A STUDY OF SELF-ESTEEM IN RELATION TO SELF-CONCIOUSNESS AND SOCIAL SUPPORT AMONG MENOPAUSAL WOMEN

ABSTRACT

Thesis
Submitted For the Degree of
Doctor of Philosophy
IN
PSYCHOLOGY

BY
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Under the Supervision of
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ABSTRACT

The present study precisely sought to determine:


2. The relationship between scores on self-esteem and actual social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

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

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

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

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

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

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

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

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

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

12. The relative incidence (in percentages) of hot flushes, night sweats and sleeplessness among pre-menopausal, transitional menopausal, menopausal and post-menopausal women on Section A of menopause symptom checklist.
13. The differences between pre-menopausal and transitional menopausal, pre-menopausal and menopausal, pre-menopausal and post-menopausal, transitional menopausal and menopausal, transitional menopausal and post-menopausal, and menopausal and post-menopausal women on Section B scores of MSC.

Two hundred women served as subjects for the present study. The four group of subjects represented the pre-menopausal (N=50), transitional menopausal (N=50), menopausal (N=50) and post-menopausal (N=50) women. Menopausal Symptoms Checklist, Self-Rating Scale, Self-Consciousness Scale, Significant Others Scale and Personal Data Sheet were used as the tools for the present study. The data were collected in two sessions. The data were analysed by means of various correlational techniques such as Pearson product moment correlations method, partial correlation, significance of partial correlation, multiple correlation, significance of multiple correlation, t-test and simple percentages.

The major findings of the present study were:
-- Significant positive correlation coefficients were found between scores on self-rating and self-consciousness scales among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.
-- No significant relationships were found to exist between scores on self-rating scale and significant others scale
(actual) among pre-menopausal, transitional menopausal and post-menopausal women.

-- Significant correlation coefficients were not found between scores on self-rating scale and significant others scale (ideal) among transitional menopausal, menopausal, and post-menopausal women.

-- Scores on self-rating scale and significant others scale (actual) correlated positively and significantly among menopausal women; significant positive relationship existed between self-rating scale and significant others scale (ideal) among pre-menopausal women.

-- Self-consciousness correlated positively and significantly with actual social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

-- Significant positive correlation coefficients were found between self-consciousness and ideal social support among the pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

-- The values of partial $r_{12.3}$ and $r_{13.2}$ were found to be significant at the 0.95 confidence interval among pre-menopausal women and partial $r_{23.1}$ were found to be significant among transitional menopausal, menopausal and post-menopausal women.
The value of R were found to be significant at 0.95 confidence interval among pre-menopausal and transitional menopausal women for the actual social support; pre-menopausal and post-menopausal for the ideal social support.

Significant differences were not found between pre-menopausal and transitional menopausal, pre-menopausal and post-menopausal, transitional menopausal and menopausal, transitional menopausal and post-menopausal and menopausal and post-menopausal women.
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# CONTENTS

## Certificate

## Acknowledgements

<table>
<thead>
<tr>
<th>Chapter I</th>
<th>INTRODUCTION</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Menopause: Concept and Definition</td>
<td>1 - 24</td>
</tr>
<tr>
<td></td>
<td>Menopausal Status</td>
<td>2 - 3</td>
</tr>
<tr>
<td></td>
<td>Menopausal Symptoms</td>
<td>4 - 5</td>
</tr>
<tr>
<td></td>
<td>Self-Esteem</td>
<td>5 - 12</td>
</tr>
<tr>
<td></td>
<td>Self-Consciousness</td>
<td>12 - 15</td>
</tr>
<tr>
<td></td>
<td>Relationship between Self-esteem and Self-consciousness</td>
<td>15 - 18</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>18 - 19</td>
</tr>
<tr>
<td></td>
<td>Research Objectives</td>
<td>19 - 22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter II</th>
<th>METHODOLOGY</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample</td>
<td>25 - 31</td>
</tr>
<tr>
<td></td>
<td>Tools</td>
<td>25 - 26</td>
</tr>
<tr>
<td></td>
<td>Procedure</td>
<td>29 - 30</td>
</tr>
<tr>
<td></td>
<td>Data Analysis</td>
<td>29 - 30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter III</th>
<th>RESULTS AND DISCUSSION</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tables</td>
<td>32 - 51</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
<td>33 - 41</td>
</tr>
<tr>
<td>Chapter IV</td>
<td>SUMMARY AND CONCLUSION</td>
<td>52 - 60</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Summary</td>
<td>52 - 58</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>58 - 60</td>
</tr>
</tbody>
</table>

**REFERENCES**

**APPENDICES**

I Menopausal Symptoms Checklist

II Self Rating Scale

III Self-Consciousness Scale

IV Significant Others Scale

V Personal Data Sheet

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CERTIFICATE

This is to certify that the thesis entitled "A Study of Self-esteem in relation to Self-consciousness and Social Support among Menopausal Women", submitted by Miss SHEEMA ALEEM for the Degree of Ph.D. in Psychology, is her original work and has been carried out under my supervision. The thesis is quite fit for submission to the examiners for evaluation.

AKBAR HUSAIN
Reader
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Chapter I

INTRODUCTION

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

**The Menopause: Concept and Definition**

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

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

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

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

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

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

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

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

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

Menopausal: Last menstruated between three and 12 months ago.

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

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

Menopausal Symptoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Self-Esteem**

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

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

**Self Consciousness**

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

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

Duval and Wicklund (1972) and Wicklund (1975) outlined five theoretical proposition of objective self awareness theory: Proposition 1. The arousal proposition; Proposition 2. A positive affect Corollary; Proposition 3. Self-evaluative reaction; Proposition 4. Avoidance - The first line defense; Proposition 5. The last resort - discrepancy reduction.

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

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

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

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

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

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

If self-esteem is the evaluation of test of self-concept then self-consciousness is the degree to which people attend to self (Rosenberg, 1979). Buss and his associates (e.g., Buss, 1980; Fenigstein et al., 1975) made a distinction between the state of self awareness and the trait of self-consciousness. Fenigstein et al. (1975) have developed scales to measure private versus public self-consciousness and social anxiety. Private self-consciousness scale items are related to attention to feelings and inner state, whereas public self-consciousness items relate to the self as a social object. Turner et al. (1978) explored the correlates of self-consciousness scale with self-esteem measure. They found that the negative relationship between the self-esteem measure and each of the self consciousness subscales. This finding was consistent with the reasoning proposed by Ickes et al.
(1973). Buss (1980) summarised evidence for the construct validity of the scales (e.g. only public self consciousness is associated with social anxiety.

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

**Social Support**

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

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

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

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

Research Objectives

The main objectives of the present study are as follows:

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

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

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

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

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

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

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

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

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

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

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

METHODOLOGY

Research methodology is a way to systematically solve the research problem. It may be understood as a science of studying how research is done scientifically. A large number of questions are usually answered when we talk of research methodology concerning an investigation or study. The questions are: Why a research study has been undertaken, how the research problem has been defined, why the hypothesis/objectives has been formulated, what data have been collected and what particular method has been adopted for the data collection, and why particular statistical technique has been used for the data analysis and so on. The present study is planned in accordance with the research objectives.

Sample: The sample consisted of 270 menopausal women. These women were drawn from the Department of Obstetrics and Gynaecology, J.N. Medical College, A.M.U., Aligarh. The menopausal women were further categorized into four groups according to McKinley and Jafferys (1974) method for defining menopausal status. The criteria used for the classification of menopausal women are:
(1) **Pre-Menopausal** menstruated within the last three months with no change in regularity of the volume in the previous year.

(2) **Transitional-Menopausal** menstruated within the last three months, but with some change in regularity of volume in the previous year.

(3) **Menopausal** Last menstruated between three and twelve months ago.

(4) **Post-menopausal** Last menstruated more than twelve months ago.

Since some of the subjects did not turn up in the second session of the data collection, the size of the sample is being reduced from 270 to 230. In order to equate the groups only 200 subjects retained in the final sample. Thus each group of menopausal women comprised 50 subjects. The age range of all the groups of menopausal women was from 40 to 55 years. Most of the menopausal women represented housewives. The break-up of the sample is as given below.

\[
\begin{array}{c|c|c|c|c}
\text{Pre-Menopausal} & \text{Transitional-Menopausal} & \text{Menopausal} & \text{Post-Menopausal} \\
(50) & (50) & (50) & (50)
\end{array}
\]
Tools:
The present study used the following tools to measure the menopausal symptoms, self-esteem, self-consciousness, social support and biographical information.

**Monopausal Symptoms Checklist** (MSC: Sharma, 1983). The MSC consists of 33 symptoms, associated directly or indirectly, with the monopause. Of these 11 were somatic, 17 psychological and 5 psychosomatic symptoms. The test-retest reliability of the MSC were found to be 0.714 for overall menopausal symptoms score; 0.822 for psychological symptoms score: 0.810 for somatic symptoms score; 0.794 for psychosomatic symptom score. The validity of the test was determined by calculating index of reliability by Spearman-Brown Prophecy Formula applied on overall menopausal symptom score.

**Scoring:** The responses to items in section A were scored as per scheme given below:

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently experiencing</td>
<td>2</td>
</tr>
<tr>
<td>Stopped experiencing</td>
<td>1</td>
</tr>
<tr>
<td>Never Experienced</td>
<td>0</td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>1</td>
</tr>
<tr>
<td>Between 6-12 months</td>
<td>2</td>
</tr>
<tr>
<td>1 year or more</td>
<td>3</td>
</tr>
<tr>
<td>Every few hours</td>
<td>3</td>
</tr>
<tr>
<td>Once a day</td>
<td>2</td>
</tr>
</tbody>
</table>
Once a week or more than a week 1
Mild 1
Moderate 2
Severe 3

The scoring for section B was done accordingly: always scored 3, often scored 2, sometimes scored 1 and never scored 0. Thus, the maximum possible score for these items was 90 and minimum was 0.

The lower the score on MSC, the lower the symptomatology.

**Self-Rating Scale** (SRS: Fleming and Courtney, 1984). The SRS consisted of 36 items with the 7-point scale. The SRS measures five factors, namely, self-regard, social confidence, school abilities, physical appearance and physical abilities. Items relating to the school abilities and physical abilities were dropped in the present study. Since items pertaining to these factors were not related to the sample under study, the 26 items from SRS were used.

**Self-Consciousness Scale** (SCS, Mittal and Balasubramanian, 1987). The SCS consisted of 19 items with the five alternative response categories. The scale has five underlined dimensions; two for private self-consciousness (self-reflectiveness and internal state awareness), two for public self-consciousness (style-consciousness and appearance-consciousness) and one for social anxiety.
Significant Others Scale (SOS: Power, Champion, and Aris, 1988). The SOS measures different functional resources of social support that may be provided by a number of significant goal relationships within an individual's social network. The SOS contained 10 items. Five items were to measure emotional support and the remaining five items were to measure practical support.

Two versions of the SOS were used in the present study. The first was labelled "actual" support and the respondent was asked to rate currently applicable relationship with the spouse on each of the 10 support function. A 1-7 point rating scale was used from 1=never, to 7=always. The second version of the SOS was regarded to measure the 'ideal' level of support and the respondent would have liked for the spouse relationship that were currently applicable. Again, they were asked to rate each of the 10 functions on a 1-7 point rating scale.

Personal Data Sheet (PDS). The PDS covered the information relating to the demographic variables.

Procedure:

The data were gathered individually from the subjects. The MSC, SRS, SCS, SOS and PDS were administered on subjects in two different sessions. Before administering these tests the investigator established rapport to the subjects. Since most of the menopausal women were reluctant
to give information, the investigator convinced them that the obtained information will be kept strictly confidential and will be used only for research purpose. In the present study the investigator followed different procedures to collect the information from the literate and illiterate subjects under study. This was done so because the illiterate subjects were not well-versed in English. The data from the illiterate subjects were collected through face to face interview method, whereas the data from the literate subjects were gathered by administration of all the tests. In addition to the information obtained by the subjects on the tests some information were noted down from the menopausal women's case sheet.

**Data Analysis:**

The data were computed by means of Pearson-product moment Correlation Coefficient, partial correlation, significance of partial $r$, multiple correlation, significance of multiple $r$, $t$-test, and simple percentages.

Pearson product moment correlation coefficients were computed to determine the relationship between self-esteem scores and self-consciousness scores, self-esteem scores and actual/ideal social support scores, and self-consciousness scores and actual/ideal social support scores among pre-menopausal, transitional menopausal, menopausal, and post-menopausal women. Partial correlation were computed for partialled out or eliminating the effects
of variables, that may influence the relationship between two variables whose relationship is to be considered. For example, in the present study, we have three personality variables namely, self-esteem, self-consciousness and two levels of social support (i.e. actual and ideal): \( r_{12.3} \) represents the partial correlation between self-esteem and self-consciousness when the third variable (actual social support or ideal social support) has been partialled out. Significance of partial \( r \) were determined at 0.95 confidence interval for the pre-menopausal, transitional menopausal, menopausal and post-menopausal women. Multiple coefficient of correlation (\( R_{1}(23) \)) were computed to determine the correlation between scores actually earned and scores predicted on the self-esteem from the two variables self-consciousness and social support. That is, to what extent self-esteem scores are related to self-consciousness and actual/ideal social support scores. Significance of multiple \( R \) were calculated at the 0.95 confidence interval for the pre-menopausal, transitional menopausal, menopausal and post-menopausal women. t-test was applied to determine the significance of difference between groups of menopausal women on menopausal symptom checklist scores. Simple percentages were computed to exhibit the tendency of pre-menopausal, transitional menopausal, menopausal and post-menopausal women on section A of menopausal symptoms checklist.
Chapter IV

RESULTS AND DISCUSSION

The data analyzed by means of various correlational techniques, t-test and percentages are presented in Tables 1-7.

Table 1: Pearson Product Moment Correlations: Relationship between Self-Esteem and Self-Consciousness and Social Support (Actual and Ideal), Self-Consciousness and Social Support (Actual and Ideal) among Pre-Menopausal, Transitional Menopausal, Menopausal and Post-Menopausal women.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Menopausal (N=50)</th>
<th>Transitional Menopausal (N=50)</th>
<th>Menopausal (N=50)</th>
<th>Post-Menopausal (N=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>r</td>
<td>r</td>
<td>r</td>
</tr>
<tr>
<td>SRS Vs SCS</td>
<td>0.49*</td>
<td>0.27**</td>
<td>0.36*</td>
<td>0.34**</td>
</tr>
<tr>
<td>SRS Vs SOS (Actual)</td>
<td>0.22</td>
<td>0.23</td>
<td>0.33**</td>
<td>0.22</td>
</tr>
<tr>
<td>SRS Vs SOS (Ideal)</td>
<td>0.46*</td>
<td>0.03</td>
<td>0.13</td>
<td>0.18</td>
</tr>
<tr>
<td>SCS Vs SOS (Actual)</td>
<td>0.28**</td>
<td>0.68*</td>
<td>0.52*</td>
<td>0.76*</td>
</tr>
<tr>
<td>SCS Vs SOS (Ideal)</td>
<td>0.34**</td>
<td>0.72*</td>
<td>0.47*</td>
<td>0.64*</td>
</tr>
</tbody>
</table>

* p < .01, ** p < .05
Table 2: Indicating the values of partial $r$ for the pre-Menopausal, Transitional Menopausal, Menopausal and Post-Menopausal women.

<table>
<thead>
<tr>
<th>Partial $r$</th>
<th>Pre-Menopausal</th>
<th>Transitional Menopausal</th>
<th>Menopausal</th>
<th>Post-Menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td>$r_{12.3}$</td>
<td>0.45*</td>
<td>0.06</td>
<td>0.24</td>
<td>0.10</td>
</tr>
<tr>
<td>$r_{12.3}$</td>
<td>0.40*</td>
<td>0.14</td>
<td>0.39*</td>
<td>0.10</td>
</tr>
<tr>
<td>$r_{13.2}$</td>
<td>0.09</td>
<td>0.02</td>
<td>0.17</td>
<td>0.05</td>
</tr>
<tr>
<td>$r_{13.2}$</td>
<td>0.35**</td>
<td>0.09</td>
<td>0.03</td>
<td>0.01</td>
</tr>
<tr>
<td>$r_{23.1}$</td>
<td>0.22</td>
<td>0.36**</td>
<td>0.45*</td>
<td>0.42*</td>
</tr>
<tr>
<td>$r_{23.1}$</td>
<td>0.14</td>
<td>0.42*</td>
<td>0.46*</td>
<td>0.32**</td>
</tr>
</tbody>
</table>

* $p < .01$, ** $p < .05$
Table 3: Indicating the values of 0.95 confidence interval for the Pre-Menopausal, Transitional-Menopausal, Menopausal and Post-Menopausal women.

<table>
<thead>
<tr>
<th>Confidence Interval of Partial r</th>
<th>Pre-Menopausal</th>
<th>Transitional Menopausal</th>
<th>Menopausal</th>
<th>Post-Menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td>$r_{12.3}$</td>
<td>0.37-0.52</td>
<td>0.03-0.15</td>
<td>0.15-0.32</td>
<td>0.01-0.19</td>
</tr>
<tr>
<td>$r_{12.3}$</td>
<td>0.32-0.44</td>
<td>0.05-0.23</td>
<td>0.31-0.46</td>
<td>0.01-0.19</td>
</tr>
<tr>
<td>$r_{13.2}$</td>
<td>0.00-0.18</td>
<td>0.07-0.11</td>
<td>0.08-0.25</td>
<td>-0.04-0.14</td>
</tr>
<tr>
<td>$r_{13.2''}$</td>
<td>0.28-0.43</td>
<td>0.00-0.18</td>
<td>0.06-0.12</td>
<td>-0.08-0.10</td>
</tr>
<tr>
<td>$r_{23.1}$</td>
<td>0.13-0.30</td>
<td>0.28-0.44</td>
<td>0.37-0.52</td>
<td>-0.35-0.49</td>
</tr>
<tr>
<td>$r_{23.1}$</td>
<td>0.05-0.23</td>
<td>0.35-0.49</td>
<td>0.39-0.53</td>
<td>-0.24-0.40</td>
</tr>
</tbody>
</table>
**Table 4:** Indicating the values of Multiple Coefficient of correlation (R) for the pre-Menopausal, Transitional-Menopausal, Menopausal and Post-Menopausal Women.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Menopausal</th>
<th>Transitional Menopausal</th>
<th>Menopausal</th>
<th>Post-Menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R1(23) Actual</strong></td>
<td>0.66</td>
<td>0.96</td>
<td>0.41</td>
<td>0.34</td>
</tr>
<tr>
<td><strong>R1(23) Ideal</strong></td>
<td>0.75</td>
<td>0.29</td>
<td>0.38</td>
<td>0.50</td>
</tr>
</tbody>
</table>

**Table 5:** Showing the significance of multiple R at 0.95 confidence interval for the Pre-Menopausal, Transitional-Menopausal, Menopausal and Post-Menopausal women.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Menopausal</th>
<th>Transitional Menopausal</th>
<th>Menopausal</th>
<th>Post-Menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual</strong></td>
<td>0.51-0.86</td>
<td>0.95-0.97</td>
<td>0.17-0.64</td>
<td>0.11-0.57</td>
</tr>
<tr>
<td><strong>Ideal</strong></td>
<td>0.64-0.86</td>
<td>0.04-0.54</td>
<td>0.15-0.61</td>
<td>0.31-0.69</td>
</tr>
</tbody>
</table>
Table 6 The percentage of women in the various menopausal groups who are 'Currently experiencing', 'stopped experiencing' and 'never experienced' hot flushes, night sweats and sleeplessness.

(a) **HOT FLUSHES**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Currently Experiencing</th>
<th>Stopped Experiencing</th>
<th>Never Experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>74%</td>
<td>10%</td>
<td>16%</td>
</tr>
<tr>
<td>Transitional Menopausal</td>
<td>86%</td>
<td>06%</td>
<td>08%</td>
</tr>
<tr>
<td>Menopausal</td>
<td>82%</td>
<td>04%</td>
<td>14%</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>82%</td>
<td>06%</td>
<td>12%</td>
</tr>
</tbody>
</table>

(a) **Experience on different parts of the body**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Face or Neck</th>
<th>Variable Site</th>
<th>Over Whole Body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Pre-menopausal</td>
<td>34</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Transitional Menopausal</td>
<td>30</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>Menopausal</td>
<td>18</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>30</td>
<td>22</td>
<td>30</td>
</tr>
</tbody>
</table>
### (c) Intensity of Hot Flushes

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Every few hours</th>
<th>At least once daily</th>
<th>Weekly or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>24</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Transitional</td>
<td>22</td>
<td>34</td>
<td>20</td>
</tr>
<tr>
<td>Menopausal</td>
<td>26</td>
<td>32</td>
<td>24</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>22</td>
<td>44</td>
<td>16</td>
</tr>
</tbody>
</table>

### (d) Time of Experience hot flushes

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Less than 6 months</th>
<th>Between 6-12 months</th>
<th>More than 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>50</td>
<td>16</td>
<td>08</td>
</tr>
<tr>
<td>Transitional</td>
<td>10</td>
<td>24</td>
<td>52</td>
</tr>
<tr>
<td>Menopausal</td>
<td>16</td>
<td>24</td>
<td>42</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>12</td>
<td>26</td>
<td>44</td>
</tr>
</tbody>
</table>
### NIGHT SWEATS

#### (a) Experience of Night Sweats

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Currently Experiencing</th>
<th>Stopped Experiencing</th>
<th>Never Experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>66</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Transitional Menopausal</td>
<td>74</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Menopausal</td>
<td>76</td>
<td>04</td>
<td>20</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>66</td>
<td>04</td>
<td>30</td>
</tr>
</tbody>
</table>

#### (b) Intensity of Night Sweats in the Body

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>44</td>
<td>06</td>
<td>16</td>
</tr>
<tr>
<td>Transitional Menopausal</td>
<td>50</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Menopausal</td>
<td>40</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>26</td>
<td>10</td>
<td>30</td>
</tr>
</tbody>
</table>
(c) **Time of Experiencing Night Sweats**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Less than 6 months</th>
<th>Between 6-12 months</th>
<th>More than 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>34</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Transitional menopausal</td>
<td>42</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Menopausal</td>
<td>16</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>12</td>
<td>43</td>
<td>36</td>
</tr>
</tbody>
</table>

(3) **SLEEPLESSNESS**

(a) **Experience of Sleeplessness**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Currently Experiencing %</th>
<th>Stopped Experiencing %</th>
<th>Never Experienced %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>52</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Transitional menopausal</td>
<td>75</td>
<td>20</td>
<td>04</td>
</tr>
<tr>
<td>Menopausal</td>
<td>80</td>
<td>14</td>
<td>06</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>34</td>
<td>08</td>
<td>33</td>
</tr>
</tbody>
</table>
(b) **Time of Experiencing Trouble Sleeping**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Less than 6 months</th>
<th>Between 6-12 months</th>
<th>More than 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>63</td>
<td>85</td>
<td>28</td>
</tr>
<tr>
<td>Transitional Menopausal</td>
<td>30</td>
<td>38</td>
<td>32</td>
</tr>
<tr>
<td>Menopausal</td>
<td>16</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>18</td>
<td>32</td>
<td>50</td>
</tr>
</tbody>
</table>

(c) **Sensation Accompanying Sleeplessness**

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Hot and Cold Sweats</th>
<th>Sensation of Falling</th>
<th>Fearful Dreams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>40</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Transitional Menopausal</td>
<td>50</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Menopausal</td>
<td>52</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>44</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>
Table 7: Showing the comparison between Pre-menopausal and Transitional menopausal, Pre-menopausal and menopausal, Pre-menopausal and Post-menopausal, Transitional menopausal, and menopausal, Transitional menopausal and Post-menopausal, and menopausal and Post-menopausal women on somatic, psychosomatic and physiological symptoms.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-values</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-menopausal</td>
<td>50</td>
<td>42.80</td>
<td>10.77</td>
<td>0.56</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Transitional menopausal</td>
<td>50</td>
<td>41.80</td>
<td>10.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-menopausal</td>
<td>50</td>
<td>42.80</td>
<td>10.77</td>
<td>2.02</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Menopausal</td>
<td>50</td>
<td>38.60</td>
<td>9.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-menopausal</td>
<td>50</td>
<td>42.80</td>
<td>10.77</td>
<td>0.46</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>50</td>
<td>41.80</td>
<td>11.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitional menopausal</td>
<td>50</td>
<td>41.60</td>
<td>10.69</td>
<td>1.45</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Menopausal</td>
<td>50</td>
<td>33.60</td>
<td>9.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitional menopausal</td>
<td>50</td>
<td>41.60</td>
<td>10.69</td>
<td>0.09</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>50</td>
<td>41.80</td>
<td>11.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menopausal</td>
<td>50</td>
<td>38.60</td>
<td>9.95</td>
<td>1.52</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>50</td>
<td>41.80</td>
<td>11.03</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion:

Significant positive correlation coefficients were found between scores on self-rating and self-consciousness scales among pre-menopausal ($r=0.49, p <.01$), transitional menopausal ($r=0.27, p <.05$), menopausal ($r=0.36, p <.01$) and post-menopausal ($r=0.34, p <.05$) women. These findings revealed that the self-esteem and self-consciousness are closely related to each other. The findings of the present study are inconsistent with the results found by Ickes et al. (1973) and Turner et al. (1978) with each of the self-consciousness subscales. One of the reasons for the difference between results of the earlier studies and the present study may be the samples employed. Women suffering from the menopause become self-aware and are generally inclined to abide by self-esteem to reduce their symptoms. In the present research it seemed evident that positive relationship between the two constructs could mean only that reporting one's trait in a way that better reflected actual behaviour. However, the important point for self-esteem theory is that self-consciousness is conceptually distinct from self-esteem (Flaming & Courtney, 1984). The menopausal women made the case as self-focussed person because they continuously lived under tension, discomfort, and exhibit negative affect to the degree that they find themselves to be closer to the self-related dimensions. One
plausible explanation for the present findings may be that the menopausal women exhibit or maintain self-esteem and self-consciousness, manifested privately, publicly or social anxiety.

No significant relationships were found to exist between scores on self-rating scale and significant others scale (actual) among pre-menopausal ($r=0.22, p < .05$), transitional menopausal ($r=0.23, p < .05$) and post-menopausal ($r=0.22, p < .05$) women, whereas only significant relationship existed between these variables among the menopausal women ($r=0.33, p < .05$).

The non-significant correlations between the scores on SAS and SOS (actual support) among women hailing from different menopausal status tend to be neither interested in maintaining self-esteem nor the source of particularly rewarding experiences in ongoing social relationships with the spouse. Pervasive anxiety and feeling of unworthiness are logically consistent with a lack of relationship between the scores obtained on two constructs in most kinds of interpersonal relationships.

The positive relationship of self-esteem with actual social support implies that interest in maintaining self-esteem and the actual support (i.e. practical and emotional) received from the spouses helped flesh out
menopausal symptoms associated with menopausal women. Menopausal women who are high in self-esteem and actual social support perceive their condition as of autonomy and independence. It is therefore, not surprising that self-esteem and actual social support are positively related.

Scores on self-rating scale and significant others scale (ideal) correlated positively and significantly among pre-menopausal women ($r=0.46$, $p < .01$). No significant correlation coefficients were found between scores on self-rating scale and significant others scale (ideal) among transitional menopausal ($r=0.03$, $p > .05$), menopausal ($r=0.13$, $p > .05$) and post-menopausal ($r=0.18$, $p > .05$) women.

The significant positive relation of self-esteem to ideal social support among pre-menopausal women revealed the way pre-menopausal women viewed and applied their general feelings of worthiness to social relationship with the spouses having a great deal to do with what they received social support in ideal. This result strongly suggests that the pre-menopausal women, high in self-esteem and ideal social support may be characterized as more effective in social interaction, considerate, attentive and friendly than the menopausal women of other status.
The non-significant correlations between self-esteem and ideal social support among transitional menopausal, menopausal and post-menopausal women imply that the perceived skill, advantage of women does not enable them to receive more social support from spouse relationships. One of the plausible reasons for the non-significant correlations may be that the lowered self-esteem and a lack of ideal social support during the menopause state. Some women also report psychological distress such as guilt, anxiety, tension, depression etc. following menopause because they are reluctant to inform others of their partner's behaviour.

Self-consciousness correlated positively and significantly with actual social support among pre-menopausal (r=0.28, p <.05), transitional menopausal (r=0.68, p <.01), menopausal (r=0.52, p <.01) and post-menopausal (r=0.76, p <.01) women. These observations have highlighted the positive roles played by self-consciousness and actual social support in psychological adjustment between menopausal women and their husbands. The significant positive relation of self-consciousness to actual social support have led to the idea that the availability of social supports bolsters the capacity to withstand and overcome frustrations and problem solving.
challenges in menopausal women. Whereas self-consciousness contributes (a) in describing persons as 'self-reflective and introspective', (b) a concern for people's social appearance and the impressions people make on others; and (c) discomfort in the presence of others. In short we may say that the availability of actual social support to the menopausal women is highly influenced by a personality factors i.e. self-esteem.

There were significant positive correlations between self-consciousness and ideal social support for the pre-menopausal (r=0.34, p <.05), transitional menopausal (r=0.72, p <.01), menopausal (r=0.47, p <.01) and post-menopausal (r=0.64, p <.01) women.

The positive correlations between these measures contribute to the understanding of the relation of self-consciousness to self-esteem among menopausal women. Menopausal women high in self-esteem and ideal social support seem to experience more positive events in their lives, and take a more optimistic view of life. These findings indicate that ideal social support protects, people in crisis from a wide variety of menopausal symptoms.
The partial correlations between self-esteem and self-consciousness scores were found to be significant when actual social support was partialled out -- a partial $r_{12.3}$ of 0.45 as against on $r_{12}$ of 0.49 among pre-menopausal women. The partial correlations between self-esteem and self-consciousness scores were found to be significant when ideal social support was partialled out: we get a partial $r_{12.3}$ of 0.40 as against $r_{12}$ of 0.49 among pre-menopausal women and partial $r_{12.3}$ of 0.39 as against an $r_{12}$ of 0.36 among menopausal women.

The partial correlation between self-esteem and ideal social support scores was found to be significant. When the scores on self-consciousness were partialled out, the result was a partial $r_{13.2}$ of 0.35 as against an $r_{13}$ 0.46 among pre-menopausal women.

The partial correlation between self-consciousness and actual social support scores were found to be significant among transitional menopausal ($r_{23.1} = 0.36$, as against an $r_{23} = 0.68$), menopausal ($r_{23.1} = 0.45$, as against an $r_{23} = 0.52$), and post-menopausal ($r_{23.1} = 0.42$, as against an $r_{23} = 0.76$) women.

The partial correlation between self-consciousness and ideal social support scores was found to be significant among transitional menopausal ($r_{23.1} = 0.42$, as against an
Since these partial correlation coefficients were found significant at 0.95 confidence interval among groups of menopausal women, the coefficients must be judged to be very stable (cf. Table 3).

Multiple coefficient of correlation existed when the self-esteem scores were correlated with self-consciousness and actual social support scores among pre-menopausal (R=0.66), transitional menopausal (R=0.96), menopausal (R=0.41) and Post-menopausal (R=0.34) women. For the pre-menopausal (R=0.75), transitional menopausal (R=0.29), menopausal (R=0.38), and post-menopausal (R=0.50) women, self-esteem scores were found to be correlated with self-consciousness and ideal social support. These results indicated that using self-esteem as the criterion variable, both self-consciousness and actual/ideal support entered as significant predictors for pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

As is evident from Table 6, hot flushes currently experienced by the pre-menopausal transitional menopausal, menopausal and post-menopausal were 74%, 86%, 82% and 82% respectively. Ten percent pre-menopausal, 6% transitional
4% menopausal and 6% post-menopausal women reported that they stopped experiencing hot flushes. Of these 16% pre-menopausal, 8% transitional menopausal, 14% menopausal and 12% post-menopausal women never experienced hot flushes. With regard to currently experiencing hot flushes on face or neck and variable site and over whole body, clear differences did not emerge. 30% pre-menopausal, 34% transitional menopausal, 32% menopausal, and 44% post-menopausal women reported flushing at least once a day. Flushing occurred every few hours in 24% pre-menopausal, 22% transitional menopausal, 26% menopausal, and 22% post-menopausal women. For pre-menopausal, transitional menopausal and post-menopausal women intensity of hot flushes occurred in 20%, 20%, 24% and 16% respectively for the period of a week or class. 50% pre-menopausal women have reported that they had started experiencing hot flushes for less than 6 months. Transitional menopausal (52%), menopausal (42%), and post-menopausal (44%) have reported that they started experiencing hot flushes for more than one year.

66% pre-menopausal, 74% transitional menopausal, 76% menopausal and 66% post-menopausal women have reported that they are currently experiencing night sweats. Premenopausal women have reported 44% mild, 6% moderate, and
16% severe intensity of night sweats in the body. Transitional menopausal women have reported 50% mild, 14% moderate and 10% severe intensity of night sweats in the body. 40% mild, 16% moderate and 20% severe intensity of night sweats were reported by menopausal women. The hierarchy of intensity of night sweats as reported by the post-menopausal women were 30% severe, 26% mild, and 10% moderate. Most of the pre-menopausal (34%) and transitional menopausal (42%) women have reported that they are experiencing night sweats for less than 6 months, whereas menopausal (33%) and post-menopausal (36%) women have reported the time of experiencing night sweats for more than one year.

62% of the pre-menopausal women, 76% of the transitional menopausal, 80% of the menopausal, and 84% of the post-menopausal women have complained of insomnia. Troubled sleeping is experienced over a varying degrees of time (less than 6 months between 6-12 months, more than 1 year) by the pre-menopausal, transitional menopausal, menopausal and post-menopausal women (cf. Table 6). 40% of pre-menopausal, 50% of the transitional menopausal, 52% of the menopausal, and 44% post-menopausal women reported hot or cold sweats along with sleeplessness. Sensations of falling along with sleeplessness are reported also by four menopausal status
groups, 12%, 16%, 20% and 20% respectively. Fearful dreams accompanying insomnia are reported by pre-menopausal 10%, transitional menopausal 10%, menopausal 8%, and post-menopausal 20% respectively.

No significant differences were found between pre-menopausal and transitional menopausal women (t=0.56, p>.05), pre-menopausal and post-menopausal women (t=0.46, p>.05), transitional menopausal and menopausal women (t=1.45, p>.05), transitional menopausal and post-menopausal women (t=0.09, p>.05) and menopausal and post-menopausal women (t=1.52, p>.05). Pre-menopausal women scored significantly higher than the menopausal women (t=2.02, p>.05). These findings indicate that the symptoms do not differentiate with menopausal status. The overall conclusion that the above analysis leads us to is that women suffer most markedly from symptoms claimed to be associated directly with menopause. This evidence suggests that the biological event of the menopause does generally give rise to a substantial increase in somatic, psychosomatic or psychological symptoms among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.
Chapter -IV

SUMMARY AND CONCLUSIONS

Summary:

The menopause is easily defined as the last menstruation. The reality of mid life is dominated by the climacteric changes and menopause in the female. In recent years menopause is the immense upsurge of interest among the menstrual disorders. The menopause may be considered to be a life stress. There is a relationship between age and the menopause. In other words, menopause represents the natural aging process. At the time of the Roman Empire the average life span of women was 23 years. Women Columbus lost his way looking for India and found America, it was 30 years, and even during the Victorian times it was only 45 years. Since today, the menopause occurs at an average age of 49 years and 9 months. Nowadays 95 percent of women in developed countries can expect to reach the menopause with 50 percent going on to reach the age of 75. Most women live about one third of their lives after the menopause, when they are no longer able to have babies and hormones which regulated their reproductive cycle are produced in smaller amounts. Psychological and social factors have greatly contributed to the menopausal years. They centre largely on the declared
aim of more varied lives for women, with interests and
challenges outside as well as inside the home.

The topic of the present study is "A study of self-
estee pm in relation to self-consciousness and social support
among menopausal women". "Introduction" chapter contains the
concept of definition of the menopause, menopausal status,
menopausal symptoms and conceptual framework of the
personality variables - self-esteem, self-consciousness and
social support. The present study has set the following
thirteen research objectives:

- To determine the relationship between scores on self-
estee pm and self-consciousness among pre-menopausal,
transitional menopausal, menopausal and post-menopausal
women.

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

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

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

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

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

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

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

- To determine the significance of partial $r (r_{12.3}, r_{13.2}, r_{23.1})$ at the 0.95 confidence interval among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.
To determine the multiple coefficient of correlations between scores actually earned and scores predicted on the self-esteem from the two variables - self-consciousness and actual/ideal social support scores among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

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

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

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

Chapter II has been devoted to "Methodology" which includes sample, tools, procedure, and data analysis. The sample consisted of 200 women: (pre-menopausal = 50,
transitional menopausal = 50, menopausal = 50, post-menopausal = 50) drawn from J.N. Medical College, A.M.U., Aligarh. The age range of all the groups of menopausal women was from 40 to 55 years. The present study employed the Menopausal Symptom Checklist, Self-Rating Scale, Self-consciousness Scale, Significant Others Scale and Personal Data Sheet as the tools to measure the menopausal symptoms, the tendency of self-esteem, self-consciousness, social support and biographical informations for the pre-menopausal, transitional menopausal, menopausal, and post-menopausal women. The menopausal symptom checklist, self-rating scale, self-consciousness scale, significant others scale and personal data sheet were administered individually on each subject in two different sessions. The data were analyzed by means of appropriate statistical techniques such as Pearson product moment correlation coefficient, partial correlation, significance of partial r, multiple correlation, significance of multiple r, t-test and simple percentages.

- Significant positive correlation coefficients were found between scores on self-rating and self-consciousness scale among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

- No significant relationship were found to exist between scores on self-rating scale and significant others scale
Significant correlation coefficients were not found between scores on self-rating scale and significant others scale (ideal) among transitional menopausal, menopausal, and post-menopausal women.

Scores on self-rating scale and significant others scale (actual) correlated positively and significantly among menopausal women; significant positive relationship existed between self-rating scale and significant others scale (ideal) among pre-menopausal women.

Self-consciousness correlated positively and significantly with actual social support among pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

Significant positive correlation coefficients were found between self-consciousness and ideal social support among the pre-menopausal, transitional menopausal, menopausal and post-menopausal women.

The values of partial $r_{12.3}$ and $r_{13.2}$ were found to be significant at the 0.95 confidence interval among pre-menopausal women and partial $r_{23.1}$ were found to be significant among transitional menopausal, menopausal and post-menopausal women.
- The values of multiple $R$ were found to be significant at 0.95 confidence interval among pre-menopausal and transitional menopausal women for the actual social support; pre-menopausal and post-menopausal for the ideal social support.

- Significant differences were not found between pre-menopausal and transitional menopausal, pre-menopausal and post-menopausal, transitional menopausal and menopausal, transitional menopausal and post-menopausal and menopausal and post-menopausal women.

**Conclusions:**

(The work reported here presents a potentially useful research and possibly fruitful areas of approach for clinical investigation.)

The findings of the present study with regard to relationship between self-esteem and self-consciousness, self-esteem and social support, and self-consciousness and social support flourish an areas of research in health and illness.

In future research, the variables of self-esteem should be related to the three dimensions of self-consciousness (i.e. private consciousness, public consciousness and social anxiety) among different menopausal status groups, in
order to confirm or disconfirm the findings of the present study. The findings of the present study are inconsistent with the previous one.

The actual social support available and satisfaction with support perceived to be available to the menopausal women in their natural environment - family (spouse, mother in law), neighbour, friends, and peer groups - needs to be carefully evaluated. This is particularly important for maintaining a healthy personality because the lay public is largely unfamiliar with it.

The client's self-consciousness - private, public - and social anxiety regarding her symptoms and regarding treatment need to be evaluated. Important considerations are self-help attempts, the client's own view of menopause, and major psychological problems that may decrease her ability to successfully cope with the problem. Systematic provision of thorough medical education, early in treatment, is helpful to menopausal women in setting realistic expectations for themselves.

Since the life span of women continues to increase, emphasis should be given on the management of menopause related problems to fulfil the best potential of women's life. Aetiology of aging is not conclusive inspite of
several attractive theories. Attention must be given to maintaining the quality of life, nature of adjustment reactions and enhancing self-esteem in the menopausal women because non-supportive others may undermine their coping.
REFERENCES


First International Conference on the Menopause (1976).


Neugarten, B.L., & Kraines, R.J. (1965). Menopausal symptoms in women of various ages. Psychosomatic Medicine, 27, 266.


APPENDICES
Appendix-I

Menopausal Symptom Checklist

SECTION 'A'

1. Hot Flashes/Flushes
   (a) Have you experienced/or are experiencing hot flashes/flushes.
       Currently Experiencing, Never Experienced, Stopped Experiencing.
   (b) On which part of your body do you experience these.
       Face or Neck, Variable Site, Over whole body.
   (c) How often do hot flashes recur in your body?
       Every Few Hours, Atleast once daily, Weekly or less.
   (d) Since how long have you been experiencing these.
       Less than six months, Between 6-12 months, More than one year.

2. Night Sweats
   (a) Do you experience/have experienced night sweats.
       Currently Experiencing, Never Experienced, Stopped Experiencing.
   (b) What is the intensity of night sweats in your body?
       Mild, Moderate, Severe.
   (c) Since when have you been experiencing these.
       Less than six months, Between 6-12 months, More than 1 yr...
3. Sleeplessness

(a) Do you experience/have experienced trouble sleeping?
Currently Experiencing, Never Experienced, Stopped Experiencing.

(b) Since when have you been experiencing trouble sleeping.
Less than six months, Between 6-12 months, More than one year.

(c) Which of the following symptoms accompanies sleeplessness in you.
Hot and cold sweats, Sensation of falling/sinking, Fearful dreams.

SECTION 'B'

The following statements have to be checked on 4-point scale.

<table>
<thead>
<tr>
<th>1. Do you experience pounding of the heart?</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Do you experience Dizzy Spells/Dissiness?</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>3. Do you suffer from Diarrhea?</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>4. Do you suffer from constipation?</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you generally feel tired?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you normally experience pains in the back part of the skull and neck?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you have fits of crying?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you experience black spots before the eyes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you suffer from headaches?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you suffer from breast pains?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you experience cold sweats?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you experience numbness and tingling sensation on the hands and feet?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Do you suffer from swollen ankles?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Do you suffer from rheumatic pains?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Do you gain/loss weight?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you feel tense (mentally) within yourself?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Do you consider yourself to be a nervous person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Is it generally difficult for you to concentrate?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
19. Do you without any particularly observable reason, consider your state as pathetic? - - - - -
20. Is your temperament irritable? - - - - -
21. Does your mind/attention fluctuate so much that you forget totally what you are doing? - - - - -
22. Do you worry about something terrible and dreadful that is at hand? - - - - -
23. Do you feel lonely and pent up (suffocated)? - - - - -
24. Do you worry about supposing your mind (being insane) in the near future? - - - - -
25. Do you experience mood fluctuations? - - - - -
26. Do you feel that you are getting afflicted with some dreadful diseases these days? - - - - -
27. Are you worried over the possibility that in old one your physical energy would be very much reduced? - - - - -
28. Do you feel restless and excited?  

29. Do you feel depressed most of the time?  

30. Do you feel that there are certain things in your heart which you are unable to expose?  

SECTION 'C'

1. Are you still menstruating?  

2. When did your last menstruation take place?  

3. Do you have menstrual periods smoothly or you experience some difficulty? (Please specify the difficulties, if any).
Appendix-II

Self Rating Scale

Direction:
Below are given certain items with which you may agree or disagree. You are required to indicate your agreement or disagreement by giving the appropriate number on the line given against each item. The seven alternative response categories are given below:

- Strongly disagree 1
- Disagree 2
- Slightly disagree 3
- Neither agree nor disagree 4
- Slightly agree 5
- Agree 6
- Strongly agree 7

1. How often do you feel inferior to most of the people you know? --

2. Do you ever think that you are a worthless individual? --

3. How confident do you feel that someday the people you know will look up to you and respect you? --

4. Do you ever feel so discouraged with yourself that you wonder whether you are a worthwhile person? --

5. How often do you dislike yourself?

6. In general how confident do you feel about your abilities?
7. How often do you have the feeling that there is nothing you can do well?

8. How much do you worry about how well you get along with other people?

9. How often do you worry about criticisms that might be made of your work by your teacher or employee?

10. Do you ever feel afraid or anxious when you are joining into a room by yourself where other people have already gathered and are talking?

11. How often do you feel self-conscious?

12. How much do you worry about whether other people will regard you as a success or failure in your job or in school?

13. When in a group of people do you have trouble thinking of the right things to talk about?

14. When you make an embarrassing mistake or have done something that makes you look foolish, how long does it take you to get over it?

15. Do you often feel uncomfortable meeting new people?
16. How often do you worry about whether other people like to be with you?

17. How often are you troubled with shyness?

18. When you think that some of the people you meet might have an unfavourable opinion of you, how concerned or worried do you feel about it?

19. How often do you feel worried or bothered about what other people think about you?

20. Have you ever felt ashamed of your physique or figure?

21. Do you often feel that most of your friends or peers are more physically attractive than yourself?

22. Do you often wish or fantasize that you were better looking?

23. Have you ever been concerned or worried about your ability to attract members of the opposite sex?

24. How confident are you that others see you as being physically appealing?
Appendix-III

Self Consciousness Scale

Directions:
Certain statements with 5 point rating scales are given below. The 5 point equal appearing interval scale is varying from extremely characteristic to extremely uncharacteristic. You are required to give your answer by putting tick (✓) mark on any of the five alternative response categories.

<table>
<thead>
<tr>
<th>Extremely characteristic of me</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much characteristic of me</td>
<td>2</td>
</tr>
<tr>
<td>Fairly characteristic of me</td>
<td>3</td>
</tr>
<tr>
<td>Not very characteristic of me</td>
<td>4</td>
</tr>
<tr>
<td>Extremely uncharacteristic of me</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I'm always trying to figure myself out. - - - - -
2. I'm concerned about my style of doing things. - - - - -
3. Generally, I'm not very aware of myself. - - - - -
4. It takes me time to overcome my shyness in new situations. - - - - -
5. I reflect about myself a lot. - - - - -
6. I'm concerned about the way I present myself. - - - - -
7. I have trouble working when someone is watching me. - - - - -
8. I get embarrassed very easily. - - - - -
9. I'm self-conscious about the way I look. - - - - -
10. I'm generally attentive to my inner feelings.

11. I usually worry about making a good impression.

12. I'm constantly examining my motives.

13. I feel anxious when I speak in front of a group.

14. One of the first things I do before I leave my house is look in the mirror.

15. I sometimes have the feeling that I'm off somewhere watching myself.

16. I'm concerned about what other people think of me.

17. I'm alert to changes in my mood.

18. I'm usually aware of my appearance.

19. I'm aware of the way my mind works when I work through a problem.
Appendix-IV

**Significant Others Scale**

**Directions:**

Below are given certain items referring to support functions. You are required to rate relationship with your (spouse) on each of the 10 support functions on a 7-point scale. You have to rate the relationship that you feel is currently applicable in terms of the actual/ideal level of support.

1. Always
2. Very frequently
3. Frequently
4. Occasionally
5. Rarely
6. Very rarely
7. Never

1. To what extent can you trust, talk to frankly and share feelings with.

2. To what extent can you lean on and turn to in times of difficulty.

3. To what extent can you get interest, reassurance and a good feeling about yourself.

4. To what extent can you get physical comfort.

5. To what extent can you resolve unpleasant disagreement if they occur.

6. To what extent can you get financial and practical help.

7. To what extent can you get suggestions, advice and feedback.

8. To what extent can you visit them or spend time with socially.

9. To what extent can you get help in an emergency.

10. To what extent can you share interests and hobbies and have fun with.
Personal Data Sheet

NAME:

AGE:

OCCUPATION:

HUSBAND'S NAME:

MARITAL STATUS:

CLINICAL DIAGNOSIS:

ADDRESS: