Original Article

Women Coping Strategies towards Menopause and its Relationship with Sexual Dysfunction

Nafiseh Shams Nateri[1], Marjan Beigi[2], Ashraf Kazemi[2], Fatemeh Shirinkam[3]

[1]Student Research Center, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, Iran, [2]Department of Midwifery and Reproductive Health, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, Iran, [3]MSc of Midwifery, Instructor and Faculty Member, Department of Nursing Health, Ramsar Nursing and Midwifery School, Babol University of Medical Science, Babol, Iran

Abstract

Background: Paying attention to sexual dysfunction and its coping strategies is essential owing to its impact on mental health in postmenopausal women and their families. This study aimed to determine the relationship between women coping strategies toward the process of menopause and sexual dysfunction in menopausal women. **Materials and Methods:** This is a cross-sectional study in which 233 married menopausal women were sampled in the first 5 years after cessation of menstrual cycle using health records in the health centers in Isfahan in 2015. The method of data collection was a demographic characteristics form, sexual function questionnaire of Rosen *et al*., along with a researcher-made coping strategies questionnaire. The validity and reliability of these instruments were assessed, and the resulting data were analyzed utilizing inferential statistical tests (*t*-test and Chi-square test) and SPSS 16 software. **Results:** According to the results of this study, the relative frequency of sexual dysfunction in menopausal women is 67.42%. The mean score of the avoidance strategy in people with overall sexual dysfunction was significantly higher than the group without disorder ($P < 0.001$). The mean of coping strategies of social support seeking ($P < 0.001$), problem-solving ($P = 0.016$), and target replacement strategy ($P = 0.004$) were significantly lower than that in the group without disorder. **Conclusions:** In line with the findings of this study, problem-oriented strategies such as social support, problem solving, and target replacement are the best strategies for decreasing sexual dysfunction or increasing sexual satisfaction. These results emphasize the reinforcement of health personnel skills in teaching approach of these strategies to this group of women.

Keywords: *Coping strategies, menopause, sexual dysfunction*

Introduction

Menopause is a physiological phenomenon caused by reduced ovarian function and occurs following the cessation of menstruation or amenorrhea for 12 months.[1] This period is associated with physical and mental symptoms such as hot flashes, urogenital symptoms, depression, irritability, sleep disturbances, troubles with concentrating, and sexual dysfunction.[2] Sexual dysfunction problems, which are the major issues of families in all stages of life, can be created or increased during menopause as a result of physiological and pathological changes.

As expected, women with the onset of menopause seem to be more active than before due to relief of pregnancy and reduced responsibilities associated with parenting. Unfortunately, most women experience intensified problems in this regard, with the impression that their attractiveness is affected. Beigi *et al*. (2012) investigated sexual problems associated with menopause among women between the ages of 50 and 65 years, and their results revealed that the prevalence of these disorders is 72% in menopausal women. While women's sexual problems in the reproductive age were reported to be 38%.[3]

Sexual dysfunction and other problems in this process of age transition make many women to face crisis and result in considerable stress. It was observed that a lot of couples' violence, controlling, and monitoring each other's work as well as increased involvement after menopause are associated with sexual dysfunction issues. Thus, they are inevitably or knowingly looking for a way to deal with these issues.[4]

People respond in different ways to emotional disorders, hence, selecting an appropriate strategy to deal with any stress is of significant importance.[5]

How to cite this article: Nateri NS, Beigi M, Kazemi A, Shirinkam F. Women coping strategies towards menopause and its relationship with sexual dysfunction. Iranian J Nursing Midwifery Res 2017;22:343-7.

Received: December, 2015. **Accepted:** January, 2017.

Address for correspondence:
Mrs. Marjan Beigi, Department of Midwifery and Reproductive Health, Faculty of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, Iran.
E-mail: Beigi@nm.mui.ac.ir

Access this article online

Website: www.ijnmrjournal.net

DOI: 10.4103/ijnmr.IJNMR_234_15

Quick Response Code:

Skills and coping strategies with stress have a broad concept of multiple cognitive and behavioral components. This strategy is described as an attempt to increase individual adaptation to the environment or efforts to avoid negative consequences of stressful conditions.[6]

Lazarus Group (1984) presented double division of strategies to deal with stresses including problem-oriented and emotion-oriented strategies.[7] Problem-oriented strategies include active methods such as problem solving, cognitive, and behavioral strategies; emotion-oriented strategies including avoidance and emotional methods.[6]

According to the research, 76% of menopausal women will benefit from coping strategies, i.e., choice depending on various factors such as individual's mental health and social relationships.[5] Therefore, responses of many menopausal women to the stresses of this period can be interpreted with the mentioned coping strategies.

Obviously, in the case of abusive conditions, adaptation is more difficult and enduring changes are associated with restlessness. Therefore, selection of appropriate coping strategies that are often acquired and objective can also decrease mental stresses during this period.[6]

It has been observed that women who select appropriate strategies according to individual and family circumstances to deal with the signs of this period do not take this period as bearing the blackout rather they think it is one of the developmental stages.

These people use the advice and experience of others to solve the problems, thereby ignoring several social discord and false traditions,[3] and do not put at risk the quality of their lives and that of their sex partners. In other words, if menopausal women are appropriately trained on coping strategies, they can improve their mental health. At present, there is no appropriate training in the health centers on how to use the coping strategies to solve the problem of sexual dysfunction in women prior to menopause or after onset. This is probably due to the lack of necessary sensitivity in health care providers when compared to these strategies or their lack of awareness of the relationship between these strategies and sexual function. Hence, this study aims to determine the sexual dysfunction in menopausal women and its relationship with coping strategies.

Materials and Methods

This is a cross-sectional study in 2015 where the study population comprised married menopausal women who had their last menstrual period at least 1 year ago, were in the first 5 years of their menopause, and who referred to the health centers to receive services for screening, care, and treatment. The sample size of this study was estimated to be 223 people with 5% confidence level and 95% accuracy. In this study, selection of the health centers was done based on stratified random sampling, and the selection of the participants was done by available method. The inclusion criteria of the study included:

Not developing a wide range of known diseases and the use of drugs by women or their husbands that affect sexual function. These diseases include vasculitis, thyroid disease, diseases of the adrenal gland cortex, diabetes, hypertension, cardiovascular diseases, central nervous system disorders, infectious diseases, trauma, and genitalia surgery. Not experiencing stresses such as marital infidelity, death, serious illness, or imprisoned spouse of close relatives in the past year. Menopausal women who are not living separately from their husbands at the time of the interview. Spouses not suffering from sexual dysfunction (impotence, premature ejaculation) and sexual perversion.

All these items were determined via investigation and questioning of the participants.

To carry out sampling, researchers obtained the number of family cases having menopausal women as randomly stratified sample from the health centers as well as inviting these people and using them in terms of nonadmission in the study. Subsequently, they were assessed after obtaining informed consent to specify the sexual dysfunction in menopausal and coping strategies.

The data collection tools were the demographic characteristics form, sexual function questionnaire of women female sexual function index (FSFI), and questionnaire of coping strategies toward menopause. Their validity and reliability were determined by content validity and Cronbach's alpha.

The content validity was utilized to determine the questionnaire validity of the sexual function while Cronbach's alpha coefficient was used to assess its reliability. Information on this study were analyzed using the Statistical Package for the Social Sciences (SPSS, v. 16, SPSS Inc., Chicago, IL, USA, SPSS) software along with descriptive statistics methods (frequency distribution table) and inferential statistics (*t*-test and Chi-square test).

Ethical considerations

Menopause women were assessed after obtaining informed consent to specify the sexual dysfunction in menopausal and coping strategies. This study was approved by the ethics committee of the university.

Results

The women who participated in this study ranged from 42 to 62 years old (mean 53 (3.51) years). The number of children were 1 to 11 (mean = 3.87; SD = 1.63); menopausal age range was from 41 to 60 years old (mean = 50 years; SD = 3.23); 14.60% were illiterates; 38.61% had elementary qualification; 20.60% had guidance school qualification; 19.73% had diploma while 6.41%

had higher education. Among these people, 202 were housewives, 25 were employed, whereas 6 were pensioners.

The results of this study indicate that the frequency of sexual dysfunction in menopausal is 67.42%, which has a significant relationship with coping strategies of people towards menopausal such that the mean score of the avoidance strategy in the people with sexual dysfunction is significantly higher than the group without disorder. Nevertheless, the mean of the coping strategies seeking social support, problem-solving, and target replacement was significantly lower than the group without disorder [Table 1]. In addition, the mean score of the avoidance strategy in people with impaired phases of desire, arousal, lubrication, orgasm, satisfaction, and pain was significantly higher than the group without disorder through the independent *t*-tests, Chi-square, and Mantel Hansel tests. However, the avoidance strategy seeking social support, problem-solving, and target replacement in people with impaired phases of desire, arousal, lubrication, orgasm, satisfaction, and pain was lower than the group without disorder [Table 2].

Discussion

The findings of this study indicate that the frequency of sexual dysfunction in menopausal women is 67.42%. The highest level of this disorder was in arousal and satisfaction. Beigi *et al*. (2008) reported this rate in Isfahan at 72.40%, indicating that the highest disorder was in the arousal phase.[3] A study carried out by Blumel *et al*. (2009) showed that 25% of American menopausal women lack sexual function due to various reasons, while in people with sexual activity, the sexual dysfunction was observed as 56.81%. In this study, the highest dysfunction was reported in the arousal phase.[8] As shown, the incidence of sexual dysfunction in menopausal ages was high. This problem can be due to physiological symptoms of menopause, changes in sexual behavior of the women's husbands, existence of some pathologic, or psychological disorders in these women and their husbands, as well as adherence to some social wrong traditions regarding sexual function during menopause.

Our results in relation to the total score of sexual dysfunction showed that the mean score of the avoidance strategy in people with this disorder was significantly higher than the group without disorder. This implies that people who had higher avoidance coping strategy score were experiencing sexual dysfunction more often than other people. However, the mean score of the coping strategies seeking social support, problem-solving, and target replacement was significantly lower than in those without the disorder. A study carried out by Katrina *et al*. (2013) in America reported similar results; according to their study, extroverts and social people had a better sexual function.

These people are defined as those who have higher acceptance to other experiences and have gained adaptation to the sexual problems of this period.[9] Our study showed similar results to people who gained higher score in terms of the coping strategies and seeking social support. This is because they enjoy the experience of people and utilize their knowledge to solve their problems. In addition, the results of this study showed that people who use positive coping strategies have better sexual function, while the sexual function of those who use negative coping strategies such as introversion is impaired.[9] The study of Ghazanfari and Ghadampour (2008) showed that, the more the individuals use problem-oriented coping strategy, the more they have good mental health and show less somatic symptoms, anxiety, social dysfunction, depression, and vice versa. Whenever an individual uses the

Table 1: The mean score of the coping strategies in terms of the existence or non-existence of the sexual dysfunction

Coping strategies	Sexual function	*n*	Mean	Std. deviation	*t*	*P*
Avoidance	With dysfunction	158	11.35	5.33	4.02	<0.001
	Without dysfunction	75	9.11	3.14		
Social support	With dysfunction	158	17.07	5.99	4.22	<0.001
	Without dysfunction	75	20.08	4.57		
Problem solving	With dysfunction	158	20.83	7.71	2.43	0.016
	Without dysfunction	75	23.52	8.26		
Replacement target	With dysfunction	158	16.97	5.55	2.89	0.004
	Without dysfunction	75	19.15	4.96		

Table 2: Comparison of mean scores of the coping strategies in terms of the sexual phases (desire, arousal, lubrication, orgasm, satisfaction, and pain)

Coping strategies	Desire	Arousal	Lubrication	Orgasm	Satisfaction	Pain
Avoidance	t=4.43, P<0.001	t=2.98, P=0.003	t=3.18, P=0.002	t=3.31, P=0.001	t=3.56, P<0.001	t=2.07, P=0.04
Social support	t=3.77, P<0.001	t=3.64, P<0.001	t=3.75, P<0.001	t=3.30, P=0.001	t=2.63, P=0.009	t=3.14, P=0.002
Problem solving	t=2.25, P=0.25	t=3.13, P=0.002	t=3.13, P=0.002	t=2.58, P=0.001	t=3.41, P=0.001	t=3.05, P=0.003
Replacement target	t=3.36, P=0.001	t=3.52, P=0.001	t=3.52, P=0.001	t=3.41, P=0.001	t=3.09, P=0.002	t=3.81, P<0.001

emotion-oriented coping strategies, they benefits from less mental health and will have more physical harm, anxiety, social dysfunction, and depression.[10]

Furthermore, the studies of Simpson and Thompson (2009) indicated that women who benefit from problem-oriented strategies, have higher self-confidence in solving problems related to menopause and they will use more deliberate measures to deal with this problem.[5]

The results showed that the average score of avoidance strategy in patients with desire phase disorder was significantly higher than the group without disorder. Nevertheless, the average coping strategies of the social support, problem-solving, and target replacement in this phase was significantly lower than the group without disorder. This implies that, people who use the avoidance emotion-oriented strategy more than the others to deal with menopausal period, have more desire phase disorders. In the study of Katrina *et al*., the use of the problem-oriented coping strategy by turning to religion showed high relationship with the desired area.[9] Similarly, the mean score of the avoidance strategy in the lubrication and arousal phase was significantly higher than the group without disorder; however, the mean of the other three coping strategies was significantly lower than this group.

These findings suggest that the use of emotion-oriented coping strategies such as avoidance has inverse correlation with the sexual function score. In addition, the studies of Barry *et al*. (2010) showed that extraversion and admission of the new experiences are likely associated with self-report of the G-spot and thus experience better sexual relation in the arousal phase.[11] Our study showed similar results in the orgasm and satisfaction phase. Therefore, the score of avoidance strategy, i.e., one of the emotional coping strategies in people with sexual dysfunction in the orgasm phase is higher than the group without disorder, however, the mean of the other strategies was lower than the group without disorder. The results of other studies confirmed our study results. According to the results of these studies, people who benefitted from social support had higher confidence and admission when compared to those who gained higher scores in orgasm phase, whereas those seeking emotional reactions such as avoidance and denial had difficulties experiencing orgasm. The study of the Katrina *et al*. (2013) illustrated the significant relationship between individuals' emotional balance and better orgasm. According to the results of this study, those who benefitted from better emotional support had better coping strategies with more favorable satisfaction and orgasm. Employing negative strategies such as introversion, lack of trust in the opinions of others, and emotional imbalance led to the inability to achieve orgasm and also reduce sexual satisfaction.[9]

In other words, using emotion-oriented strategies, such as avoidance can lead to reduction of the people's sexual satisfaction and vice versa, the problem-oriented strategies are associated with increased sexual function score.

In addition, there was a significant relationship between the emotional balance and sexual satisfaction of the people. Those who benefit better from an emotional support have better coping strategies and more favorable sexual satisfaction.

While further investigations in the pain phase showed that the mean score of the avoidance strategy in people with sexual dysfunction in this phase was significantly higher than the group without the disorder, the mean score of coping strategies seeking social support, problem-solving, and target replacement was significantly lower than the group without disorder. The study of Katrina *et al*. investigated the score of sexual function of the FSFI in the pain phase and showed the positive relationship of this area with the emotion-oriented strategies.[11] In our studies, the emotion-oriented functions were specified in the avoidance coping strategies form. In this way, people who are more emotionally stable suffer less pain in their sexual relationships. This claim was confirmed in other studies. There is a significant relationship between the use of experiences and less pain and distress during sexual relationship. Similarly, this relationship was observed with the extraversion of people. The results of our study indicated that people who benefitted from higher social support suffered less pain in their sexual relationship.

Furthermore, the use of negative strategies, such as self-blame, is associated with high pain and distress in sexual relationship, while using positive strategies such as instrumental support and problem-solving can decrease the rate of difficulty and distress of a marital relationship. As a result, it can be said that inappropriate use of coping strategies to deal with the problems of menopause is significant during sexual relations.[9] Unknown diseases in menopausal women that effect on sexual function was limitation of this study.

Conclusion

According to the results of this research, problem-oriented strategies such as social support, problem solving, and target replacement are the best strategies to improve performance or increase sexual satisfaction, whereas emotion-oriented strategies such as avoidance are associated with increased sexual dysfunction.

Considering the importance of mental health of postmenopausal women by eliminating or reducing sexual dysfunction along with emphasis on this importance by health policymakers and coping with sexual dissatisfaction is recommended through the use of problem-oriented strategies. The role of health professionals in the field of educating these strategies to women in premenopausal ages is emphasized to prepare them before entering the sensitive and vulnerable period of menopause.

Acknowledgement

The authors would like to appreciate the valuable cooperation of health centers staff in Isfahan for implementing the research plan. (project no 394269)

Financial support and sponsorship

This study was financially sponsored by the research deputy of Isfahan University of Medical Sciences.

Conflicts of interest

There are no conflicts of interest.

References

1. Makvandi S, Zarghar Shoushtari SH, Yazdizadeh H, Zakerhosseini AB. The frequency and severity of menopausal symptoms and its relationship to individual factors in women before or after menopause age in Ahvaz. Journal of Obstetrics Gynecology1392;16:7-15.
2. Mushtaq AY. Coping strategies used by post-menopausal women in srinagar district of kashmir valley. Anthropologist 2014;17:1003-6.
3. Beigi FF. A comparative study on sexual function before and after menopause. Iranian Journal of Nursing and Midwifery 2012;17:72-5.
4. Potdar MS. Psychological Problems and Coping Strategies Adopted By Post Menopausal Women. International Journal of Science and Research (IJSR) 2014:2319-7064.
5. Simpson WT. Stressful life events, psychological appraisal and coping style in postmenopausal women. Maturitas2009;63:357-64.
6. Forouzande N, Aein F, Forouzande SD. The effect of group cognitive behavioral therapy on the use of coping skills in nursing and midwifery students. Journal of Clinical Nursing and Midwifery1391;1:1-9.
7. Leandro DC. Coping with stress and its relationship with personality dimensions, anxiety and depression. Procedia Social and Behavioral Sciences 2010;5:1562-73.
8. Blümel J, Chedraui P, Baron G, Belzares E, Bencosme A, Calle A, *et al*. Sexual dysfunction in middle-aged women: a multicenter Latin American study using the Female Sexual Function Index. American menopause journal 2009;16:1139-48.
9. Crisp CC. Is Female Sexual Dysfunction Related to Personality and Coping? An Exploratory Study. Sex Med 2013;1:69-75.
10. Ghazanfari GP. evaluate the relationship between coping strategies and mental health residents of the city of Khorramabad. The Quarterly Journal of Fundamentals of Mental Health 2008;9:47-54.
11. Burri AV, Cherkas DS. Genetic and environmental influences on self-reported G-spots in women: A twin study. Journal of Sex Med 2010;7:1842-52.