceive self-concept less positively than pre-, and postmenopausal women".

Premenopausal, perimenopausal and postmenopausal group-wise differences on menopausal symptoms. It was hyothesized that perimenopausal women will experience more menopausal symptoms than pre-, and postmenopausal women.

In order to see the difference among three groups of pre-, peri-, and postmenopausal women, the means, standard deviations, and F-values, and post hoc test on Greene Climacteric Symptoms Scale and its subscales were computed. The results are shown in Tables 29 to 34.

Table 29

Means, Standard Deviations, and F values for pre-, peri-, and postmenopausal groups on Total and subscales of Green Climacteric Symptoms Scale (N = 348)

Scales	Premenopausal (n = 116)			Perimenopausal (n = 116)			Postmenopausal (n = 116)				
		95% CI			95% CI			95% CI			
	M (SD)	*LL*	*UL*	*M (SD)*	*LL*	*UL*	*M (SD)*	*LL*	*UL*	*F*	*p*
Psychological	9.40(5.76)	8.35	10.46	15.54(6.93)	14.27	16.81	12.83(3.06)	12.26	13.39	13.21	.000
Somatic	6.11(3.30)	5.50	6.72	9.19(3.94)	8.46	9.91	8.45(2.81)	7.93	8.96	26.12	.000
Vasomotor	1.26(.87)	1.09	1.42	2.12(1.46)	1.85	2.39	1.78(1.32)	1.54	2.03	14.14	.000
Sexual	1.24(1.02)	1.05	1.43	2.03(.79)	1.89	2.18	1.92(.77)	1.78	2.06	28.42	.000
Green Climateric Symptoms Scale	18.02(9.79)	16.22	19.82	28.89(6.51)	26.67	31.11	24.98(6.51)	22.83	25.09	37.14	.000

Between Groups $df = 2$; Within Groups $df = 345$; Total $df = 347$

Note = CI =Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

The results shown in Table 29 indicates the significant differences (p<.05) among pre-, peri-, and postmenopausal women on all subscales and total of Greene Climacteric Symptoms Scale. The significant differences reveal that perimenopausal women experience more psychological symptoms and physiological symptoms (p<.05) than pre-, and postmenopausal women.

Table 30

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Psychological subscale of Greene Climacteric Symptoms Scale (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	-6.14*	.72	.000	-7.84	-4.44
	Postmenopausal	-3.42*	.72	.002	-5.12	-1.72
Perimenopausal	Premenopausal	6.14*	.72	.000	4.44	7.84
	Postmenopausal	2.72*	.72	.001	1.02	4.41
Postmenopausal	Premenopausal	3.42*	.72	.000	1.72	5.12
	Perimenopausal	-2.72*	.72	.001	-4.41	-1.02

*p< .05

The results shown in Table 30 indicates the significant differences (p<.05) among pre-, peri-, and postmenopausal women on Psychological subscale of Green Climateric Symptoms Scale. The significant difference reveals that perimenopausal women experience more psychological symptoms than pre-, and postmenopausal women (p<.05). The difference between peri- and postmenopausal women is not significant (p>.05); however, perimenopausal women have slightly high scores on Psychological subscale than postmenopausal women

Table 31

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Somatic subscale of Greene *Climacteric Symptoms Scale (N = 348)*

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	-3.08*	.44		-4.12	-2.03
	Postmenopausal	-2.34*	.44		-3,38	-1.29
Perimenopausal	Premenopausal	3.68*	.44		2.03	4.12
	Postmenopausal	.74	.44		-.30	1.79
Postmenopausal	Premenopausal	2.34*	.44		1.29	3.38
	Perimenopausal	-.74	.44		-1.79	0.30

*$p< .05$

The results shown in Table 31 indicate the significant differences ($p<.05$) among pre-, peri-, and postmenopausal women on Somatic subscale of Greene Climacteric Symptoms Scale. The significant difference reveals that perimenopausal women experience more somatic symptoms than prei-, and postmenopausal women ($p<.05$). The difference between perimenopausal women and postmenopausal women is not significant ($p>.05$) but perimenopausal women have slightly high mean scares on Somatic subscale.

Table 32

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Vasomotor subscale of GCSS (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*P*	*LL*	*UL*
Premenopausal	Perimenopausal	-.86*	.16	.000	-1.25	-.48
	Postmenopausal	-.53*	.16	.004	-.91	-.14
Perimenopausal	Premenopausal	.86*	.16	.000	.48	1.25
	Postmenopausal	.34	.16	.100	-.05	.72
Postmenopausal	Premenopausal	.53*	.16	.004	.14	.91
	Postmenopausal	.34	.16	.100	-.72	.05

*$p< .05$

The post hoc findings shown in Table 32 indicate that perimenopausal women experience significantly severe vasomotor symptoms as compared to the pre-and postmenopausal women ($p<.05$). Results also indicate that the difference between perimenopausal and postmenopausal women is not significant ($p>.05$). However, perimenopausal women have slightly high mean scores on vasomotor symptoms than postmenopausal women.

Table 33

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Sex subscale of Greene Climacteric Symptoms Scale (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*p*	*LL*	*UL*
Premenopausal	Perimenopausal	-.79*	.11	.000	-1.06	-.53
	Postmenopausal	-.68*	.11	.000	-.95	-.41
Perimenopausal	Premenopausal	.79*	.11	.000	.53	1.06
	Postmenopausal	.11	.11	.587	-.16	.38
Postmenopausal	Premenopausal	.68*	.11	.000	.41	.95
	Perimenopausal	-.11	.11	.587	-.38	.16

*$p< .05$

The post hoc test results shown in Table 33 indicate that perimenopausal women have significantly lost interest in sex as compared to the premenopausal women ($p<.05$). The comparison between perimenopausal and postmenopausal women is not significant ($p<.05$). However, perimenopausal women have slightly high mean scores than postmenopausal women.

Table 34

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on GCSS (N = 348)

I (Groups)	J (Groups)	Mean Diff (I-J)	*SE*	*p*	*LL*	*UL*
Premenopausal	Perimenopausal	-10.87*	1.28	.000	-13.88	-7.86
	Postmenopausal	-6.97*	1.28	.000	-9.97	-3.96
Perimenopausal	Premenopausal	10.87*	1.28	.000	7.86	13.88
	Postmenopausal	3.91*	1.28	.007	.89	6.91
Postmenopausal	Premenopausal	6.97*	1.28	.000	3.96	9.97
	Perimenopausal	-3.91*	1.28	.007	-6.91	-.89

*$p < .05$

The results shown in Table 34 indicate the significant differences ($p<.05$) between pre-and perimenopausal women on total Greene Climacteric Symptoms Scale. The significant difference reveals that perimenopausal women experience more severe symptoms than premenopausal women. The difference between peri-and postmenopausal women is not significant ($p<.05$). However, perimenopausal women experience more menopausal symptoms than postmenopausal women.

The analytical comparison revealed from the results shown in Tables 29 to 34 that the perimenopausal women have high mean scores on Greene Climacteric Symptoms Scale which indicate that perimenopausal women experience more psychological and physical (Som, Vas, Sex) menopausal symptoms than pre-, and postmenopausal women.

These differences support hypothesis that "perimenopausal women will experience more severe symptoms than pre-, and postmenopausal women.

Premenopausal, perimenopausal and postmenopausal group-wise differences on marital satisfaction. It was hypothesized that premenopausal women will have more marital satisfaction than peri-, and postmenopausal women.

To see the difference among three groups of pre-, peri-, and postmenopausal women, the means, standard deviations, F-values, and post hoc test on Marital Satisfaction Scale were computed. The results are shown in Tables 35 and 36.

Table 35

Means, Standard Deviations, and F-values for pre-, peri-, and postmenopausal groups on Marital Satisfaction Scale (N = 348)

			95% CI			
Groups	*N*	*M (SD)*	*LL*	*UL*	*F*	*P*
Premenopausal	116	37.34(7.98)	35.88	38.81		
Perimenopausal	116	32.34(4.81)	31.46	33.23	15.05	.000
Postmenopausal	116	33.59(8.35)	32.06	35.13		
Total	348	34.43(7.51)	33.64	35.22		

Between Groups *df* = 2; Within Groups *df* = 345; Total *df* = 347

Note = CI =Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

The results shown in Table 35 indicate significant differences ($p<.05$) among pre-, peri-, and postmenopausal women Enrich Marital Satisfaction Scale. The significant difference reveals that premenopausal women have more satisfied marital life than peri-, and postmenopausal women.

Table 36

Tukey's Honesty Significant Difference (HSD) Post Hoc Test on Marital Satisfaction Scale (N = 348)

I (Groups)	*J (Groups)*	*Mean Diff (I-J)*	*SE*	*p*	*LL*	*UL*
Premenopausal	Perimenopausal	5.00*	.95	.000	2.77	7.23
	Postmenopausal	3.75*	.95	.000	1.52	5.98
Perimenopausal	Premenopausal	-5.00*	.95	.000	-7.23	-2.77
	Postmenopausal	-1.25*	.95	.005	-3.48	.98
Postmenopausal	Premenopausal	-3.75*	.95	.000	-5.98	-1.52
	Perimenopausal	1.25	.95	.005	-.98	3.48

*$p< .05$

Table 36 shows that there are significant differences ($p<.05$) among pre-, peri-, and postmenopausal women on marital satisfaction scale. As compared to peri-, and postmenopausal women premenopausal women are more satisfied in their marital life.

The results shown Tables 35 and 36 indicate that premenopausal women have high mean scores on MSS, which suggest, that premenopausal women have more marital satisfaction than peri-, and postmenopausal women.

These differences support the hypothesis that premenopausal women experience more marital satisfaction than perimenopausal and postmenopausal women.

Overall these results suggest that premenopausal women have positive self-concept, perceive more psychological well-being, experience more marital satisfaction and less menopausal symptoms as compared to perimenopausal and postmenopausal women.

Predicting psychological and physical menopausal symptoms by physical self-concept, family self-concept and academic attainment self-concept.

It was hypothesized in hypothesis 4. Physical self-concept, Family self-concept, and academic attainment self-concept predicts psychological and physical menopausal symptoms among pre, peri and postmenopausal women, and for this purpose somatic, vasomotor, and sexual symptoms subscales were combined to measure the physical menopausal symptoms.

In order to test the hypothesis and difference among three groups of pre-, peri-, and postmenopausal women, the multiple regression analyses (step-wise) were carried out. The results are shown in Tables 37- 39.

Table 37

Hierarchical Multiple Regression Analysis on PHY, AAS, and FAM as *predictors of menopausal symptoms for premenopausal women (n = 116)*

Predictors	Psychological Symptoms			Physiological Symptoms		
	B	*SE*	*β*	*B*	*SE*	*β*
Step I						
Constant	53.69	2.29		32.08	1.46	
PHY	-.88	.05	.87***	-.51	.03	-.85***
Step II						
Constant	62.65	2.93		35.96	1.96	
PHY	-.63	.07	-.63***	-.40	.05	-.67***
FAM	-.51	.11	-.31***	-.22	.08	-.23**
Step III						
Constant	57.33	2.65		31.86	1.66	
PHY	-.42	.07	-.42***	-.24	.04	-.39***
FAM	.08	.14	-.16**	.23	.08	.24**
AAS	-.75	.12	-.59***	-.58	.07	-.76**

For step 1: R^2= .77; F= 376.25
For step 2: R^2= .80; F= 228.75; ΔR^2= .03; ΔF=19.66
For step 3: R^2= .85; F= 220.25; ΔR^2= .05; ΔF=41.07

For step 1: R^2= .73; F= 305.63
For step 2: R^2=.75; F=166.63; ΔR^2=.02; ΔF=8.23
For step 3: R^2=.84; F= 191.49; ΔR^2=.09; ΔF=61.83

Table 37 reveals significant predictive relationships between premenopausal symptoms and self-concept. The first model in Table 37 is suggesting that Physical Self-Concept is a significant predictor for psychological symptoms and physiological symptoms. The values of R^2 (.77 for Psychological symptoms and .73 physiological symptoms) indicate that the above mentioned variable can predict 77% of psychological symptoms and 73% physiological menopausal symptoms for premenopausal women. As the *B*-values are negative which are indicative of the fact that the prediction is in the opposite direction. In other words higher the scores on physical self-concept will predict less psychological and physiological menopausal symptoms. The prediction is significant as [F (1,114) =376.25 and p<.01)] for physiological symptoms and [F (1,114) =305.63.50 and p< .01)] for physiological menopausal symptoms.

The second model include Family subscale as other predictor of psychological symptoms, the values of R^2 (.80 for psychological symptoms and .75 for physiological symptoms) indicate that family self-concept can predict 80% of psychological symptoms [*F* (2, 113) =228.75and *p*< .01)], and 75% of physiological symptoms [*F* (2, 113) =166.63 and *p*<.01)].

In step III Academic/work was also found to be the significant predictor for psychological and physiological symptoms. The values of R^2 indicate (.85 for psychological symptoms and .84 for physiological symptoms) reveal that Academic attainment self-concept can also predict 65% of psychological symptoms [F (3, 112) = 220.27 and *p*<.01)], and 84% of physiological symptoms [*F* (3, 112) =191.49 and *p*<.01)] for premenopausal women.

Table 38

Hierarchical Multiple Regression Analysis on Physical, Academic/work, and Family self-concept as *predictors of menopausal symptoms for perimenopausal women (N = 116)*

Predictors	Psychological Symptoms			Physiological Symptoms		
	B	*SE*	β	*B*	*SE*	β
Step I						
Constant	53.07	3.26		38.36	3.02	
Physical self	-.79	.07	-.73***	-.56	.06	-.63***
Step II						
Constant	50.22	7.30		29.58	6.63	
Physical self	-.81	.09	-.75***	-.63	.08	-.71***
Family self	.09	.22	.04	.29	.20	.13
Step III						
Constant	37.47	6.66		17.89	6.00	
Physical self	-.34	.11	.32**	-.20	.09	-.23*
Family self	.63	.21	-.23	.29	.19	.35
Academic self	-.84	.14	-.67**	-.77	.12	-.76***

For step 1: R^2= .52; F= 127.87***
For step 2: R^2= .53; F= 63.58***; ΔR^2= .001; ΔF=.19
For step 3: R^2= .64; F= 69.03***; ΔR^2= .12; ΔF=38.14***

For step 1: R^2= .40; F= 75.77***
For step 2: R^2=.41; F=39.39***; ΔR^2=.01; ΔF=2.21
For step 3: R^2= .57; F= 48.71***; ΔR^2=.16; ΔF=39.94***

Table 38 reveals predictive relationships between perimenopausal status and self-concept. The first model in above Table is suggestive of that Physical Self-Concept is a significant predictor for psychological symptoms and physiological symptoms for perimenopausal women. Values of R^2 indicate that physical self-concept can predict 52% of psychological symptoms perimenopausal and 40% of psychological symptoms for. The prediction is significant F (1,114) = 127.87 and p> .01)] for psychological symptoms and [F (1,114) = 26.99 and p> .01)] for physiological symptoms. As the B values are negative which indicative of the fact that the prediction is in the opposite direction. In other words higher the scores on physical self-concept will predict fewer score on psychological and physiological menopausal symptoms for both perimenopausal women.

The second model includes Family self-concept as predictor of menopausal symptoms. The results indicate that family self-concept was not a significant predictor for menopausal symptoms for perimenopausal women. In step 3 ACA was also found to be the significant predictor for psychological and physiological symptoms for perimenopausal women. The prediction is significant as [F (1,114) = 69.83 and p>.001)] for psychological symptoms and [F (1,114) = 48.71 p<.001)] for physiological symptoms.

Table 39

Hierarchical Multiple Regression Analysis on physical, academic/work, and family self as *predictors of menopausal symptoms for postmenopausal women (N = 116)*

Predictors	Psychological Symptoms			Physiological Symptoms		
	B	*SE*	*β*	*B*	*SE*	*β*
Step I						
Constant	39.46	2.66		24.59	3.19	
Physical self	-.58	.06	-.68***	-.31	.07	-.38***
Step II						
Constant	35.06	2.80		20.90	3.46	
Physical self	-.77	.08	-.92***	-.47	.09	-.59**
Family self	.34	.09	.34***	.28	.11	.29
Step III						
Constant	35.39	2.61		21.17	3.37	
Physical self	-.38	.12	-.40**	-.14	.15	-.18
Family self	.26	.08	.26	.22	.11	.23
Academic/Work self	-.40	.09	-.49***	-.34	.12	-.44*

For step 1:R^2= .46; F= 99.04*** For step 1: R^2= .15; F= 19.39***
For step 2:R^2= .52; F= 61.55***; ΔR^2= .06; ΔF=13.34 For step 2: $R^{2=}$..19; F=13.21; $\Delta R^{2=}$.04; ΔF=6.16*
For step 3: R^2= .58; F= 53.31***; ΔR^2= .07; ΔF=18.15*** For step 3: R^2= .24; F= 11.95; ΔR^2= .05; ΔF=7.31*

Table 39 reveals significant predictive relationships between premenopausal symptoms and self-concept. The first model in above Table is suggesting that Physical Self-Concept is a significant predictor for psychological symptoms and physiological symptoms. The values of R^2 (.46 for Psychological symptoms and .15 physiological symptoms) indicate that the above mentioned variable can predict 46% of psychological symptoms and 15% physiological menopausal symptoms for postmenopausal women. As the B values are negative which are indicative of the fact that the prediction is in the opposite direction. In other words higher the scores on physical self-concept will predict less psychological and physiological menopausal symptoms. The prediction is significant as [(*F* (1, 114) =99.04 and *p*<.01)] for physiological symptoms and [(*F* (1, 114) =19.39 and *p*< .01)] for physiological menopausal symptoms.

The second model include Family subscale as other predictor of psychological symptoms, the values of R^2 (.52 for psychological symptoms and .19 for physiological symptoms) indicate that family self-concept can predict 52% of psychological symptoms (F (2, 113) =61.55and *p*< .01), and 19% of physiological symptoms [*F* (2, 113) =13.21 and *p*<.01)].

In step III Academic/work was also found to be the significant predictor for psychological and physiological symptoms. The values of R^2 indicate (.58 for psychological symptoms and .24 for physiological symptoms) reveal that Academic attainment self-concept can also predict 65% of psychological symptoms [*F* (3, 112) = 53.31 and *p*<.01)], and 84% of physiological symptoms [*F* (3, 112) =11.95 and *p*<.01)] for postmenopausal women.

The analytical comparison revealed from the results shown in Table 37-39 that these results partially support our hypothesis as it was hypothesized that "physical, family, and academic/work self-concept will be the predictor of psychological and physiological symptoms for pre-, peri-, and postmenopausal women", but results indicate that family self-concept was not found a significant predictor for peri-, and postmenopausal women. Family self-concept was also not found significant predictor of psychological symptoms in postmenopausal women.

Indirect effect (mediation) analyses of self-concept on menopausal symptoms through marital satisfaction. Indirect effect of self-concept on menopausal symptoms through marital satisfaction is analyzed by (mediation) regression analysis where steps are suggested by Barron and Kenny (1986) which is further validated by the Sobel test.

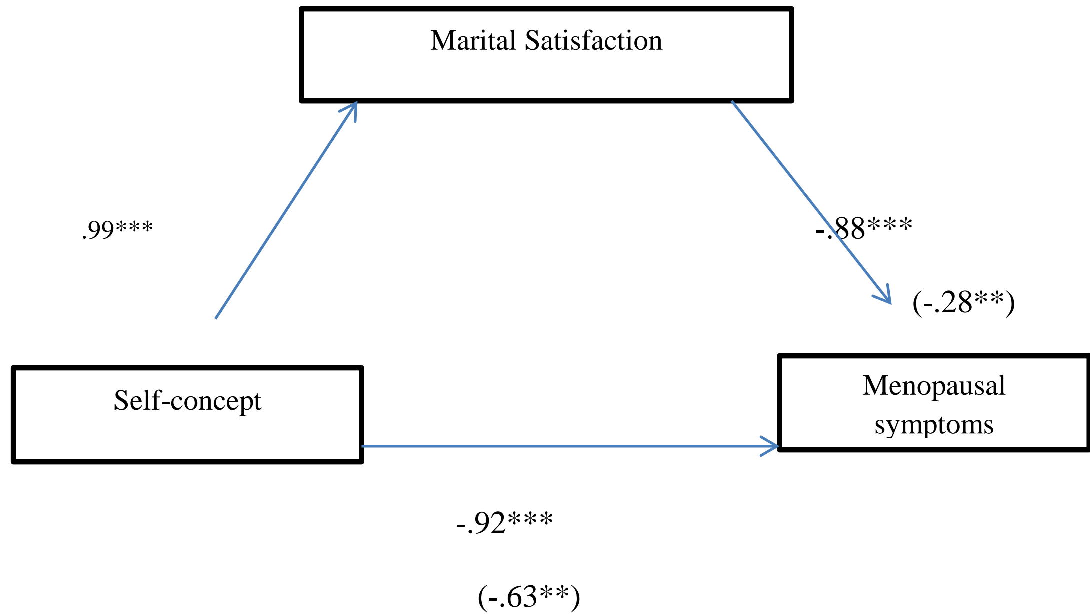

Figure 1. Mediating effect of Marital Satisfaction on relationship of Self-Concept and Menopausal Symptoms among premenopausal women.

Table 40

Hierarchical Regression Analysis of self-concept on Menopausal symptoms through marital satisfaction in case of premenopausal women (n=116)

			Menopausal symptoms	
			Model 3	
Variables	Model 1 *B*	Model 2 *B*	*B*	95% CI
Constant	41.88**	98.31**	92.27***	[78.36, 106.08]
Age	-.94**	.24	.05	[-.27, .38]
Education	-7.26***	-.09	-1.47	[-3.24, ,28]
Employment	3.38	-2.49	-2.88**	[-5.22, -.54]
Family income	8.44***	5.63	6.86**	[4.96, 8.76]
Self-concept		-.39***	-.27**	[-.39, -.16]
Marital Satisfaction			-.46**	[-.91, -.02]
R^2	.20	.91	.92	
F	6.97***	231.22***	199.15***	
ΔR^2		.71	.01	
ΔF			4.21*	

Note. B=unstandardized regression coefficient, R^2=explained variance, CI=confidence interval
****p*< .001, ***p*<.01, **p*<.05

Table 40 shows the role of marital satisfaction as a mediator between self-concept and menopausal symptoms. The table shows that after controlling the effect of age, education, employment status, and family income (model 1) there is significant negative relationship between self-concept and menopausal symptoms

explaining 91% variance in model 2. In model 3, marital satisfaction partially mediates the relationship of self-concept and menopausal symptoms explaining 92% variance. Model 3 also indicates that self-concept is indirectly related to menopausal symptoms through marital satisfaction.

Table 41

Hierarchical Regression Analysis of Self-Concept on menopausal symptoms through marital satisfaction in case of perimenopausal women (n=116)

			Menopausal symptoms	
			Model 3	
Variables	Model 1 *B*	Model 2 *B*	*B*	95% CI
Constant	48.13***	118.72**	122.16***	[99.77, 144.56]
Age	.11	.43*	.39*	[.04, .76]
Education	-.83	-1.48	-1.00	[-3.5, 1.36]
Employment	-.75	2.85	2.20	[-1.79, 6.19]
Family income	-6.73***	-5.00**	-6.24***	[-.63, -.41]
Self-concept		-.38***	-.52**	1.41, 1.71]
Marital Satisfaction			1.06	
R^2	.22	.59	.63	
F	7.95***	31.61***	30.37***	
ΔR^2		.36	.04	
ΔF			10.48**	

Note. B=unstandardized regression coefficient, R^2=explained variance, CI=confidence interval
***p< .001, **p<.01, *p<.05

Table 41 shows the role of marital satisfaction as a mediator between self-concept and menopausal symptoms the result revealed that after controlling the effect of age, education, employment status, and family income (model 1), there is significant negative relationship between self-concept and menopausal symptoms explaining 59% variance in model 2. In model 3, marital satisfaction does not mediate the relationship of self-concept and menopausal symptoms explaining 63% variance. Model 3 also indicates that self-concept is not indirectly related to menopausal symptoms through marital satisfaction.

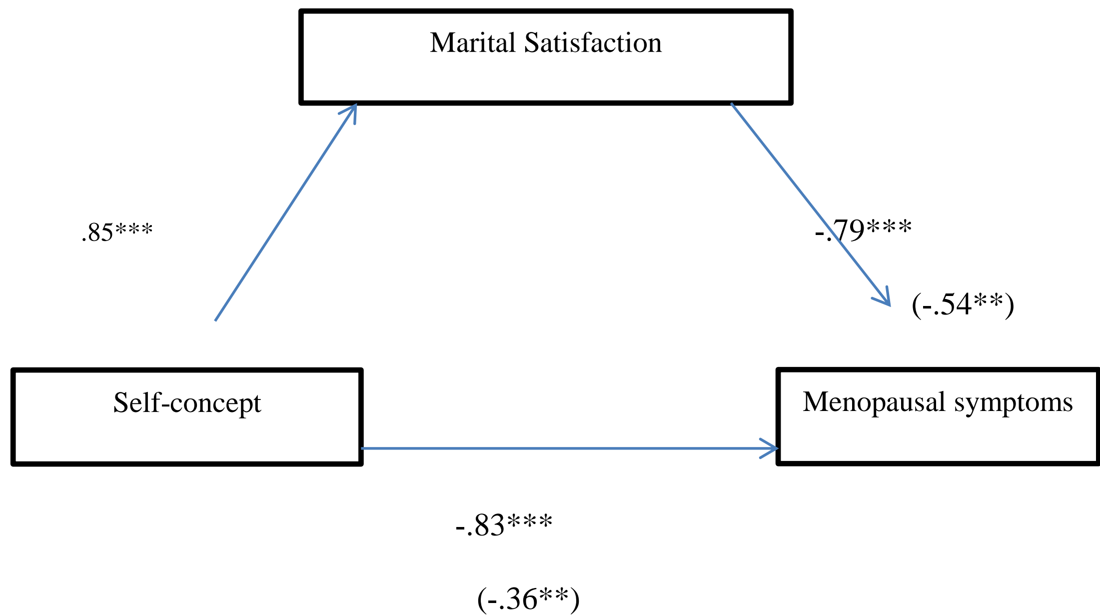

Figure 2. Mediating effect of marital satisfaction on relationship of self-concept and menopausal symptoms among postmenopausal women.

Table 42

Hierarchical Regression Analysis of self-concept on Menopausal symptoms through marital satisfaction in case of postmenopausal women (n=116)

			Menopausal symptoms	
			Model 3	
Variables	Model 1 *B*	Model 2 *B*	*B*	95% CI
Constant	24.53**	99.95**	98.94***	[80.40, 111.00]
Age	.22	-.01	.03	[.29, .06]
Education	.59	1.28	-2.05**	[-2.15, .67]
Employment	-5.69**	-2.28	.43	[-4.13, 1.16]
Family income	-2.19	-3.94**	-2.83**	[-6.91, -3.45]
Self-concept		.23**	-.11	[-.16, .-.04]
Marital Satisfaction			-.61**	[-.85, -.38]
R^2	.13	.59	.65	
F	4.13**	31.43***	36.78***	
ΔR^2		.45	.08	
ΔF			26.73***	

Note. B=unstandardized regression coefficient, R^2=explained variance, CI=confidence interval
****p*< .001, ***p*<.01, **p*<.05

Table 42 shows the role of marital satisfaction as a mediator between self-concept and menopausal symptoms. The table shows that after controlling the effect of age, education, employment status, and family income (model 1) there is

significant negative relationship between self-concept and menopausal symptoms explaining 59% variance in model2. In model 3, marital satisfaction fully mediates the relationship of self-concept and menopausal symptoms explaining 65% variance. Mediation was confirmed through the Sobel test (Sobel-t= 4.73, p<.001).

Indirect effect (mediation) analyses of self-concept on menopausal symptoms through psychological well-being. Indirect effect of self-concept on menopausal symptoms through psychological well-being was analyzed by (mediation) regression analysis.

Table 43

Hierarchical Regression Analysis of self-concept on Menopausal symptoms through psychological wellbeing in case of premenopausal women (n=116)

			Menopausal symptoms	
			Model 3	
Variables	Model 1 *B*	Model 2 *B*	*B*	95% CI
Constant	49.98***	94.64***	70.19**	[56.89, 3.48]
Age	-.88*	.25	.28*	[.05, .51]
Education	-4.86**	-1.01	-1.08*	[-2.01, -.14]
Employment	-3.41	-.14	.18	[-1.52, 1.88]
Family income	8.66***	-.38***	5.18***	[3.98, 6.39]
Self-concept		-.39***	-.44***	[-.47, -.41]
Psychological Well-being			.16***	[.11, .21]
R^2	.20	.91	.94	
F	7.31***	233.06***	264.56***	
ΔR^2		.71	.22	
ΔF			36.28***	

Note. B=unstandardized regression coefficient, R^2=explained variance, CI=confidence interval
****p*< .001, ***p*<.01, **p*<.05

Table 43 shows that after controlling the effect of age, education, employment status, and family income (model 1), there is significant negative relationship between self-concept and menopausal symptoms explaining 91% variance in model 2. In model 3, psychological well-being does not mediate the relationship between self-concept and menopausal symptoms.

Table 44

Hierarchical Regression Analysis of self-concept on menopausal symptoms through psychological wellbeing in case of perimenopausal women (n=116)

			Menopausal symptoms	
			Model 3	
Variables	Model 1 *B*	Model 2 *B*	*B*	95% CI
Constant	48.13***	118.17**	119.60**	[91.89, 147.32]
Age	.11	.43**	.44*	[.04, .84]
Education	-.83	-1.49	-1.56	[-1.39, 7.35]
Employment	-.76	2.85	2.98	[-7.90, -2.03]
Family income	-6.71***	-5.01**	-4.96**	[-.46, -.30]
Self-concept		-.38***	-.38***	[-.14, .11]
Psychological Well-being			-.01	
R^2	.22	.59	.57	
F	7.95***	31.61***	26.11***	
ΔR^2		.37	.00	
ΔF			.04	

Note. B=unstandardized regression coefficient, R^2=explained variance, CI=confidence interval
****p*< .001, ***p*<.01, **p*<.05

Table 44 shows the role of psychological well-being as a mediator between self-concept and menopausal symptoms. The table shows that after controlling the effect of age, education, employment status, and family income (model 1) there is significant negative relationship between self-concept and menopausal symptoms explaining 59% variance in model 2. In model 3, the effect of psychological well-being is non significant, which indicate that the relationship between self-concept and menopausal symptoms was not mediated by marital satisfaction.

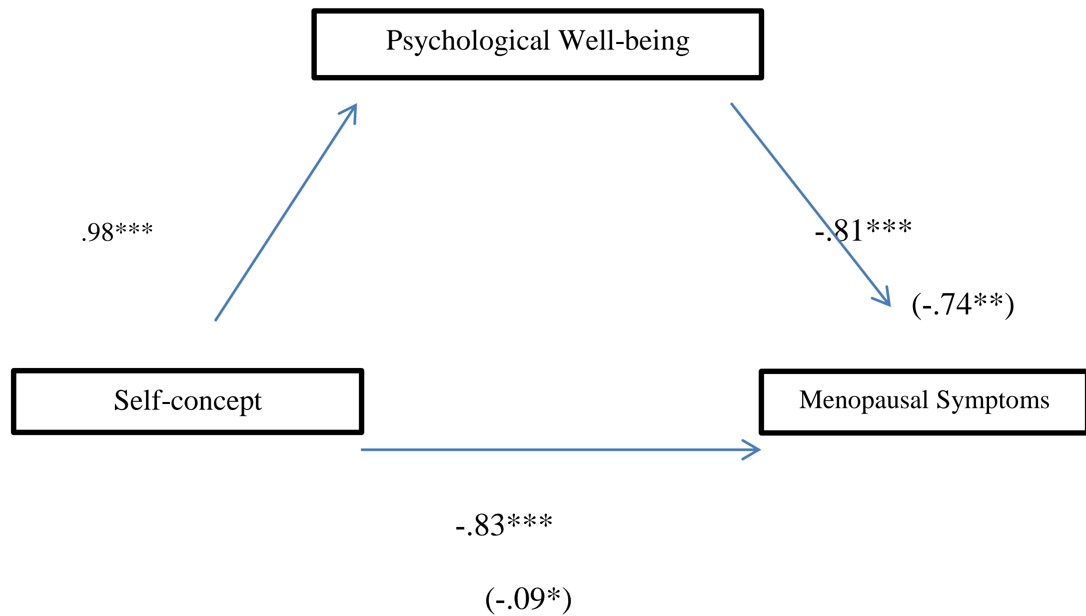

Figure 3. Mediating effect of psychological well-being on relationship of self-concept and menopausal symptoms among postmenopausal women.

Table 45

Hierarchical Regression Analysis of self-concept on Menopausal symptoms through psychological wellbeing in case of postmenopausal women (n=116)

			Menopausal symptoms	
			Model 3	
Variables	Model 1 B	Model 2 B	B	95% CI
Constant	24.53**	99.95***	98.44***	[84.25, 112.64]
Age	.22	-.01	.03	[-.13, .19]
Education	.59	-1.29	-2.05**	[-2.15, 3.00]
Employment	-5.69**	-2.28	.43	[-4.44, -1.21]
Family income	-2.19	-3.94***	-2.83**	[-.11, .09]
Self-concept		.23***	-.05	[-.33, -.18]
Psychological Well-being			-.26***	
R^2	.13	.59	.71	
F	4.13**	31.43**	45.01***	
ΔR^2		.46	.13	
ΔF			47.06***	

Note. B=unstandardized regression coefficient, R^2=explained variance, CI=confidence interval
****p*< .001, ***p*<.01, **p*<.05

Table 45 shows the role of psychological well-being as a mediator between self-concept and menopausal symptoms. The table shows that after controlling the effect of age, education, employment status, and family income (model 1) there is significant negative relationship between self-concept and menopausal symptoms

explaining 59% variance in model 2. In model 3, psychological well-being fully mediates the relationship of self-concept and menopausal symptoms explaining 71% variance. Mediation was confirmed through Sobel test (Sobel-t=5.99, p<.01).

The analytical comparison revealed from the results shown Table 40-45 that these results partially support our hypothesis as it was hypothesized that "Marital satisfaction and psychological well-being mediates the relationship between self-concept and menopausal symptoms". Marital satisfaction and psychological well-being were significant mediators only for premenopausal and postmenopausal women not for perimenopausal women.

Demographic variables-wise differences of menopausal symptoms. To find out whether the experience of menopausal symptoms is differing on certain demographic variables e.g., employment status, education level, and monthly income of the family, Two-way ANOVA analyses were carried out.

It was hypothesized that "working women will experience less menopausal symptoms than non-working women. To test the hypothesis Two-Way ANOVA analyses were done." The results are shown in Tables 46-75.

Table 46

Means and standard deviations of pre, peri, and postmenopausal women on Psychological subscale of GCSS, from working and non-working groups (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Employment status	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*
Non-working	59	11.84	9.86	63	18.24	8.09	69	14.32	4.59
Working	57	8.05	7.52	53	15.01	8.00	47	11.43	5.35

Table 47

F-values of pre, peri, and postmenopausal women on Psychological symptoms from working and non-working groups (N= 348)

Source	*SS*	*Df*	*MS*	*F*	*P*	η_p^2
Menopause	2511.96	2	1255.98	22.56	000	.12
Employment	968.06	1	968.06	17.39	000	.05
Menopause×employment	13.09	2	6.54	.11	.889	.00
Error	19034.44	342	55.66			
Total	83772.320	348				
Corrected total	22596.51	347				

In Table 47 Two-way ANOVA results indicate that there is significant main effect of the menopausal status on Psychological symptoms, (F (2, 342) = 22.56, p < .01, η_p^2 =.12). There is also a significant main effect of employment status on Psychological symptoms, (F (2, 339) = 17.39, p < .01, η_p^2 =.05). There is a non significant interaction effect between menopausal status and employment status on Psychological symptoms, (F (2, 339) = .11, p >.05, η_p^2 =.00). These results also indicate that working women in all three menopausal statuses have less mean scores than non-working women in three menopausal statuses (see Table 46).

Table 48

Mean and standard deviation of pre, peri, and postmenopausal women on Somatic subscale of GCSS, from working and non-working groups (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Employment status	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*
Non-working	59	4.64	3.47	63	8.74	4.95	69	7.94	3.61
Working	57	4.10	3.35	53	7.16	4.46	47	5.56	2.54

Table 49

F values of pre, peri, and postmenopausal women on Somatic subscale of GCSS from working and non-working groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	765.41	2	382.70	24.85	.000	.13
Employment	191.91	1	191.91	12.46	.000	.04
Menopause×employment	48.64	2	24.32	1.58	.008	.04
Error	5249.81	341	15.39			
Total	20719.00	347				
Corrected total	6297.76	346				

In Table 49 results of Two-way ANOVA indicate that there is a significant main effect of the menopausal status on Somatic subscale, (F (2, 342) = 24.85, p < .01, η_p^2 =.13). There is also a significant main effect of employment status on Somatic subscale, (F (2, 339) = 12.46, p < .01, η_p^2=.04). There is also a significant interaction effect between menopausal status and employment status on Somatic subscale, (F (2,339) = 1.58, p < .05). These results also indicate that working women in all three menopausal statuses experience less somatic menopausal symptoms than non-working women in three menopausal statuses (See Table 48).

Table 50

Means and Standard Deviations of pre, peri, and postmenopausal women on Vasomotor subscale of GCSS, for working and non-working groups (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Employment status	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
Non-working	59	1.37	1.11	63	2.64	1.76	69	1.94	1.78
Working	57	0.85	0.83	53	2.03	1.50	47	1.43	0.94

Table 51

F-values of pre, peri, and postmenopausal women on Vasomotor subscale of GCSS, from working and non-working groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	85.56	2	42.78	21.66	.000	.11
Employment	25.80	1	25.80	13.06	.000	.04
Menopause×Employment	.26	2	.13	.06	.934	.00
Error	675.42	342	1.97			
Total	1838.00	348				
Corrected total	789.67	347				

In Table 51 results of Two-way ANOVA indicate that there is a significant main effect of the menopausal status on Vasomotor, [F (2, 342) = 21.66, p < .01, η_p^2 =.11)]. There is also a significant main effect of employment status on Vasomotor symptoms, [F (2, 339) = 13.06, p < .01, η_p^2 =.04)]. There is a non significant interaction effect between menopausal status and employment status on Vasomotor, [F (2, 339) = .06, p>.05, η_p^2 =.00)]. These results also indicate that working women in all three menopausal statuses experience less vasomotor menopausal symptoms than non-working women in three menopausal statuses as indicated by the mean differences (see Table 50).

Table 52

Means and Standard Deviations of pre, peri, and postmenopausal women on Sexual symptom subscale of GCSS, from working and non-working groups (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Employment status	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*
Non-working	59	1.77	1.45	63	2.11	0.81	69	2.02	0.71
Working	57	0.98	1.04	53	1.90	0.86	47	1.79	0.98

Table 53

F-values of pre, peri, and postmenopausal women on total of Sexual symptom subscale of GCSS from working and non-working groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	25.90	2	12.95	12.93	.000	.07
Income	15.41	1	15.11	15.11	.000	.04
Menopause×Emplyment	6.16	2	3.07	3.07	.047	.02
Error	342.51	342	1.00			
Total	1488.00	348				
Corrected total	390.51	347				

In Table 53 results of Two-way ANOVA indicate that there is a significant main effect of the menopausal status on Sexual symptoms, [F (2, 342) = 12.93, p < .01, η_p^2 =.07)]. There is also a significant main effect of employment status on Sexual symptoms, [F (2, 339) = 15.11, p < .01, η_p^2 =.04)]. There is also a significant interaction effect between menopausal status and employment status on Sexual symptoms, [F (2, 339) = 3.07, p<.05)]. These results also indicate that working women in all three menopausal statuses experience less sexual menopausal symptoms than non-working women in three menopausal statuses as indicated by the mean differences (see Table 52).

Table 54

Mean and Standard Deviations of pre, peri, and postmenopausal women on GCSS, from working and non-working groups (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Employment status	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
Non-working	59	19.64	15.19	63	31.74	14.69	69	26.23	9.34
Working	57	14.00	12.28	53	26.13	13.96	47	20.27	8.50

Table 55

F-values of pre, peri, and postmenopausal women on total of GCSS, from working and non-working groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	8461.95	2	4230.97	26.51	.000	.13
Income	2822.87	1	2822.87	17.69	.000	.05
Menopause& income	2.16	2	1.08	1.35	.008	.04
Error	54414.51	342	159.57			
Total	253543.60	348				
Corrected total	66002.35	347				

In Table 55 results of Two-way ANOVA indicate that there is a significant main effect of the menopausal status on total Greene Climacteric Symptoms Scale, [F (2, 342) = 26.51, p < .01, η_p^2 =.13)]. There is also a significant main effect of employment status on Greene Climacteric Symptoms Scale, [F (2, 339) = 17.69, p < .01, η_p^2 =.05)]. There is also a significant interaction effect between menopausal status and employment status on total Greene Climacteric Symptoms Scale, [F (2, 339) = 1.35, p<.05, η_p^2 =.04] These results also indicate that working women in all three menopausal statuses experience less sexual menopausal symptoms than non-working women in three menopausal statuses as indicated by the mean differences (see Table 54).

The analytical comparison revealed from the results shown in Tables 50 to 59, that menopausal status has significant main impact on all subscales (PSY, SOM,

VAS, and SEX), and total GCSS. Results also reveal that employment status has significant main effect only on all subscales and total of Greene Climacteric Symptoms Scale. The interaction effect between menopausal status and employment status is significant for all three subscales (PSY, SOM, SEX), and total Greene Climacteric Symptoms Scale except vasomotor symptoms.

These differences support our hypothesis that "working women will experience less menopausal symptoms than non-working women.

It was hypothesized that "women with lower education level will experience more menopausal symptoms than women with higher education level". To test the hypothesis, two way ANOVA analyses were carried out.

Table 56

Mean and Standard Deviations of pre, peri, and postmenopausal women on Psychological subscale of GCSS, from less and highly educated groups (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Employment status	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*
Lower education	68	11.11	9.19	61	19.09	7.55	71	13.74	4.55
Higher education	48	8.37	8.46	55	14.61	8.20	45	12.20	5.79

Table 57

F-values of pre, peri, and postmenopausal women on Psychological subscale of GCSS, from less and highly educated groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	2820.08	2	1410.42	25.22	.000	.13
Education	750.52	1	750.52	13.42	.020	.04
Menopause× education	138.59	2	69.30	1.24	.291	.01
Error	19116.28	342	55.89			
Total	83772.32	348				
Corrected total	22596.51	347				

In Table 57 Two-way ANOVA was computed to see the impact of menopausal status and education on psychological symptoms of menopause. There is

a significant main effect of the menopausal status, [F (2, 339) =25.22, p< .01, η_p^2 =.13)]. .There is also a significant main effect of education on psychological menopausal symptoms, [F (2, 339) = 13.42, p<.05)]. There is a non significant interaction effect between menopausal status and education on psychological menopausal symptoms, [F (2, 339), = 1.24, p >.05, η_p^2 =.01)]. Results also indicate that women with lower level of education experience more psychological menopausal symptoms as compared to the women with higher education level in all three menopausal statuses (see Tables 56 & 57).

Table 58

Mean and Standard Deviations of pre, peri, and postmenopausal women on Somatic subscale of GCSS, from less and highly educated groups (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Education	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
Lower education	68	4.39	3.15	61	9.03	5.13	71	7.78	3.51
Higher education	48	4.35	4.31	55	7.08	4.26	45	5.64	2.81

Table 59

F-values of pre, peri, and postmenopausal women on Somatic subscale of GCSS, from less and highly educated groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	788.51	2	394.25	25.59	.000	.13
Education	160.65	1	160.65	10.43	.001	.03
Menopause& education	75.81	2	37.90	2.46	.087	.01
Error	5251.91	342	15.40			
Total	6297.76	348				
Corrected total	4550.58	347				

In Table 59 Two-way ANOVA was computed to see the impact of menopausal status and education on somatic symptoms of menopause. There is a significant main effect of the menopausal status, *(F* (2, 339) = 25.59, p < .01, η_p^2 =.13). There is a significant main effect of education on experience of somatic symptoms, [F (2, 339) = 10.43, p <.01)]. This significant main effect of education

indicates that less educated women in all three (pre-, peri-, and postmenopausal) groups having high mean scores as compared to the highly educated women in all three (pre-, peri-, and postmenopausal) groups (see Table 58). There is a non significant interaction effect between menopausal status and education on somatic menopausal symptoms, [F = (2, 339) = 2.46, p >.05, η_p^2 =.01)].

Table 60

Mean and Standard Deviations of pre, peri, and postmenopausal women on Vasomotor subscale of GCSS, from less and highly educated groups (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Education	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
Lower education	68	1.38	1.09	61	2.85	1.92	71	1.74	1.79
Higher education	48	0.75	0.76	55	1.91	1.25	45	1.71	0.79

Table 61

F-values of pre, peri, and postmenopausal women on Vasomotor subscale of GCSS, from lower and higher educated groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	98.19	2	49.09	25.28	.000	.13
Education	24.68	1	24.68	12.71	.000	.04
Menopause× education	12.18	2	6.09	3.13	.045	.02
Error	663.98	342	1.94			
Total	1838.00	348				
Corrected total	789.67	347				

In Table 61 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status, [F (2, 339) = 25.28, p< .01, η_p^2 =.13)]. There is also a significant main effect of education on vasomotor menopausal symptoms [F (2, 339) = 12.71, p <.1, η_p^2 =.04)]. There is a significant interaction effect between menopausal status and education on vasomotor menopausal symptoms [F (2, 339) = 8.16, p < .05, η_p^2 =.02)]. Results also indicate that less educated women in all three (pre-, peri-, and postmenopausal) groups having high mean scores as compared to the

highly educated women in all three (pre-, peri-, and postmenopausal) groups (see Table 60).

Table 62

Mean and Standard Deviations of pre, peri, and postmenopausal women on Sexual subscale of GCSS, from lower educated and highly educated groups (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Education	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*
Lower education	68	1.47	1.54	61	2.14	0.67	71	1.88	0.71
Higher education	48	1.27	0.93	55	1.90	0.95	45	2.00	1.02

Table 63

F-values of pre, peri, and postmenopausal women on Sexual symptoms subscale of GCSS, from lower educated and highly educated groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	28.21	2	14.10	13.38	.000	.07
Education	1.13	1	1.13	1.07	.029	.05
Menopause& education	2.13	2	1.11	4.86	.008	.04
Error	360.55	342	1.05			
Total	1488.00	348				
Corrected total	390.51	347				

In Table 63 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on sexual symptoms of menopause, [F (2, 339) = 13.38, p < .01, η_p^2 =.07)]. There is also a significant effect of education on sexual symptoms of menopauses [F (2, 339) = 1.07, p<.05, η_p^2 =.05)]. There is also significant interaction effect between menopausal status and education on sexual symptoms of menopause [F (2, 339) = 4.86, p< .01, η_p^2 =.04)]. These results indicate that less educated women experience more sexual symptoms during menopause. In all three groups of menopausal status (pre-, peri-, and postmenopausal) less educated women have high mean scores (see Table 62)

Table 64

Mean and Standard Deviations of pre, peri, and postmenopausal women on GCSS, from lower educated and highly educated groups (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Education	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
Lower education	68	18.36	14.20	61	33.12	14.34	71	25.04	13.91
Higher education	48	14.75	13.74	55	25.51	13.92	45	20.97	13.37

Table 65

F-values of pre, peri, and postmenopausal women on the total GCSS, from less educated and highly education groups (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	9266.99	2	4633.49	28.80	.000	.14
Education	2064.46	1	2064.46	12.83	.000	.04
Menopause× education	302.18	2	151.09	.93	.392	.00
Error	54848.60	342	160.84			
Total	253543.60	348				
Corrected total	39710.51	347				

In Table 65 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on overall menopausal symptoms, [F (2, 339) = 28.80, $p< .01$, η_p^2 =.14)]. There is a significant effect of education on menopausal symptoms [F (2, 339) = 12.83, $p >.01$, η_p^2 =.04)]. There is a non significant interaction effect between menopausal status and education on menopausal symptoms [F (2, 339) = .93, $p> .05$)]. In all three groups of menopausal status (pre-, peri-, and postmenopausal) less educated women, have high mean scores (see table 64).

The analytical comparison revealed from the results shown in Tables 60 to 69 , that menopausal status has significant impact on all subscales (PSY, SOM, VAS, and SEX), and total Greene Climacteric Symptoms Scale. Results also reveal that education has significant main effect ($p<.05$) only on all subscales and total of GCSS. The interaction effect between menopausal status and education is only significant for Vasomotor, Sexual, and total Greene Climacteric Symptoms Scale.

These differences partially support our hypothesis that "women with lower education level will experience more menopausal symptoms than women with higher education level".

It was hypothesized that "women belonging to lower income families will experience more menopausal symptoms than higher income families". To test the hypothesis, two way ANOVA analyses were done.

Table 66

Mean and Standard Deviations of pre, peri, and postmenopausal women on Psychological subscale of GCSS, from lower and higher income families (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Monthly income	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*
20000-39000	34	14.11	12.09	33	22.03	7.73	48	15.47	5.36
40000-59000	65	9.33	7.55	36	17.77	6.60	45	15.06	3.36
60000 & above	17	8.38	9.31	47	12.16	7.74	23	10.47	4.07

Table 67

F-values of pre, peri, and postmenopausal women on Psychological subscale of GCSS, from lower and higher income families (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	2198.63	2	1099.31	21.99	.000	.12
Income	445.01	2	222.50	4.45	.012	.03
Menopause& income	2485.89	4	621.47	12.43	.000	.13
Error	16945.48	339	49.98			
Total	83772.32	348				
Corrected total	22596.51	347				

In Table 67 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on psychological menopausal symptoms, [F (2, 339) = 21.99, p< .01, η_p^2 =.12)]. There is a significant main effect of monthly income on psychological menopausal symptoms [F (2, 339) = 4.45, p <.05, η_p^2 =.03)]. There is a significant interaction effect between menopausal status and monthly income on menopausal symptoms [F (2, 339) = 12.43, p < .01, η_p^2 =.13)]. These results indicate

that women belonging to lower income families experience more psychological menopausal symptoms during menopause. The mean differences show that premenopausal women belong to 60000 & above income group have high mean scores (p<.05) than other two income groups. Perimenopausal women belonging to lower income families have high mean scores (p<.05) than other two income groups. Whereas, postmenopausal women belonging to higher income families have high mean scores than other two income groups (see Table 66).

Table 68

Mean and Standard Deviations of pre, peri, and postmenopausal women on Somatic subscale of GCSS, from lower and higher income families (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Monthly income	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
20000-39000	34	7.58	5.76	33	10.68	5.02	48	8.25	3.98
40000-59000	65	4.24	2.72	36	8.22	4.54	45	5.86	2.71
60000 & above	17	3.02	2.33	47	6.04	4.10	23	6.39	2.42

Table 69

F-values of pre, peri, and postmenopausal women on Somatic subscale of Greene Climacteric Symptoms Scale, from lower and higher income families (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	553.37	2	276.68	19.91	.000	.11
Income	89.83	2	44.91	3.23	.041	.02
Menopause& Income	651.13	4	162.78	11.71	.000	.12
Error	4695.84	339	13.89			
Total	20719.00	348				
Corrected total	6297.76	347				

In Table 69 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on somatic menopausal symptoms, [F (2, 339) = 19.91, p < .01, η_p^2 =.11)]. There is a non significant main effect of monthly income on somatic menopausal symptoms [F (2, 339) = 3.23, p >.05, η_p^2 =.02)]. There is a significant interaction effect between menopausal status and monthly income on somatic menopausal symptoms [F (2, 339) = 11.71, p < .01)]. These results indicate

that women belonging to lower income families experience more somatic menopausal symptoms. The mean differences show that premenopausal women belong to 60000 & above income group have high mean scores (*p*<.05) than other two income groups. Perimenopausal women belonging to lower income families have high mean scores (*p*<.05) than other two income groups. Whereas, postmenopausal women belonging to higher income families have high mean scores on Somatic subscale of Greene Climacteric Symptoms Scale (*p*<.05) than other two income groups (see Table 68).

Table 70

Mean and Standard Deviations of pre, peri, and postmenopausal women on Vasomotor subscale of GCSS, from lower and higher income families (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Monthly income	*N*	*M*	*SD*	*N*	*M*	*SD*	n	*M*	*SD*
20000-39000	34	1.32	0.76	33	3.34	2.11	48	2.64	1.57
40000-59000	65	1.03	1.15	36	2.55	1.25	45	1.00	1.14
60000 & above	17	1.05	0.82	47	1.73	1.09	23	1.26	0.91

Table 71

F-values of pre, peri, and postmenopausal women on Vasomotor subscale of GCSS, from lower and higher income families (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	93.05	2	46.52	27.87	.000	.14
Income	74.20	2	37.10	22.23	.000	.11
Menopause& income	37.34	4	9.33	5.59	.003	.06
Error	565.75	339	1.66			
Total	1838.00	348				
Corrected total	789.67	347				

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In Table 71 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on vasomotor menopausal symptoms, [F (2, 339) = 27.87, p < .01, η_p^2 =.14)]. There is also a significant main effect of monthly income on vasomotor menopausal symptoms [F (2, 339) = 22.23, p = .01, η_p^2 =.11)]. There is a significant interaction effect between menopausal status and monthly income on

vasomotor menopausal symptoms [F (2, 339) = 5.59, p < .01, η_p^2 =.06)]. These results also indicate that women belonging to lower income families experience more vasomotor menopausal symptoms during menopause. The mean differences show that women in premenopausal, perimenopausal, and postmenopausal women belong to lower income family group have high mean scores (p<.05) than other two income groups (see Table 70).

Table 72

Mean and Standard Deviations of pre, peri, and postmenopausal women on Sexual subscale of GCSS, from lower and higher income families (N= 348)

	Premenopausal (n=116)			Perimenopausal (n=116)			Postmenopausal (n=116)		
Monthly income	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
20000-39000	34	1.76	1.25	33	2.31	0.47	48	2.02	0.14
40000-59000	65	1.38	1.44	36	2.80	0.69	45	1.51	1.03
60000 & above	17	1.20	1.09	47	1.16	1.05	23	2.56	0.84

Table 73

F-values of pre, peri, and postmenopausal women on Sexual subscale of GCSS, from lower and higher income families (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	21.81	2	10.90	11.06	.000	.06
Income	5.09	2	2.50	2.54	.080	.02
Menopause& income	27.69	4	6.92	7.02	.002	.08
Error	334.06	339	.98			
Total	1488.00	348				
Corrected total	390.51	347				

In Table 73 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on sexual menopausal symptoms, [F (2, 339) = 11.06, p < .01, η_p^2 =.06)]. There is a non significant main effect of monthly income on vasomotor menopausal symptoms [F (2, 339) = 2.54, p >.05)]. There is a significant interaction effect between menopausal status and monthly income on sexual menopausal symptoms [F (2, 339) = 7.02, p < .01, η_p^2 =.08)]. These results also indicate that women belonging to lower income families in perimenopausal stage

(who experience more menopausal symptoms than pre, and postmenopausal women) have high mean scores ($p<.05$) than other two income groups (see table 72).

Table 74

Mean and Standard Deviations of pre, peri, and postmenopausal women on Sexual subscale of GCSS, from lower and higher income families (N= 348)

	Premenopausal (*n*=116)			Perimenopausal (*n*=116)			Postmenopausal (*n*=116)		
Monthly income	*N*	*M*	*SD*	*N*	*M*	*SD*	*n*	*M*	*SD*
20000-39000	34	13.94	13.25	33	38.37	14.49	48	27.97	9.89
40000-59000	65	16.40	12.26	36	30.72	11.98	45	20.28	7.01
60000 & above	17	24.52	19.50	47	29.50	13.33	23	20.69	7.39

Table 75

F-values of pre, peri, and postmenopausal women on GCSS, from lower and higher income families (N= 348)

Source	*SS*	*df*	*MS*	*F*	*P*	η_p^2
Menopause	70.85.41	2	3542.52	24.83	.000	.13
Income	15.08.41	2	754.20	5.28	.005	.03
Menopause & income	6905.95	4	1726.48	12.10	.000	.13
Error	48213.47	339	142.64			
Total	253543.60	348				
Corrected total	66002.356	347				

In Table 75 Two-way ANOVA results indicate that there is a significant main effect of the menopausal status on Total Greene Climacteric Symptoms Scale, [F (2, 339) = 24.83, $p < .01$, η_p^2 =.13)]. There is also a significant main effect of monthly income on total Greene Climacteric Symptoms Scale, [F (2, 339) = 5.28, $p < .01$, η_p^2 =.03)]. There is a significant interaction effect between menopausal status and monthly income on total Greene Climacteric Symptoms Scale, [F (2, 339) = 12.10, $p < .01$, η_p^2 =.13)]. These results also indicate that women belonging to lower income families in perimenopausal (who experience more menopausal symptoms than pre, and postmenopausal women) have high mean scores ($p<.05$) than other two income groups (see Table 74).

The analytical comparison revealed from the results shown in Tables 71 to 80 , that menopause status has significant impact on all subscales (Psychological, Somatic, Vasomotor, and Sexual), and total scores of Greene Climacteric Symptoms Scale. Results also reveal that monthly income has significant main effect only on all subscales except vasomotor symptoms. The interaction effect between menopausal status and monthly income is significant for all the subscales (Psychological, Somatic, Vasomotor, and Sexual) and total Greene Climacteric Symptoms Scale.

These differences fully support our hypothesis that "women belonging to lower income families will experience more menopausal symptoms than higher income families".

Discussion

The present research was carried out to explore the differences among pre-, peri-, and postmenopausal women regarding experience of menopausal symptoms, psychological well-being, self-concept, and marital relationship. Another objective of the research was to find out whether pre-, peri-, and postmenopausal women with different education and family income differ on experience of menopausal symptoms.

Phase IV of the study comprised of main study. This phase deals with the hypotheses testing and data were collected from Rawalpindi and Islamabad. Sample (*N*=348) comprised of pre-, peri-, and postmenopausal women. The demographic sheet included self-report questions to assess the menopausal status of women (meaning assessing whether the woman is in pre, peri or postmenopausal group). The inclusion criteria for sample of main study have already been mentioned in Phase-IV. Data was statistically analyzed using SPSS (Statistical Package for Social Sciences). Psychometric properties of the instruments were evaluated through statistical

analysis. The main objectives of the pilot study were pre-testing of scales on a small group and to establish the psychometric properties of the all three scales Ryff Scale of Psychological well-being Scale (RSPWB), Tennessee Self-Concept Scale-2 (TSCS-2), and Green Climacteric Symptoms Scale (GCSS). Alpha reliability coefficients, Item total correlations, and inter scales correlations were computed to find out the internal consistency and construct validity of three scales.

Alpha reliability coefficients (see Table 8) of RSPWB-Urdu ranged from .72 (for autonomy) to .91 (for environmental mastery). The coefficients of TSCS-2 are ranged from .70 (for moral self) to .91 (for Physical self). For GCSS alpha reliability coefficients are ranged from .76 (for Vasomotor) to .90 (for Psychological). These findings show that all the items of all the measures are internally consistent and sufficiently reliable. However alpha coefficients for purpose in life the subscale of Psychological well-being, Moral subscale of TSCS-2, and Vasomotor subscale of GCSS were somewhat low in the results of pilot study but results of main study indicated these reliability coefficients are above .70 which is satisfactory. As predicted in the discussion of pilot study, large sample size has increased the values of reliabilities of some subscales of present study.

The item-total correlation analysis of RSPWB-Urdu version indicates that all the items of all the subscales have shown high positive correlations with total score. All the items have significant positive correlation ranged from .33 to .89 (p<.01) (see Table 9). On TSCS-2 Urdu version all the item of all the subscales have significant positive correlations with total score ranged from .25 (p<.01) for moral self to .88 (p<.01) for academic/work self (see Table 10). Positive significant correlations indicate that all the items are measuring the same construct like the scale as a whole.

All the items of subscales of GCSS-Urdu have also shown significant positive correlations with total score ranged from .44 (p<.01) to .88 (p<.01) (see Table 11). Item total correlations of MSS-Urdu have also shown significant positive correlations with total scores ranged from .43 (p<.01) to .91 (p<.01) (see Table 12). Thus, indicating consistency of items with the total of the scale. The item-total correlations also establish that the constructs measured by the instruments exist in Pakistani culture in the similar way as in other cultures.

The internal consistency was further determined by inter scale correlation of all scales. The positive correlation of all the subscales with the total indicates that the subscales are also measuring the same constructs as the main scale. The results were satisfactory and the calculated values of reliability, item-total correlations and inter-scale correlations gave satisfactory results.

There is positive correlation between RSPWB, TSCS-2, and MSS. It indicates that participants with high psychological well-being also have positive self-concept and high marital satisfaction. Moreover, participants with positive self-concept found to have high marital satisfaction. Whereas, the scores on RSPWB, TSCS-2 and are MMS found to have negative correlation coefficients with GCSS.

Results indicate that those respondents who experience more menopausal symptoms have low levels of psychological well-being. Research was conducted by Deeks and McCabe (2004) and the evidence suggested that participants with more menopausal symptoms had low quality of life and personal psychological well-being.

Inter-scale correlations also indicated negative relationship between menopausal symptoms and self-concept. The result is consistent with the findings of previous researches. Researchers have found that participants having high opinions of

their abilities and other aspects of their own personality report relatively less menopausal symptoms (Bromberger et al., 2003; Shu et al., 2007).

Another suggested that women having more menopausal symptoms experience lesser marital satisfaction. A research conducted by Cifcili et al. (2009) found that menopausal women reported emotional instability due to the experience of menopausal symptoms and these symptoms affect various aspects of their lives including marital relationship. High frequency of menopausal symptoms led to marital conflicts and subsequently marital dissatisfaction.

Further statistical analyses were conducted to test the hypotheses of main study. The salient objective of the main study was to investigate whether the premenopausal, perimenopausal, and postmenopausal women differ on their levels of Psychological well-being, Self-Concept, Marital Satisfaction, and experience of menopausal symptoms.

Premenopausal, Perimenopausal and Postmenopausal Group-Wise Differences of Psychological well being

Causal model of psychological well-being provided the basis for this analysis that had integrated the *top-down*, and *bottom-up* views. This model explained that individual's life events influence the way in which they interpret the circumstances of his/her life and in turn these interpretations influence subjective well-being. Menopause is a life event that significantly changes women's interpretation and they feel negative toward themselves.

The results of present study (see Table 14) revealed that psychological well-being appear to change with menopausal status. Further, post hoc differences (see Table 15) reveal that premenopausal women as compared to the perimenopausal and

postmenopausal women have more sense of environmental mastery and are able to manage everyday affairs, aware of surrounding opportunities, and have a sense of control over external world. Results shown in Table 16 reveal that as compared to the other two groups of the women premenopausal women are more concerned about others as they have close, warm and trusting relationships with others. Group wise differences (see Table 17) indicate that women who belong to premenopausal group have feeling of continued development, and see themselves as growing and expanding as compared to the peri-, and postmenopausal women. Similar findings were found by a study conducted by Deeks and McCabe (2004) and the study found that women who were in perimenopausal and postmenopausal stages did not feel as positive about their role/s in life as premenopausal women, regardless of their age. The results suggested that the menopause may indicate that women's role/purpose in life is changing. The psychosocial aspects of women's lives have been incorporated in most of the studies of menopause.

The results shown in Table 18 indicate that premenopausal women possess a positive attitude toward themselves, acknowledgement and acceptance good and bad aspects of their personalities as compared the perimenopausal and postmenopausal women, and perimenopausal women perceived self-acceptance less positively these findings are also in accord with those earlier researchers (e.g., Deeks & McCabe, 2004). The significant differences shown in Table 19 indicate that premenopausal women are more self-determined and independent within their selves and evaluate themselves by personal standards as compared to the peri-, and postmenopausal women. Premenopausal women also have goals in life and a sense of directedness and have more objectives and aims for living as compared to the peri-, and postmenopausal women (see Table 20). The significant differences between three

groups on total RSPWB (see Table 21) reveal that premenopausal women perceive their psychological well-being more positively than perimenopausal and postmenopausal women.

These findings suggest that menopausal transition may associate with several physical and psychological changes that may impact women's perception of psychological well-being less positively. These findings are also consistent with those of earlier researches (e.g., Fuh, Wang, & Lee, 2003).

Premenopausal, Perimenopausal and Postmenopausal Group-Wise Differences of Self-Concept

Several psychological approaches can be used to explain the results of Table 22-28, for example, Erickson (1958), stated that self-concept is a conscious and cognitive evaluation of person's own thoughts and opinions, sociological perspective narrated that self-concept is an interpretation of our experiences, and Rogers (1961) also stated that new experiences change our feeling and thoughts and affect our self-concept. Findings shown in Table 22-28 indicate the differences between pre-, peri-, and postmenopausal women on TSCS-2 and its subscales. Results shown in Table 22 reveal that premenopausal women significantly differ on physical, personal, family, social, and academic/work self, and total TSCS-2. These differences were further analyzed by using Post hoc test. Significant differences on physical self (see Table 23) indicate that premenopausal women have positive points of views about their features and health conditions than peri-, and postmenopausal women when experiencing biological menopause they value their body as an emerging issue (Shu, Luh, & Ming, 2006). The significant difference on personal self (see Table 24) reveal that premenopausal women have integrated personalities, and are well adjusted

individuals than peri-, and postmenopausal women because mid-life women experience transition which means individual changes and adaptations to the lifestyle which further contribute to the individual's psychological development. In this stage women face the psychological crisis generativity versus stagnation. On family self (see Table 25) premenopausal women also significantly differ from peri-, and postmenopausal women, which indicates that mid-life women have a lower level of control with regard to family life (Shu et al., 2006). Results shown in Table 26 indicate that premenopausal women have also high mean scores on social self which means that premenopausal women have a sense of adequacy and worth in social interaction with other people, and usually viewed by both themselves and others as being friendly, ease to be with and extroverted. The significant difference on academic/work self (see Table 27) reveals that premenopausal women perceive themselves more confident and competent in learning and work situations. They are comfortable when have to do new tasks. They do not feel disturbed by the early failures that usually come with new learning and creative activity, and they tend to seek out help and relevant information and opportunities to practice new skills. On total Tennessee self-concept scale-2 premenopausal women are also significantly differ from peri-, and postmenopausal women that indicate that premenopausal women have high self-concept and self-esteem. These findings are also in accordance with earlier researches (Bloch, 2002; Elavsky & McAuley, 2005; Shu et al., 2006).

In this study it is found that perimenopausal women reported more menopausal symptoms, including psychological, somatic, vasomotor and sexual symptoms than pre-, and postmenopausal women (see Table 29-34). The post hoc test results reveal the significant difference between peri-, and premenopausal women on psychological symptoms (see Table 30). Results indicate that psychological

symptoms were reported by perimenopausal women significantly more often than the others. These findings probably reflect the factors that for perimenopausal women presumably psychological and social stresses are greatest e.g., they have the psychological threat of loss of reproductive ability, and empty-nest period of the family cycle for perimenopausal women. The other factor of these findings might be the endocrine changes that come with climacteric period. During this period endocrine changes are expected to produce more symptoms than in other periods. On physical symptoms (somatic, vasomotor, and sex) there were significant differences between premenopausal and perimenopausal women. Perimenopausal women have significantly had high scores as compared to the premenopausal women (see Table 31, 32, and 33). However, the difference between peri-and postmenopausal women is non significant. The low scores of postmenopausal women indicate the recovery from symptoms despite their continued low endocrine status. The increased frequency of symptoms in perimenopausal women at this major developmental stage is due to biological and psycho-social changes (Neugarten & Kraines, 1965).

Premenopausal, Perimenopausal and Postmenopausal Group-Wise Differences of Self-Concept

Different models explained different facets of marital satisfaction which provided the basis for these analyses for example, social exchange model explained that marital relationship is a reciprocal exchange of needed and valued possessions, and according to the role expectation model husband or wife is satisfied to the extent that he or she feels that partner is satisfying role expectations. Menopause transition negatively impacts the reciprocal exchange and need, and role expectation, and produce feeling of displeasure.

When marital satisfaction is considered, it appeared that Premenopausal women also experience high level of marital satisfaction as compared to peri-, and postmenopausal women (see Tables 35 and 36).These findings are also in accordance with previous researches (Fielder & Kurpius, 2010). Post hoc test results reveal that the difference between peri-and postmenopausal women is not significant. The results support Heidrich's (1993) findings that women grow and develop from the successful management of the menopausal transition they face, and in various researches, marital satisfaction is found to be associated with smooth smooth menopausal transition in female lives, therefore, social support plays a significant role.

Self-concept predicts physical and psychological symptoms among pre, peri- and postmenopausal women

One of the salient hypotheses of present study dealt with prediction of menopausal symptoms by physical self-concept, family self-concept and academic/work self-concept. Results (see Table 37-39) revealed that physical self-concept and academic/work self-concept are significant predictors of menopausal symptoms (physical and psychological) among premenopausal women. Whereas, the family self-concept found a significant predictor of both physical and psychological symptoms among premenopausal women.

Among perimenopausal women, physical and academic/work self-concept are significant predictors for both physiological and psychological menopausal symptoms. Family self-concept was not found to be a significant predictor for both physiological and psychological symptoms.

Among postmenopausal women, physical, family and academic/work self-concept are significant predictors for both physiological and psychological menopausal symptoms.

Marital Satisfaction and Psychological Well-being mediates the relationship of self-concept and menopausal symptoms

Another objective of main study was to find the mediatory role of psychological well-being and marital satisfaction in relationship of self-concept and menopausal symptoms among pre, peri and postmenopausal women. Self-concept is relatively global concept and incorporates a person's view about all the aspects of his/her life (both internal and external). Self-concept is learned, organized, and dynamic. According to self-concept theory of Rogers (1961) new experiences, approval or disapproval from others affect self-concept. Self-concept changes with change in thoughts and feelings. So, existing self-concept affect the evaluation of new experiences as menopausal women's self-concept defines their interpretations of menopause as a new experience.

Furthermore, top-down and bottom-up (integrated model of well-being), explained that personality as well as objective life events (e.g., physical health, daily hassels, world assumptions) influence the way of one's perception. Women also feel negative towards themselves during menopause. The negative impact may lead to low opinion about one's own abilities and performance which ultimately affect their self-concept.

Above mentioned theories and models were considered and formed the basis of this analysis. Results revealed that for premenopausal group, 92% variance has been explained by the presence of marital satisfaction in the relationship of self-

concept and menopausal symptoms (see Table 40). It also indicates that marital satisfaction partially mediates in the relationship of self-concept and menopausal symptoms but psychological well-being does not mediates between the self-concept and menopausal symptoms (see Table 43).

In perimenopausal group, results showed that self-concept is not indirectly related to the menopausal symptoms. It means that the relationship between self-concept and menopausal symptoms is not mediated by the presence of psychological well-being and marital satisfaction (see Tables 41 and 44).

In postmenopausal group, results showed that 71% variance has been explained by the presence of and marital satisfaction in the relationship of self-concept and menopausal symptoms and (see Tables 42 and 45). It means psychological well-being and marital satisfaction are mediators in the relationship of self-concept and menopausal symptoms.

From the results it can be concluded that there is serial mediating relationship between the study variables. Marital satisfaction and psychological well-being act as mediators in the relationship of self-concept and marital satisfaction. Evaluation of one's own self is affected by many factors and interpersonal relationship is the most significant in this regard. For menopausal woman the most important interpersonal relationship is marital, as sexual life of women is affected (Dennerstein et al., 2003; Mitchell, 2002). If there is a negative change in this relationship, self-concept will be adversely affected (Dennerstein et al., 2005). Similarly good physical and psychological health will lead to positive self-concept and among menopausal women, when physical health deteriorates, psychological health is also affected and consequently women feel low about themselves (Avis et al., 2004). So it can be

assumed that low marital satisfaction and low psychological well-being are explaining the negative relationship of self-concept and menopausal symptoms among pre, peri- and postmenopausal women.

Demographic Variables and Women's Experience of Menopausal Symptoms

In present research certain demographic variables were also examined to see their effect on the women's experiences of menopausal symptoms.

Employment Status

Findings of the employment status comparisons with regards to the menopausal symptoms indicate that working women experience less menopausal symptoms. Psychological symptoms e.g., anxiety, depression, irritability, and loss of interest in most things are frequently experienced by non-working women than working women (see Table 51). The reason might have been that multiple roles increase self-confidence and feeling of self-worth and expand the arrangements of satisfaction and social support. These finding are also in accordance with the earlier researches (e.g., Orgulo, Kucuk, Aksu &, 2011; Mathews & Bromberger, 1994).The non-working women also experience more somatic symptoms e.g., muscle or joint problems, headache, and breathing difficulties, and vasomotor symptoms e.g., hot flushes, sweating at night than working women (see Table 55). This might be because working women are more likely to take care of themselves and make changes in their diet and lifestyle (walking, exercise). These results are also in line with the findings of others researchers (e.g., Orgulo et al., 2011; Kakkar et al. 2007).

There is no clear evidence concerning possible changes in female sexuality with menopause. However, with increasing age sexual desire decreases, particularly

when women are in their late 40s and 50s (Howon et al, 1994; Osborn et al, 1988). Table 44 indicates that non-working women have less interest in sex than working women. Non-working women are more likely to have urinary problems and dryness of vagina. The reason might be that working women take more care of their personal hygiene. Being mobile and economic independence, may have been rendering them in better position to deal with urinary and vaginal dryness problems (Ogrulo et al., 2011).

The results of Two-way ANOVA with GCSS also reveal that overall working women experience less menopausal symptoms than non-working women (see Table 53). These results support our hypothesis that “working women experience less menopausal symptoms than non-working women” and also indicate that employment status has a positive effect on menopausal symptoms (Mathews & Bromberger, 1994; Stopes & Cochrane, 1981). This may be because working women are financially independent and they have a routine of looking after their health, hygiene and personal grooming. As many researchers (Kaewboonthum, 2003; Gannon, 1999) have explained the contribution of environmental factors towards the aggravation of menopausal symptoms.

Education

Regarding the educational level of women Jokinen et al. (2003) believed that higher level of education in women would effectively reduce the symptoms of menopause. In current study also, women with higher level of education, experience less menopausal symptoms (see Table 60 to 69). On all subscales (physical, somatic, vasomotor, sex) and total of Greene climacteric symptoms scale women with lower level of education experience more menopausal

symptoms than women of lower level of education. Lower level of education in women could lead to psychological changes, which would be basis for menopausal symptoms (Blumel et al., 2002). It seems that higher level of education bring the person better job, income and social positions. Also, higher education contributes to better knowledge in various aspects of personal aspects. So, educated women could reduce the effect of the problems resulted from symptoms and changes of menopause. In addition, those with higher education level, have higher social positions and economically independent, to some extent.

Economic Status

Gerber (2001) found that women with good economic status experience lesser menopausal symptoms or would bear them better. The results of current research also reveal that women belonging to higher income families experience less menopausal symptoms as compared to the women of lower income families (see Tables 70 to 79). It seems that better economic status results from higher education and better job. So, these would be effective factors to reduce symptoms and changes of menopause (Fahami, Beygi, Zahraei, & Arman, 2007).

Chapter-VII

General discussion

Menopause has gained the attention of most researchers in the recent times. It has become an important developmental phase in the life of women with a global impact. Menopause influences almost all the facets of a woman's life. Menopausal symptoms and their impact vary from country to country and culture to culture. Present research was aimed to study the menopausal symptoms among three groups of menopausal women in three different stages of menopause and its impact on psychological well-being, self-concept, and marital satisfaction.

Literature review and focus group discussions highlighted certain variables regarding experience of menopause that is why present research aimed to find interrelationships (mediation) between the variables (psychological well-being, self-concept, marital satisfaction, and menopausal symptoms) that were considered important for the current research. Previous researches conducted in Pakistan have not studied these interrelationships. Previous evidences were not sufficient in this regard as there was not a single study available for Pakistani women, so, focus group discussions were conducted. The findings of focus group discussions revealed that menopausal symptoms, psychological well-being, self-concept, and marital satisfaction are interrelated. There is difference across the three stages (pre-, peri-, and postmenopausal) regarding these variables.

Psychometric properties of the scales were tested in the first place, initially in pilot study and then again in main study. Reliability of all the scales and subscales were satisfactory in pilot study and were reconfirmed through the findings of the main study. Satisfactory results of reliability suggested the consistency of the scales and

implied that instruments can be used for the main study. Relationship of study variables were calculated in the pilot study and the direction of relationships were in accordance with the hypotheses and existing literature. The results of pilot study also purport that further study can be conducted.

In this section, findings of the current study are discussed in the terms of our indigenous context as well as the empirical evidences of the other researches. The relationship between study variables was a significant objective of this study. Relationships among scales and subscales measuring menopausal symptoms, psychological well-being, self-concept and marital satisfaction showed distinctive pattern of significant positive as well as negative relationships. Most of these relationships were consistent with the previous research evidences and theories (Curhan et al., 2004; Kolod, 2009; Shu et al., 2010).

The study was aimed to find the differences in the menopausal symptoms of pre, peri and postmenopausal women. Findings suggest that perimenopausal women reported more menopausal symptoms, including psychological, somatic, vasomotor and sexual symptoms than pre-, and postmenopausal women. Results indicated that psychological symptoms were reported by perimenopausal women significantly more often than the others. These findings probably reflect the factors that for perimenopausal women presumably psychological and social stresses are greatest. Perimenopausal women experience more physical symptoms (somatic, vasomotor, and sexual) as compared to the premenopausal women. Physical symptoms in perimenopausal women at this major developmental stage are due to biological and psychosocial changes (Neugarten & Kraines, 1965).

The main objective of the main study was to investigate whether the premenopausal, perimenopausal, and postmenopausal women differ on their levels of psychological well-being, self-concept, marital satisfaction, and experience of menopausal symptoms. It was hypothesized that peri- and postmenopausal women will high level of psychological well-being than premenopausal women. The results revealed that psychological well-being change with menopausal status. Furthermore, premenopausal women as compared to the perimenopausal and postmenopausal women have more sense of mastery and are able to manage everyday affairs. Similar findings were found by a study conducted by Deeks and McCabe (2004) and it can be suggested that psychosocial aspects of women's lives are incorporated in most of the studies of menopause.

Self-concept is another potent variable of present study dealing with the mental and conceptual understanding and persistent regard that one holds for his/her own existence (Kostelink et al., 2002). It was hypothesized that peri- and postmenopausal women will have less positive self-concept than premenopausal women. Evidences of present study indicated that premenopausal women possess a positive attitude toward themselves, acknowledge and acceptance good and bad aspects of their personalities as compared to the perimenopausal and postmenopausal women, these findings are also in accord with those earlier researches (e.g., Deeks & McCabe, 2004). Significant differences regarding physical self-concept indicating that premenopausal women have positive points of views about their features and health conditions than peri-, and postmenopausal women (Shu et al., 2006). The significant difference on personal self-concept revealed that premenopausal women have integrated personalities, and are well adjusted individuals than peri-, and postmenopausal women because mid-life women experience transition and transition

means individual changes and adaptations to the lifestyle which further contribute to the individual's psychological development.

On family self-concept premenopausal women are also significantly differ than peri-, and postmenopausal women, which indicates that mid-life women have a lower level of control with regard to family life which is consistent with the findings of Shu et al. (2006). Moreover, premenopausal women have also high social self-concept which means that premenopausal women have a sense of adequacy and worth in social interaction with other people, and usually viewed by both themselves and others as being friendly, ease to be with and extroverted. The significant difference on academic attainment/work self-concept reveals that premenopausal women perceive themselves as more confident and competent in learning and work situations. They are comfortable in initiating new tasks. They do not feel disturbed by the early failures that usually come with new learning and creative activity, and they tend to seek out help and relevant information and opportunities to practice new skills. These findings are also in accordance with earlier researches (Bloch, 2002; Elavsky & McAuley, 2005; Shu et al., 2006).

It was hypothesized that premenopausal women will have more marital satisfaction than peri and postmenopausal women. When marital satisfaction was considered, it appeared that premenopausal women also experience high level of marital satisfaction as compared to peri-, and postmenopausal women. These findings were also in accordance with previous researches (Fielder & Kurpius, 2005; Kurpius et al., 2001). The results support Heidrich's (1993) findings that women grow and develop from the successful management of the menopausal transition.

Another hypothesis considered physical self-concept, family self-concept, and academic attainment/work self-concept predicts psychological and physical menopausal symptoms among pre, peri- and postmenopausal women. Results partially supported the study hypothesis as family self-concept was not found as a significant predictor for peri- and postmenopausal women. Furthermore, academic/work self-concept was a significant predictor of psychological symptoms in postmenopausal women. Previous researches (Bromberger et al., 2003; Brown et al., 2008; Shu et al., 2007) supported the findings of present study.

This study also explored the mediatory role of marital satisfaction and psychological well-being in the relationship of self-concept and menopausal symptoms. The results revealed mediating role of the above mentioned variables which can lead to the conclusion that marital satisfaction and psychological well-being explains the relationship between self-concept and menopausal symptoms.

Certain demographic variables were also examined in this study, to see their effect on the experience of menopausal symptoms. It was hypothesized that working women will experience fewer menopausal symptoms than non-working women. Findings of the employment status comparisons with regards to the menopausal symptoms indicate that working women experience fewer menopausal symptoms. Psychological symptoms e.g., anxiety, depression, irritability, and loss of interest are frequently experienced by non-working women than working women. The reason might have been that multiple roles increase self-confidence and feeling of self-worth and expand the arrangements of satisfaction and social support. These finding are also in accordance with the earlier researches (e.g., Orgulu et al., 2011; Mathews & Bromberger, 1994).

While making the comparison between working and non-working women it was found that non-working women also experience more somatic symptoms e.g., muscle or joint problems, headache, and breathing difficulties, and vasomotor symptoms e.g., hot flushes, sweating at night than working women. This might be that working women are more likely to care themselves and make changes in their diet and lifestyle (walking, exercise). These results are also in line with the findings of others researches which indicate that women who were more physically active reported significantly less severe vasomotor and somatic symptoms (e.g., Elavsky & McAuley, 2005; Kakkar et al., 2007; Nelson et al., 2008; Orgulu et al., 2011; Skrzypulec, Dabrowska, & Drosdzol, 2010).

It has been reported consistently that with increasing age sexual desire decreases, particularly when women are in their late 40s and 50s (Howon et al., 1994; Osborn et al., 1988). Results indicate that non-working women have less interest in sex than working women. The reason might be that working women take more care of their personal hygiene. Being mobile and economic independence, may have been rendering them in better position to deal with urinary and vaginal dryness problems (Orgulu et al., 2011). These results support the hypothesis that "working women experience fewer menopausal symptoms than non-working women" and also indicate that employment status has a positive effect on menopausal symptoms (Mathews & Bromberger, 1994; Stopes & Cochrane, 1981).

Regarding educational level, it was hypothesized that women with higher educational level will experience fewer menopausal symptoms than those women with lower educational level. The findings of current study suggested that women with higher level of education, experience fewer menopausal symptoms. Women with lower level of education experience more menopausal symptoms (vasomotor,

somatic, and sexual) than women of lower level of education. Lower level of education in women could lead to psychological changes, which would be basis for menopausal symptoms (Blumel et al., 2002). It seems that higher level of education bring the person better job, income and social positions. Moreover, higher education may be contributing to better knowledge in various aspects of personal positions.

Present study also considered economic status of the women and as Gerber (2001) found that women with good economic status experience fewer menopausal symptoms or would bear them better. It was hypothesized that women belonging to lower income families will experience more menopausal symptoms than higher income families. The results of current research also reveal that women belonging to higher income families experience fewer menopausal symptoms as compared to the women of lower income families. It seems that better economic status results from higher education and better job. So, these would be effective factors to reduce symptoms and changes of menopause (Fahami et al., 2007).

Present study found that pre- and post-menopausal women experience more physical as well as psychological symptoms as compared to premenopausal women. Psychological well-being and marital satisfaction were high among premenopausal women as compared to peri, and postmenopausal women. Similarly, positive self-concept was found in premenopausal women as compared to peri- and post-menopausal women. Previous researches conducted in Asian countries suggested that Asian women experience fewer menopausal symptoms as compared to European and American women. Present study also suggested that menopausal status and symptoms are associated with decrease in psychological well-being (for example Nisar & Sohoo, 2010; Butt, 2014), it also purports that women with high marital satisfaction and positive self-concept experience fewer menopausal

symptoms. Present study also suggested that psychological well-being and marital satisfaction mediate the relationship between menopausal symptoms and self-concept (as per our knowledge self-concept and marital satisfaction were not found to have been related to menopausal status and symptoms in previous Pakistani researches. The current study has provided overall empirical evidences and theoretical understanding about menopause and its relationship with psychological variables like psychological well-being, self-concept, and marital satisfaction. The findings of the current study contribute to enhance the understanding among pre-, peri-, and postmenopausal women regarding menopause and how it influence psychological phenomenon like psychological well-being, marital satisfaction, and self-concept.

Conclusion

The present study reveals that psychological well-being, self-concept and marital satisfaction appear to change with menopausal status. Menopausal symptoms have negative effect on psychological well-being, and perimenopausal women perceive psychological well-being factors less positively. In this study we have also found that physical self-concept, family self-concept and academic attainment/work self-concept are the significant predictors for menopausal symptoms in negative direction. Women with higher physical, family, and academic self-concept experience fewer physical and psychological menopausal symptoms. It is also found that peri-menopausal women are less satisfied with their marital life, so, they experience more menopausal symptoms. Working status, education and economic status have positive effects on experience of menopausal symptoms.

Limitations and Suggestions

1) The cross-sectional design of the present study suggests that there may be the differences in the way women of different menopausal statuses feel about their psychological well-being, self-concept, marital satisfaction and experience of menopausal symptoms. Longitudinal studies may help mental health practitioners to understand women's experience as they move through the menopausal transition and would help to identify potential fundamental relationships.

2) Qualitative researches that allow woman to reveal their experiences and perceptions during midlife would expand the understanding of this midway life stage.

3) The sample size used in the present research is not large enough. For further research a larger sample may be included in the study. Such a sample is necessary for the results to be confidently generalized.

4) In the present research employment status, education, and monthly income were the only demographic variables under consideration. Other demographic variables such as duration of marriage, No. of children, age at time of marriage, marriage type, family system, and religion also need to be taken into account.

5) As the findings of the demographic variables reveal that stress might be the underline mechanism leading to psychological well-being, self-concept, and marital satisfaction. In future research measures of stress could be used.

6) Further research can be carried out on pre-, peri-, and postmenopausal women without determining any age range to eliminate the confounding effect of age.

7) In the present research we did not make comparison regarding the women taking hormonal treatment to manage the menopausal symptoms and the women do

not take any treatment. Future researches can be done to make such type of comparisons.

Implications

1) This study highlights the unique topic like menopause, which is considered as forbidden to talk about in our society. Even if the sample is not representative of all cities and rural areas of Pakistan, still it provides picture of psychological factors associated with menopause like psychological well-being, self-concept, and marital satisfaction.

2) Present study will be helpful to enhance the awareness regarding menopause among people regarding physical, psychological, and social aspects of menopause.

3) The Present research could present useful recommendations to other sectors of the government to improve the educational level of women during menopause, provide equal job opportunities, and improve the economic status of menopausal women; more efforts are needed to improve the awareness of the menopausal women.

4) The present research can be useful to develop awareness and educate husbands to change their views, beliefs, and attitudes towards menopause because present research also provided the mediating role of marital satisfaction regarding menopausal symptoms.

5) The Present research provided greater understanding into the critical role of lifestyle, social support, gynecological health and socio demographic variables in menopausal symptoms.

6) The identification of critical variables that deteriorate the physical and psychological health, provide some bases for developing individual and group counseling interventions which help the menopausal women to enhance and sustain

the positive self-concept, and psychological well-being and suppress the negative effects of complications resulting from menopause that lead towards psychological distress.

7) Awareness and education about menopause and related health issues should be provided at school and college level.

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Appendix-X

Original Greene Climacteric Symptoms Scale

Please indicate the extent to which you are bothered at the moment by any of these symptoms by placing a tick in the appropriate box:

S. No	Statements	Not at all	A little	Quite a bit	Extremely
1.	Heart beating quickly and strongly.				
2.	Feeling tense or nervous.				
3.	Difficulty in sleeping.				
4.	Excitability				
5.	Attacks of panic.				
6.	Difficulty in concentration.				
7.	Feeling tired or lacking in energy.				
8.	Loss of interest in most things.				
9.	Feeling unhappy or depressed.				
10.	Crying spells.				
11.	Irritability				
12.	Feeling dizzy or faint.				
13.	Pressure or tightness in head or body.				
14.	Parts of body feeling numb or tingling.				
15.	Headache.				
16.	Muscles or joint pain.				
17.	Loss of feeling in hands or feet.				
18.	Breathing difficulties.				
19.	Hot flushes.				
20.	Sweating at night.				
21.	Loss of interest in sex.				

Appendix-VIII

Original Tennessee Self-Concept Scale TSCS-2

There are no rights or wrong answers. Just answer as accurately as possible. Please answer all items.

S. No	Statements	Always false	Mostly false	Partly false/true	Mostly true	Always true
1.	I am an attractive person.					
2.	I am an honest person.					
3.	I am a member of a happy family.					
4.	I wish I could be more trust worthy.					
5.	I do not feel at ease with other people.					
6.	Math is hard for me.					
7.	I am a friendly person.					
8.	I am satisfied with my moral behavior.					
9.	I am not as smart as the people around me.					
10.	I do not act the way my family thinks I should.					
11.	I am just as nice as I should be.					
12.	It is easy for me to learn new things.					
13.	I am satisfied with my family relationships.					
14.	I am not the person I would like to be.					
15.	I understand my family as well as I should.					
16.	I despite myself.					
17.	I don’t feel as well as I should.					
18.	I do well at math.					

S.No	Statements	Always false	Mostly false	Partly false/true	Mostly true	Always true
19.	I am satisfied to be just what I am.					
20.	I get along well with other people.					
21.	I have a healthy body.					
22.	I consider myself a sloppy person.					
23.	I am a decent sort of person.					
24.	I try to run away from my problems.					
25.	I am a cheerful person.					
26.	I am a nobody.					
27.	My family would always help me with any kind of trouble.					
28.	I get angry sometimes.					
29.	I am full of aches and pains.					
30.	I am a sick person.					
31.	I am amorally weak person.					
32.	Other people think I am smart.					
33.	I am a hateful person.					
34.	I am losing my mind.					
35.	I am not loved by my family.					
36.	I feel that my family doesn't trust me.					
37.	I am not at the work I do.					
38.	I am mad at the whole world.					
39.	I am hard to be friendly with.					
40.	Once in a while I think of things too bad to talk about.					
41.	Sometimes when I am not feeling well, I am cross.					
42.	I am neither too fat nor too thin.					

S.No	Statements	Always false	Mostly false	Partly false/true	Mostly true	Always true
43.	I'll never be as smart as other people.					
44.	I like to work with numbers.					
45.	I am a sociable as I want to be.					
46.	I have trouble doing the things that are right.					
47.	Once in a while I laugh at a dirty joke.					
48.	I should have more sex appeal.					
49.	I shouldn't tell so many lies.					
50.	I can't read very well.					
51.	I treat my parents as well as I should.					
52.	I am too sensitive about the things people in my family say.					
53.	I should love my family more.					
54.	I am satisfied with the way I treat other people.					
55.	I ought to get along better with people.					
56.	I gossip a little at times.					
57.	Sometimes I feel like swearing.					
58.	I take good care of myself physically.					
59.	I try to be careful about my appearance.					
60.	I am true to my religion in my everyday actions.					
61.	I sometimes do very bad things.					
62.	I can always take care of myself in any situation.					
63.	I do as well as I want to at almost any job.					

S.No	Statements	Always false	Mostly false	Partly false/true	Mostly true	Always true
64.	I feel good most of the time.					
65.	I take a real interest in my family.					
66.	I try to understand the other person's point of view.					
67.	I'd rather win a game than lose one.					
68.	I am not good at games and sports.					
69.	I look fine just the way I am.					
70.	I do not know how to work well.					
71.	I have trouble sleeping.					
72.	I do what is right most of the time.					
73.	I am no good at all in social situations.					
74.	I solve my problems quite easily.					
75.	I am a bad person.					
76.	I am satisfied with my relationship with God.					
77.	I quarrel with my family.					
78.	I see something good in everyone I meet.					
79.	I find it hard to talk with strangers.					
80.	Sometimes I put off until tomorrow what I ought to do today.					
81.	It's easy for me to understand what I read.					
82.	I have a lot of self-control.					

Appendix-XII

Back translation of Greene Climacteric Symptoms Scale

1. Heart beating quickly and strongly.
2. Feeling of tension and worry.
3. Difficulty in sleeping.
4. Excitability.
5. State of worry/nervousness.
6. Difficulty in concentration.
7. Feeling tiredness or lack of energy.
8. Loss of interest in most things.
9. Feeling unhappy or depressed.
10. Crying spells.
11. Irritation.
12. Feeling dizzy or faint.
13. Stress or pressure in head or body.
14. Numbness of the parts of body or itching.
15. Headache.
16. Muscles or joints pain.
17. Lack of feeling in hands or feet.
18. Difficulty in breathing.
19. Suddenly feel hot.
20. Sweating at night.
21. Loss of interest in sexual relationships.

Appendix-IX

Back translation of Tennessee self-concept scale TSCS-2

1. I am an attractive person.
2. I am an honest person.
3. I am a member of a happy family.
4. I wish I could be a more trustworthy. despise
5. I do not feel ease with other people.
6. Math is difficult for me.
7. I am a friendly person.
8. I am satisfied with my moral behavior.
9. I am not as clever as the people around me.
10. I do not act as my family thinks I should.
11. I am as good as I should be.
12. It is easy for me to learn new things.
13. I am satisfied with my family relationships.
14. I am not the person what I want to be.
15. I understand my family as well as should.
16. I hate myself.
17. I do not feel as good as I should.
18. I am good in math.
19. I am satisfied what I am.
20. I have good relations with others.
21. I have a healthy body.
22. I consider myself careless.
23. I am a decent sort of person.
24. I try to escape from my problems.
25. I am a happy person.
26. I am nobody.
27. My family will help me in any kind of problem.

28. Sometimes, I get angry.
29. I am full of aches and pains.
30. I am a sick person.
31. Morally, I am a weak person.
32. Other people think I am a clever person.
33. I am a hateful person.
34. I am losing my mind.
35. My family does not love me.
36. I feel that my family does not trust me.
37. I am not good at work I do.
38. I am angry with the whole world.
39. It is hard to be friendly with me.
40. Sometimes, I think about those things that are very bad to think about.
41. Sometimes, when I do not feel well, I become irritate.
42. I am neither too fat nor too thin.
43. I could not be clever like other people.
44. I like to do calculations.
45. I am so sociable as I want to be.
46. I feel difficulty to do right things.
47. Sometimes, I laugh at dirty jokes.
48. I should have more sexual attraction.
49. I should not tell many lies.
50. I cannot read very well.
51. I treat my parents as well as I should.
52. I am very sensitive about the things what my family say.
53. I should love more to my family.
54. I am satisfied, how I behave with people.
55. I should have good relationships with people.
56. I gossip very little.
57. Sometimes, I feel like to use swearwords.
58. I take good care of myself physically.

59. I am very careful about my appearance.
60. I am religious in my daily matters.
61. Sometimes, I do very bad things.
62. I can always take care of myself in any situation.
63. I can do better almost any kind of work as I want.
64. Most of the time I feel good.
65. I take real interest in my family.
66. I try to understand the other person's point of view.
67. In games I prefer to win rather lose.
68. I am not good in games/sports.
69. I look good as I am.
70. I do not know how to do good work.
71. I feel difficulty in sleeping.
72. Most of the time I do what is right.
73. I am not very good in social situations.
74. I solve my problems very easily.
75. I am a bad person.
76. I am satisfied with my relationships with God.
77. I quarrel with my family.
78. I find something good in everyone I meet.
79. I feel difficulty to talk with strangers.
80. Sometimes, I leave work over tomorrow which I should do today.
81. It's easy for me to understand what I read.
82. I have a lot of self-control.