NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
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MASTER'S THESIS

INVESTIGATION OF THE EFFECTS OF MENOPAUSE ON WOMEN'S MENTAL HEALTH AND SEXUAL LIFE

Seren AKMAN

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Clinical Psychology Master Program
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Investigation of The Effects of Menopause on Women's Mental Health and Sexual Life

We certify the thesis is satisfactory for the award of degree of
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Abstract

Investigation of The Effects of Menopause on Women's Mental Health and Sexual Life

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The aim of this study was to analyze the effects of menopause on women's mental health and sexual life. In this study, data was collected in Antalya, Turkey and participants of the study consisted of 100 females (50 menopausal women and 50 non- menopausal women). The range age of the paticipants was between 35-65 years. Participation to the study was voluntary and the participants were selected through snowball sampling method. The symptoms of menopausal period were assessed by the Menopausal Symptoms Scale (MRS) psychological symptoms were assessed by the Symptoms Check List (SCL-R 90), sexual functions were assessed by Arizona Sexual Experience Scale (ASEX) and Golombok Rust Sexual Satisfaction Scale (GRISS).

This study shows that the mean scores of all subscales of SCL-R 90 were significantly higher among menopausal women compared to non-menopausal women. Finally, there were no significant difference between menopausal and non-menopausal women about sexual satisfaction. However, the mean scores of vaginusmus and anorgasmia subscales of GRISS were found to be significantly higher among menopausal women.

The results of the study suggests that psychological support may be helpful for menopausal as they suffer from psychological symptoms more in this period.

Keywords: ***Menopause, Psychological Symptoms, Sexual Satisfaction***

ÖZ

Menopozun Kadınların Akıl Sağlığına ve Cinsel Hayatına Etkisinin İncelenmesi

Hazırlayan: Seren Akman

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Bu çalışmanın amacı; menopozun kadınların akıl sağlığına ve cinsel hayatına etkisinin incelenmektir. Bu çalışmaya,Türkiye'nin Antalya ilinde yaşayan 50 menopoza girmiş, 50 menopoza henüz girmemiş 100 kadın katılmıştır. Katılımcıların yaşı 35-65 yaş arasındadır. Katılımcılar gönüllü olarak araştırmaya katılmış ve kar topu yöntemi ile seçilmiştir. Gönüllü katıldıklarına dair her katılımcıdan, onay formu doldurulması istenmiştir. Katılımcılara, menopoz semptomlarını belirlemek amacıyla Menopoz Semptomları Değerlendirme Ölçeği, menopozun psikolojik etkilerini belirlemek amacıyla Belirti Tarama Testi, menopozun cinsel hayata etkisini değerlendirmek amacıyla ise Arizona Cinsel Yaşantılar Ölçeği ve Golombok-Rust Cinsel Doyum Ölçeği uygulanmıştır.

Menopozun psikolojik etkilerini incelediğimizde ise menopoza giren kadınlar ile menopoza henüz girmemiş kadınların arasında anlamlı bir fark bulunmuştur. Son olarak, menopozun cinsel hayata etkisini incelediğimizde ise menopoza girmiş olan kadınlar ile menopoza henüz girmemiş kadın katılımcıların cinsel doyumları açısından anlamlı bir fark bulunmamıştır. Fakat, Golombok-Rust Cinsel Doyum ölçeğinin, menopoza giren kadınlar ile menopoza girmemiş kadınların orgazm ve vajinismus puanları arasında anlamlı bir fark bulunamamıştır.

Anahtar Kelimeler:*Menopoz,Psikolojik Semptomlar, Cinsel Doyum*

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ABBREVIATIONS

MRS: Menopausal Symptoms Scale

SCL-R 90: Symptoms Check List

ASEX: Arizona Sexual Experiences Scale

GRISS: Golombok-Rust Sexual Satisfaction Scale

1. INTRODUCTION

1.1. Definition of Menopause

Menopause; which means months and cut the term "men" and "pause" is derived from the word for the first time in 1816 by French physician Gardanne "menespausi" was used as. Gardanne have dealt with various aspects of menopause, observations were collected in a book on this subject. Even at that time, according to European Gardanne publication was interpreted as just pieces cut menopause (Atasü, 2001, 23).

Menopause is one of women's natural and normal life stages. The World Health Organization (WHO), according to the definition of menopause, "the loss of ovarian activity as a result of the permanent termination of menstruation. In the world, the menopause between the ages of about 45-55 and in our country is reported to be in 45-47years (Özcan,2013,157).

Menopause is an Ancient Greek in men (months) and pausis (termination) is the origin of the word. In, 1976, the first international congress in menopause; loss of activities of menopause, the ovaries result of menstruation was defined as termination permanent (Kıvanç, 2009, 44).

Women as they enter menopause around the age of 50 in Aristotle's "Historia Animoli" was recorded in the books. Menopause is believed to be the last period in the life of women, as the loss of a woman's sexuality and fertility away was thought to frequently ill. The start of the event described as positive scientific medicine 17-18.century (Atasü, 2001, 22).

The change perspectives on menopause care from yesterday to today. The actual life of many scientific and technological developments are increased the quality and ensure the growth of the elderly population in the world (Ertüngealp, 2003, 7).

Gynecological Endocrinology Society for the first time our country was founded in 1986. The aim of this association established conventions and meetings in order to postgraduate education for physicians. For this purpose, the first congress was held in 1987. In Turkey, menopause and hormone replacement therapy for the first time spoken in this conference and discussed. Met in 1992 doctors who are interested in the subject, and has established the National Menopause and Osteoporosis Society called "Menopause" is the first congress of the First National Symposium on Menopause and Osteoporosis name was held on 22-24 September 1993 (Atasü, 1991, 52).

1.1.1. Classification of Menopause

1.1.1. a. Early Menopause

Early Menopause is the natural menopause that occurs below the age of 40 years, can be termed as "premature menopause" or "premature ovarian failure". According to the observations the naturally menopause women is ranged from 1-4 % (Çanga, 1979, 13).

1.1.1. b. Natural Menopause

Menopause has three types and can be described in terms of age of onset various stages. The first type is natural menopause which is related with the exhaustion in physiological conditions (Garner, 1985, 55).

1.1.1. c. Surgical Menopause

Surgical menopause is certain operations that require the removal of ovaries, gonadectomy. For instance, it can be needed in the situations such as presence of cyst in ovaries or other pathological conditions (Kişnişçi, 1987, 830).

1.1.2. Factors Affecting the Menopause

1.1.2. a. Genetic Factors

Menopause might be also related with the genetical factors. The genes have an important influence on issues such as the concretical location. As it is seen that the almost all the women of a family has slightly the same age for the menopausal period (Sayıner, 1987, 34).

1.1.2. b. Genital Factors

The balance of ovarian function has an important role in the occurence of menopause. Women who has irregular menstrual cycles enters the period of menopause earlier when it is compared with the women who has regular menstrual cycles. Moreover the fertility status, age at menarche, hormonal contraceptive use, focuses on the factors that may affect the time of menopause as well as breastfeeding more than two years (Sayıner, 1987, 34).

1.1.2. c. Psychic Factors

Psychic trauma is considered as a factor that accelerates the onset of menopause. War, migration, the social events such as earthquakes or the life-long prison units may elevates the menopause after the sudden and premature interruption (Sayıner, 1987, 33).

1.1.2. d. Physical and Environmental Factors

Those who live in cold climates, socio-cultural reasons women working under difficult circumstances can be severe and menopause at an earlier age. Environmental pollution, radiation, and living at high altitudes causes premature menopause (Sayıner, 1987, 33).

1.1.2. e. Smoking

Today majority of diseases are related with the use of cigarettes and smoking. The time of menopause is also affected by smoking as well as it is causing other diseases. Heavy smokers are subjected to have menopause 1.5-2 years earlier then compared to nonsmokers (Yılmazer, 2000, 92).

1.1.2. f. Social Factors

Some studies that performed in Europe and North America; between the rural and traditional society, the menopause age was found to be 1-1.5 years earlier. Race, education, marital life, social class, or if the village is mentioned as the effects of social factors on menopausal age living in the city is not fully approven (Hotun, 1988, 92).

1.1.3. The Symptoms and Clinical Findings of Menopause

1.1.3. a. Physical Symptoms

Physical symptoms for menopause are hot flashes and night sweats, vaginal dryness and atrophic vaginitis and urinary disorders. Hot flashes and night sweats are the most common

menopausal symptoms (Speroff, et al., 1996, 102). Hot flashes starts primarly on face, head and chest but sometimes it is not aggreed spread to the whole body temperature. The prevalence of hot flashes, are the highest level in the last menstrual period within the first year (Hatcher, et al., 1990, 115). These physical symptomps mainly the hot flashes can be seen at anytime during the day and night.are any time of the day and night occurring. Hot flashes that occur at night can cause sleeping pattern disorders. (Pattern, 1992, 85).

The mechanism of hot flashes is not known yet. The hypothalamus of the midbrain is thought to be the responsible for disorders associated with hot flashes and sweats (Payer, 1991, 102). In the normal conditions, the body produces sweat according to the environment of the surroundings to keep the homeostasis of the body balanced. In postmenopausal women, it is thought that the temperature changes have regulator function. Small changes in bodys temperature can lead to regular sweating and tremor (Donald et al., 1996, 140).

Hot flashes are particularly affected and more increased by the factors such as consuming alcohol, smoking, obesity, consumption of hot beverages as well as being in an hot environment. (Hammond, 1994, 152). Therefore, lifestyle of an individual plays very important role in vasomotor symptoms (Atosu, 1996, 138). According to the records of women's health in recent years, it is suggested that, for the control of vasomotor symptomps in an individual, changing in lifestyle is way better than applying to hormonal theraphy to the individual. By meaning the change of a lifestyle to recude the symptomps are as follows 1) regular physical exercise 2)weight control 3)smoking cessation 4)reducing in the amount of alcohol consumption 4)avoide of hot drinks (Hammond et al., 1994, 155).

Physical symptoms can be associated with atrophic vaginitis, vaginal dryness and lack of estrogen within the body. Urogenital system in women contains the organs such as vagina, urethra and bladder (Şahmay, 1996, 148). In these urogenital tissues, the receptors for the estrogen exist. In the case of estrogen deficiency atrophy of these tissues occurs. Common vaginal symptoms in postmenopausal women are associated with due to the long-term lack of estrogen and progressive symptoms (Hammond, 1994, 155). These symptoms are vaginal dryness and dyspareunia (Huber, 1997, 228).

There are also changes in the skin which is associated with menopause, these include dryness and thinning of the skin as well as increase in skin sensitivity and reduced in sensory perception (Hammond, 1994, 155). The Pierard et al., (1990) hormones improving the skin elasticity and reformation of replacement therapy have therefore proved to be a protective effect on the skin of estrogen (Pierard et al., 48, 1990).

1.1.3. b. Psychological and Emotional Symptoms

Today, at least one of the third of women in the menopausal periods (pre / peri / post menopause) spends in the period. Particularly the increase in population of postmenopausal women in the social life of women in developed countries aims to improve the quality of life in women (Ersoy, 1998, 56).

Transition process from the postmenopausal period to perimenopause may take more than 10 years. The process might begin at the age of 40 years up to about 60 years and causes important psychological changes that can affect the roles of women being (Taşkın, 1994, 75).

There is a dynamic interaction in the menopause process between the physiological and non-physiological changes. In particular, parallel to the advanced age-related change in the

psychological and social problems. When these problems associated with the loss of independence and mobility, it directly affects the quality of life of women in postmenopausal period which can lead to have more serious distortion (Kaptanoğlu 1996, 125).

During menopause, the hormonal changes in the body is associated with the emotional situations is very different. The patient's response to menopause can be affected by many factors, such as the regulation of lifestyle and aging process (Kaptanoğlu, 1996, 126).

Loss of menstrual function therefore causing loss of fertility has an impact on women's well-being. Lose of ability to have children, the loss of youth, changes in skin, mood and anxiety-related changes in behavior, anxiety and irritability, are profoundly affect the psychological health of due to decreased libido (Kaptanoğlu,1996, 128).

The fact that to lose the ability of having children might be depended on some various factors. For example, for some women having and raising children are seen as an important source of status and self-confidence, and therefore loss of fertility can cause great stress and lead to depression (Peykerli, 2001, 110).

With menopause, regardless of the impact that loss of fertility, symbolized by understanding and created by the sadness of the loss of youth is expressed in a difficult distress (Aydın, 1998, 110). Unlike its becoming a general condition for matured society, for the youth society it has a high value. Therefore it may be traumatic menopause with the evidence of aging. The degree of effect on young generation to lose is associated with the value given to personal appearance of the woman. Aging of women might cause depression and anxiety but this cannot be said for all the women because in some women this is not important.(Şahin, 1998, 111).

As a result of changing in psychological conditions person can get into a depression and can lead to behavioral changes as well. Depression is usually considered as a common problem specially for women and elderly patients. Mood of depression, anxiety, irritability, may accompany different psychological symptoms such as lethargy and lack of energy. Also unhappy state of being depressed or pessimistic person loses interest in the event, irritability, crying spells, fatigue or lack of energy. Physiological changes that occur with menopause as a result of reflection on womens psychology, psychological symptoms are assumed to occur in postmenopausal women (Aydemir and Gülseren. 1999, 27).

Depression is more closely associated with hormonal changes when it is compared to other psychological problems in perimenopausal period. Many studies about the psychological treatments showed healing after starting estrogen therapy in postmenopausal women showed improvement on healing in depression (Igarashi, Jasienka, 2000, 100).

On the other hand, some of the symptoms related to menopause might be originated from psychological status. Some studies in the literature indicate that most of the women associated with the menopausal transition mental stage have major life changes. Prospective epidemiological studies shows that the menopause which is associated with psychological problems were reported most likely to be not related to any period of historical menopausal problems. Psychological problems are related with the stresses of life (Cooke, Greene, 1981, 55).

Many women during the perimenopausal period showed an increase in the levels of anxiety and irritability. Sometimes anxiety, worrying or being nervous, panic attacks, severe heart or getting easily nervous, or sleeping pattern problems, are associated with the problems such as difficulty on concentrating. Anxiety and irritability may be increased by decrease in the

vasomotor symptoms occurring as a result of sleep-pattern disorders, (Borissava, 2001, 113). However, various studies about the psychological symptoms showed that during the transition stage of menopause is related with the presence of estrogen but, however there is no evidence that can support the changes. Likely similar to depression, including many psychosocial factors increased in anxiety and irritability status of estrogen is thought more closely to be related with the premenopausal period, (Bosworth, Dennerstein, 2002, 114).

Some of the most important concern for women that surgical or natural menopause can cause is to decrease in libido or sexual satisfaction. Vaginal changes which are associated with menopause may lead it to decrease as well. The role of androgens in pre or post menopausal period libido is infact unclear. As it is reported, postmenopausal women are more likely to have low testosterone levels than the women in premenopausal period, (Borissava, 2001, 112).

1.1.4. c. Nervous System Symptoms

Estrogen deficiency of the central nervous system has seen to be on the impact assessment recently. Women most oftenly have trouble on concentration in the perimenopausal period and may experience short-term memory loss. These symptoms may be due to the effects of sleep latency, sleep disorders accompanied by aging alone or hot flushes. Estrogen appears to be a direct effect on mental function and hormone replacement therapy in postmenopausal women in short and has been shown to both improve the long-term memory (Nelson, 2008, 70).

Related to menopause type of headache is migraine headache. In menopause is a decrease the frequency of migraines. Migraine is well show a changing hormone levels decreased and this decrease in blood levels of estrogen in the attack. Due to variations in the estrogen hormone in premenopausal is increase in the frequency of migraine attacks (Lynch, 2009, 159).

1.2. Menopause and Sexual Life

1.2.1. Sexual Physiology of Women

First phase is request phase. It means that, sexuality required by the individual and involves desire. Requests and communications to create sexual desire by individuals, the media, fantasy, partner relationships and so on. It creates motivation to ensure the achievement of complex behavior. This phase includes the psychogenic sexual orientation and subjective stimulation. The most important stage is the sexual cycle (Masters, 1994, 9).

Stimulation phase is the second phase. The first phase is the physiological changes on body. Plateau phase is that, a significant increase of the stimulation phase and is part of the pleasure to approach orgasm. Women in the wet and genitals swell, erection occurs in men. Female nipples, genitals muscle spasms occur in men, while in the target. It is a stage in a long time. It may be reduced by an inappropriate stimulus during sexual intercourse or off. Sexual cycle to maintain arousal and sexual gratification at this stage and entered the plateau phase with increasing excitement (Masters, 1994, 12).

Orgasm phase of a very short time compared to other physiological stages but that stage is most intense pleasure and in the muscles around the vagina in women's rhythmic contractions occur at this stage. Women in the pelvic region of the brain pleasure center of the sensed and perceived by a very strong sense of gratification experienced. Both women and men increaseingly powerful 3-5 contractions of orgasm and the pursuit of violence are characterized by decreasing spasms. This spasm of violence may vary from woman to woman and sexual pleasure

experienced. Women arousal after orgasm, can orgasm again with the continuation of the existing sexual stimulation (Masters, Johnson, 1994, 32).

Thawing stage that, sexual cycle is the last stage. Following in the wake of the sexual orgasm, if not experienced orgasm following a plateau in body and decrease the stimulation of the sexual organs and the desertion. Solving the stage has physiological advantage men (Masters, 1994, 39).

1.2.2. Menopause and Female Sexuality

Sexual dysfunction is increase in menopausal period. Biologically, ovarian function with age and progress circulating estrogen with menopause, progesterone and testosterone levels decrease. Accordingly, the decrease in sexual desire and fantasies, sexual arousal and orgasm problems can arise. An especially sensitive area such as the stimulation threshold raises nipple and clitoris. Vaginal dryness and dyspareunia accordingly, decreased vaginal lubrication with a reduction in systemic levels of estrogen, vaginal dryness, and menopause as well as a reduction in libido and sexual desire with the effects of aging. As a result menopause can be influenced orgasm and sexual satisfaction in a negative way (Philips, 2000, 136).

Estrogen affects indirectly on libido. As the central nervous system and psychotropic manage neurotropic factors improves more secondary sex characteristics and gives the female identity. It also affects the pelvic floor, and therefore protects the honesty of the sexual way. Androgens directly affect the libido. In particular, they increase sexual motivation (Atasü, 2001, 34).

The simple of these statements depending on, such as estrogen and androgen reduction in biological plants can be experienced difficulties, depression, anxiety, stress and insomnia, chronic

form of improvements. Erotic dreams, fantasies, the number of spontaneous thoughts and mental decline in emerging sexual stimulation are occurs with the sense of touch. Reduction of estrogen causes dryness of the lips and is reflected in the sense of taste in this case. Therefore, from kissing and oral sexual pleasure is reduced. Estrogen is the hormone that regulates emotion and emotion disorders seen in postmenopausal period (Seyisoğlu, Şahin, 2000, 24).

Also vasomotor symptoms, such as sleep disorders are also associated with estrogen reduction are among the factors that affect the sexual life, indirectly. Physical diseases (Alzheimer's disease), uses drugs (antidepressants) and diabetes also affect the sexual life (Özekici, 2001, 92).

The clinical effects of postmenopausal sexual dysfunction are loss of libido, sexual sensation difficulty in waking and orgasm difficulties. After menopause, another feature is the increase in the survival rate after disappointing sex. Elderly women in a decrease in sexual activity causes loss of partner, partner's disease, the illness itself, partner of active women have less chance of finding a partner after his death (Ertüngealp, 2002, 17).

1.2.3. Menopause and Psychological Symptoms

According to the psychoanalytic theory of the neuroses that menopausal women mourn the loss of his sexuality and reproductive ability. Menopause is often described as a problem or a disease, which adversely affects the power relations between the sexes. For example, a female menopause increases tend to unhappiness and depression if you see it as an inevitable loss (Ersoy, 1998, 128).

In one study ,period climacterium-nervousness, irritability 10-91%,depression 13-86%, and 82% loss of concentration, sleep disorders 9%, 77% lack of motivation, memory defects

75%, 37% hot flashes, it is stated that 18% perspiration. Many menopausal women experienced emotional distress, but this starting from the pre-menopausal period of discomfort moved is it menopause or is it impossible to distinguish which starts directly during menopause. During menopause, the emotional state of every woman is the emergence of fluctuations and behavioral disorders and menopause are directly related with the findings of studies showing that emotional syndrome is not available (Freeman, 2005, 135).

Freud describes the cause of neurosis are often puberty or menopause emerge flour psycoeconomy model. The change in this balance suppressed impulses in power increase or decrease the power of the reason for the reduction. Some psychoanalysts the menopause productivity and loss of femininity as discussed and gets lost response indicates that life evolved the idea of aimlessness. According to cope very difficult menopause, narcissistic situation is infamous and coping with psychological backlash against organic decline is the most difficult tasks in the life of woman. If the self-esteem and life satisfaction of a woman is low, as in all areas menopause will also suffer many problems. It has developed a wholesome personality and years of age related to the loss experienced by an individual during menopause have gained the power to live a self-living in a constructive way has a positive spins (Patterson,1988,185).

The prevalence of psychiatric disorders encountered in the menopausal women measuring techniques applied to the selected sample of menopausal status (premenopausal, natural or surgical) shows significant differences (Bromberger, 2001, 88).In several studies show that menopausal period in depression, although the reported increased prevalence of anxiety and other psychiatric syndromes, including large sample groups opposed to the results obtained in several studies. Psychiatric symptoms of menopause by itself cannot be seen as part of indicated. (Bromberger, 2001, 90) .

Increase in psychiatric symptoms in the period immediately preceding the menopause, after menopause has been reported that reduce the prevalence of depression. Some workers, vasomotor symptoms of menopause, changes in mood or other physical symptoms those are secondary to defend (Kronenberg, 1994, 231).

Although it is not specific psychiatric disorders, menopause, menopausal mood disorders, especially depression may be considered. In patients with previous history of depression, postpartum mood disorder, premenstrual dysphonic disorder, or have a history of weak social support during menopause is a risk factor for psychiatric disorders. Considering that research carried out in Turkey on the subject is, however, a number of studies that examined the relationship between depression and menopause. The reason for this trend is that menopausal women are largely negative impact on mental health and the opinions of the majority of women were suffering from depression is not common in this period (Kişnişçi, 1996, 142).

1.3. The Purpose and Importance of the Study

The purpose of the study is to analyze the effects of menopause on women's mental health and sexual life. Birth, death, or transitions to adolescence are important points of human life. One of these important situations is in the change to old age. The most important point is the end of the transition to old age in women's fertility "menopause " creates (Ersoy, 1998, 82). Women's life is composed five periods. These are childhood, adolescence, sexual maturity, menopause and aging.Each of these periods' is physical, psychological and hormonal differences. This is the period of puberty and menopauses are the most important period because of their impact on women's lives.Many menopausal women experienced emotional distress, but did you moved to the menopause, starting from the pre-menopausal period of these conditions, or is it

impossible to distinguish which starts directly during menopause. During menopause each of women feeling that the emergence of fluctuations and disturbances and directly related to menopause, each of study findings indicate that emotional syndrome is not available.

Socio-cultural and economic status are high in society, sexuality is important for especially young women. The situation of women menopause in these societies, productivity, and femininity can be as the end of sex appeal. Particularly any women which who does not have children in this opinion may be differ. Women can be depression. Between husband and wife can be disruption of communication. Men can have middle-aged syndrome crisis. Because of this reason, men cannot be enough support of wife. Menopause is punishment for youth excessive emphasis society. However, Indian, Arab society and in our country, women living in rural areas, the differentiation status, the disappearance of danger be pregnant because of that reasons menopause is like reward. According to some results of research, in these societies are less physical and psychological problems in menopausal period.

In other words, we can say, culture, beliefs, values and depending on the individual's attitude menopause by unimportant or traumatic, positive or negative effects. In addition to these factors, it can be effects on types of menopausal symptoms and the psychological symptoms.

In our country, a limited search associated with the menopausal woman. This research is examining the effects of menopause on women's mental health and sexual life. It shows that the creation of new research facilities to the literature with are researching. Additionally this work is expecting to be useful to those who working in clinical areas and clinicians.

1.4. Hypothesis of the study

Menopause has relationship with sexual satisfaction, sexual experiences and also psychological symptom.

Woman who enter menopausal period have higher menopausal symptoms than woman who doesn't enter menopausel period.

Woman who enter menopausal period have lower sexual satisfaction than woman who doesn't enter menopausal period.

Woman who enter menopausal period have higher psychological symptoms than woman who doesn't enter menopausel period.

Woman who enter menopausal period have less sexual experiences than woman who doesn't enter menopausal period.

2. LITERATURE REVIEW

Menopause in many works was associated with psychological symptoms which are depending on the population, although the women is the changing prevalence and clinical samples than women in the general population, is reported, to have more symptoms. Menopausal period included variety of depressive symptoms indirect relationship with the dramatic decrease in estrogen. Particularly, it can lead to disruption of sleep. Insomnia and psychiatric symptoms caused by similar to the depressive symptoms. Sexual dysfunction induced menopause hormone deficiency disorder; also anxiety can lead to fall in relations with decreased self-esteem and their

partners. The loss of changes in body and an important source of satisfaction it may play a role in development of the depression. However, menopause should not be consider as a major cause of depressive symptoms. The research of emphasizes that the perimenopausal period of high risk for depression, but a clear correlation was detected between the poles as the severity of mood symptoms and serum hormone levels (Bezircioğlu, 2004, 138).

Research conducted in Turkey, showed higher levels of depressive symptoms in postmenopausal period before menopause. Anxiety levels did not differ between the groups. After menopause affects the severity of depressive symptoms and also other factors of risk for anxiety, while a lower level of education that they cannot prepare for the changes that will be encountered in postmenopausal women in this group (Kişnişçi, 1996, 140).

Schmidt and Rubinow suggested that (1998), the major evidence that menopause increases the risk of depression is to specify whether perimenopausal period suggest the psychological syndrome of symptoms can be unimportant (Schmidt-Rubinow, 1998, 87). Anxiety, fatigue, crying attacks, mood swings and decreased libido may occur. In addition, joint and muscle pain, headaches, palpitations, irritability and insomnia may be occur as well (Schmidt, 1998, 88). If you have a slight mood disorders in perimenopausal year, its usually because of menstruation consists of total loss which is much earlier than 3-4 years (Bromberger, 2001, 93).

Menopause causes chronic sleep disorder, insomnia, irritability, and can lead to short-term memory and concentration disorders (Beck, 1989, 120). Complaints of hot flashes in postmenopausal women are 60% less than 7 years of progress, it can take 15 years or more is 15%. This problem sweating, palpitations, may accompany other symptoms such as anxiety and

depression (Pattern, 1989, 102). The frequent repetition of episodes of hot flashes in postmenopausal women unrest may also increase other psychological problems, such as sadness and distress. Eventually vasomotor symptoms are reduces the quality of life (Donald et al., 1996, 135).

Nappi and her friends (2002), it is detected in women whom aged between 45-60 pain and decreased libido during the sexual imtercourse which is the most seen complaints in the period of climateric.It is also detected that sexual satisfaction has been decreased to its minimum in the late of climateric period. Altinsoy (2002), 52.3% of women aged between 40-75 has sexual problems and in 44.3% detected a decrease in interest to sexual attraction.

Arslan and his friends (2004), decrease in seuxal intercourse up to 42.4% on premenopause and %5.2 on postmenopause stage which had a sexual attraction 3-4 times a week. Also decrease in foreplay from 69.4% to 24.5% and between these data there is a important difference. Women who joined to the experiment, it is also detected the dryness of vagina, decrease in the interest to sexual attraction, sexual interaction with pain, decrease in having orgasm etc. Özkan ve Alataş said that the sexual interaction has been significantly decreased in the period of postmenopausal stage. In the stage of premenopause 73% women said they usually had 1-2 sexual activity in a week, but this has been decreased up to 42% after the menopause.

3. METHOD AND MATERIAL

3.1. Method of the study

This study was applied in the Antalya, Turkey and participants of study were consisted of 100 females. 50 of them were menopausal women and 50 of them were not menopausal women. Participants are between 35-65 years of age. Participiation to the study was voluntary and the participants were selected through snowball sampling procedure..

Study survey includes five questionnaires which are Socio-demographic Information Form, Menopause Rating Scale (MRS), Symptom Check List (SCL-90), Arizona Sexual Experience Scale (ASES) and Golombok-Rust Sexual Satisfaction Inventory (GRISS). Questionnaires are applied by researcher to participants and all of questionnaires took fifteen minutes approximately.

3.2. Materials of the study

3.2.1. Socio-demographic information form

Socio-demographic information form was prepared according to aim of the study by researcher. Demographic Information Form is utilized to collect information related to various demographic characteristics. Form includes age, gender, nationality, job, education level, socio-economic level, form of marriage and number of children. Also form includes menopausal status, psychological status and etc.

3.2.2. Menopause Rating Scale (MRS)

Menopause rating questionnaire were used as a basis for assessing menopausal symptoms in this study, this is a self-administered instrument which has been widely used and validated and have been used in many clinical and epidemiological studies, and in research on the etiology of menopausal symptoms to assess the severity of menopausal symptoms .MRS was developed by Schneider and Heineman (1996).

The MRS is composed of 11 items and was divided into three subscales: (a) somatic-hot flushes, heart discomfort/palpitation, sleeping problems and muscle and joint problems; (b) psychological-depressive mood, irritability, anxiety and physical and mental exhaustion and (c) urogenital-sexual problems, bladder problems and dryness of the vagina. Each of the eleven symptoms contained a scoring scale from "0" (no complaints) to "4" (very severe symptoms) (Gürkan, 2005).

MRS was translated and adapted into Turkish by Gürkan (2005). Reliability analysis was performed on the adapted Menopause Rating Scale questionnaires with Cronbach's alpha of somatic subscale 0.712, psychological subscale 0.743 and urogenital subscale 0.821. Therefore, this study determined the prevalence of menopausal symptoms and not the severity of the symptoms (Gürkan, 2005).

3.2.3. Symptom Check List (SCL-90)

It was developed by Derogatis in 1977(Dağ et.al, 1991). Turkish validity and reliability study of the scale was made by Dağ (Dağ, 1991).The SCL-90 is formed form of 90 items, each rated on a 5-point scale of distress. These items are includes in nine dimensions. 'Somatization' reflects distress arising from perceptions of bodily dysfunction. Complaints focused on

cardiovascular, gastrointestinal, respiratory and other systems with strong autonomic mediation have been included. 'Obsessive-Compulsive' reflects behaviors that are closely identified with the clinical syndrome. The focus of this criterion is on thoughts, impulses and actions that are experienced as unremitting and irresistible by the individual but are of an ego-alien or unwanted nature. 'Interpersonal Sensitivity' focuses on feelings of personal inadequacy and inferiority, particularly by comparison with other individuals. Self-deprecation, feelings of uneasiness, and marked discomfort during interpersonal interactions are characteristics of people showing high levels for this dimension. Feelings of self-consciousness and negative expectations regarding interpersonal communications are further typical sources of distress. 'Anxiety' subsumes a set of symptoms and experiences usually associated clinically with a high degree of manifest anxiety.. 'Hostility' is organized around three categories of hostile behavior: thoughts, feelings, and actions. Items range from feelings of annoyance and urge to break things, to arguments and uncontrollable temper outbreaks. 'Phobic Anxiety' reflects symptoms that have been observed with a high incidence in conditions termed phobic anxiety state or agoraphobia. 'Paranoid Ideation' derives from the notion that paranoid behavior is the best considered from a syndrome point of view. Projective ideation of hostility, dishonesty, importance, delusions, loss of autonomy, and grandiosity as cardinal paranoid characteristics are assessed within the limitations imposed by a self-report format. 'Psychoticism' represents florid, acute symptomatology, as well as behaviors typically viewed as more oblique, less definitive, indicators of psychotic processes. Global scores for SCL-90 items are Total SCL-90 score (sum of all items), the number of items rated positively (PST), and the positive symptom distress index (PSDI), which is calculated by dividing the sum of all items by the score for PST (Derogatis,1994) .

3.2.4 Golombok –Rust Sexual Satisfaction Inventory (GRISS)

GRISS is a 28-item self-report scale was developed by Rust and Golombok (1983). The aim of the scale is to measure the quality of sexual relationship and the presence and severity of both male and female sexual problems. Each item is rated on a 5 point Likert type scale and answers options range from "never" to "always". Scores of scale are calculated by summing up item scores after necessary items are converted. Higher scores indicate higher level of sexual dysfunction and lower level of sexual quality (Tuğrul, Öztan, Kabakçı, 1993, 85).

GRISS has two different forms for men and women. It includes 7 subscales and 5 of them are the same for both men and women forms; avoidance, satisfaction, communication, sensuality and frequency of sexual activity. Additionally, women form consists of vaginismus and anorgasmia subscales and men form contains premature ejaculation and erectile dysfunction subscales. The total score of GRISS gives information about general aspect of sexual functioning and, subscales gives detailed information for different aspects of sexual functioning and can be used as a diagnostic tool. Split-half reliability was reported .87 for women and .94 for men and also, internal consistency reliability for subscales ranged between .61 and .83. Validity of the scale was assessed through applying the scale to both patients having sexual dysfunction and sexually healthy individuals and showing that the scale distinguished those groups except for sensuality, avoidance and communication subscales for male and communication subscale for female (Tuğrul, Öztan, Kabakçı, 1993, 85).

GRISS was translated and adapted into Turkish by Tuğrul, Öztan and Kabakçı (1993). Cronbach's alpha value was reported .92 for males and .91 for females for the total scale and for subscales, Cronbach"s alphas reported between .51 and .88 for women and between .63 and .91

for men. In addition, the split-half reliability coefficients calculated .91 ($p < .001$) in females and .90 ($p < .001$) for males. Discriminate validity of the scale was obtained through applying the scale to both clinical and nonclinical groups and showing that both total scores and subscale scores distinguished those groups except for communication subscale for female in adaptation study. Even if factor analysis suggested different results when compared to Rust and Golombok's findings, items obtaining sexual dysfunctions gathered under different factors and this was a similar finding as indicated (Tuğrul, Öztan, Kabakçı, 1993, 85).

3.2.5 Arizona Sexual Experiences Scale (ASEX)

ASEX was developed by Mc Gahuey (2000).Five-item measure which was developed to detect and follow up sexual difficulties in men and women with depression. Five major domains of sexual difficulties are assessed with one item for each: sex desire, arousal, erection, ability to reach orgasm, and satisfaction from orgasm. Responses are coded on a six-point likert scale with varying responses (e.g., 1 = extremely easily; 6 = never). Higher scores reflect poorer sexual functioning (possible range is 5 to 30) (Soykan, 2004).

A total ASEX score greater than 19, any one item with a score greater than 5 or any three items with a score greater than 4 are the criteria used to determine whether an individual has a sexual dysfunction (Soykan, 2004). The ASEX may be self-or clinician-administered; completed by heterosexual and non heterosexual individuals; and is suitable for use with persons who do not have a sexual partner. Items were generated through a literature review of sexual dysfunction theory; no other information was provided about the item generation process (Soykan, 2004).

Turkish validity and reliability study of the scale made by Soykan (2004). The ASEX demonstrated good scale score reliability ($\alpha = .91$) and strong test-retest reliability. $r = .80$ ($p < .01$) $r = .89$ ($p < .01$).

3.3. Statistical Analysis

For the evaluation of the research questions, all the analyses was performed by using a computer program for the multivariate statistics; Statistics Package for the Social Sciences (SPSS), version 13 for Windows. For comparing socio-demographic characters of menopausal women and non-entering menopausal women analyzed Chi-Square statistical method are applied. In addition the menopausal women scores and non-entering menopausal period scores of menopausal symptoms are analyzed Independent sample t-test method are applied. Also, sexual satisfaction scales scores of menopausal period and non-entering menopausal period of women are analyzed by Independent sample t-test statistical method are applied. Finally, correlation between age score and psychological symptoms scale subtests scores and education levels are analyzed by Spearman Correlation statistical method.

4. RESULTS

Table 1. ***Comparison of age of menopausal women and non-menopausal women***

Age	Menopausal	Non-Menopausal	Total
36-45	11 (36.7%)	19(63.3%)	50(50%)
46-65	39(55.7%)	31(44.3%)	50(50%)
Total	50(100%)	50(100%)	100(100%)

X^2=3.048, df=1, p=0.063

In the present study age and between individuals with menopausal women and non-menopausal women were compared by Chi-Square. There were no statistical significant differences between age rates and individuals with menopausal women and non-menopausal women. (X^2=3.048, df =1, p=0.063).

Table 2. ***Comparison of education level of menopausal women and non-menopausal women***

Participants Education Level	Menopausal	Non-Menopausal	Total
Primary School	11(73.3%)	4 (27%)	15 (100%)
Middle School	5 (42%)	7 (58.3%)	12(100%)
High School	20 (56%)	16 (44.4%)	36(100%)
University	11(39.3%)	17(61%)	28(100%)
Master and Doctorate	3(33.3%)	6(67%)	9(100%)
Total	50 (100%)	50 (100%)	100(100%)

X^2=6.330, df =4, p=0.176

In the present study participants education level and individuals with menopausal women and non-menopausal women were compared by Chi-Square. There was no statistical significant differences between participants education level rates and individuals with menopausal women and non-menopausal women (X^2=6.330, df =4, p=0.176).

Table 3. ***Comparison of having psychological treatment between individuals with menopausal period and non-menopausal period of women***

Having psychological treatment	Menopause	Non-Menopause	Total
Yes	10(25%)	4(10%)	17(20%)
No	40(74 %)	46(90%)	67(80%)
Total	50(100%)	50(100%)	84(100%)

X^2=3.030, df=1, p=0.082

In the present having psychological treatment and individuals with menopausal and non-menopausal period of women were compared by Chi-Square. There were no statistical significant differences between having psychological treatment rates and individuals with menopausal period and non-menopausal period of women. (X^2=3.030, df =1, p=0.082)

Table 4. ***Comparison of having physiological disorder between individuals with menopausal period and non-menopausal period of women***

Having physiological disorder	Menopause	Non-Menopause	Total
Yes	3(60%)	2(40%)	5(100%)
No	47(50%)	48(51%)	95 (100%)
Total	50(100%)	50(100%)	100(100%)

X^2=0.211, df=1, p=0.500

In the present having physiological disorder and individuals with menopausal and non-menopausal period of women were compared by Chi-Square. There were no statistical significant differences between having physiological disorder rates and individuals with menopausal period and non-menopausal period of women. (X^2=0.211, df =1, p=0.500).

Table 5. ***Comparison of having psychological complaints between individuals with menopausal period and non-menopausal period of women***

Having psychological complaints	Menopause	Non-Menopause	Total
Yes	4(100%)	0(0%)	4(100%)
No	46(47.9%)	50(52.1%)	96(100%)
Total	50(100%)	50(100%)	100(100%)

X^2=4.167, df=1, p=0.059

In the present having psychological complaints and individuals with menopausal and non-menopausal period of women were compared by Chi-Square. There were no statistical significant differences between having psychological complaints rates and individuals with menopausal period and non-menopausal period of women. (X^2=4.167, df=1, p=0.059).

Table 6. ***Comparison of having drug use between individuals with menopausal period and non-menopausal period of women***

Drug Use	Menopause	Non-Menopause	Total
Yes	10(30.3%)	23(69.7%)	33(100%)
No	40(59.7%)	27(40.3%)	67(100%)
Total	50(100%)	50(100%)	100(100%)

X^2=7.644, df=1, p=0.005

In the present having psychological complaints and individuals with menopausal and non-menopausal period of women were compared by Chi-Square. There were statistical significant

differences between having drug use rates and individuals with menopausal period and non-menopausal period of women. (X^2=7.644, df=1, p=0.005). The individuals with menopausal women were not use drug use with non-menopausal women.

Table 7 . ***Comparison of subscale of menopausal symptoms scale women's somatization scores between with entering the menopausal period and non-menopausal period***

	Somatization scores	
	m±sd	t (p)
Menopausal	9.56±3.79	
Non-Menopausal	5.31±2.14	6.894
		(0.000)

P<0.05 for significant

The mean of the somatization scores of menopausal symptoms scale subtest individuals with menopausal and non-menopausal period were compared by Independent sample t-test. There were statistical significant differences between the mean of somatization scores of individuals with menopausal period and non-menopausal period of women (t=6.894, p=0.000). The mean of the somatization subscale scores of individuals with non-menopausal period of women was lower than individuals with menopausal period.

Table 8. ***Comparison of subscale of menopausal symptoms scale women's psychological complaints score between with menopausal period and non-menopausal period***

	Psychological Complaints	
	m±sd	t (p)
Menopausal	8.92±3.41	
Non-menopausal	5.52±2.48	5.687
		(0.000)

P<0.05 for significant

The mean of the women's psychological complaints scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's mean psychological complaints scores of individuals with menopausal period and non-menopausal period (t=5.687, p=0.000). The mean of the women's psychological complaints scores with menopausal period was higher than individuals with non-menopausal period.

Table 9.*Comparison of subscale of menopausal symptoms scale women's urogenital complaints scores between with entering the menopausal period naturally and surgical menopausal period of women*

	Urogenital complaints	
	m±sd	t (p)
Menopausal	5.80±2.51	
Non-menopausal	2.94±1.19	7.257
		(0.000)

P<0.05 for significant

The mean of the women's urogenital complaints scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There were statistical significant differences between the mean of the women's mean urogenital complaints scores of individuals with menopausal period and non-menopausal period (t=7.257, p=0.000). The mean of the women's urogenital complaints scores with menopausal period was higher than individuals with non-menopausal period.

Table 10. ***Comparison of subscale of menopausal symptoms scale women's somatization scores between with entering the menopausal period naturally and surgical menopausal period of women***

	Somatization	
	m±sd	t (p)
Entering the Menopausal Period Naturally	9.03±4.04	3.058
Surgical Menopausal	6.68±3.36	(0.003)

P<0.05 for significant

The mean of the women's somatization scores of individuals with entering menopausal period naturally and surgical menopausal period were compared by Independent sample t-test. There were statistical significant differences between the mean of the women's mean somatization scores of individuals with entering menopausal period naturally and surgical menopausal period (t=3.058, p=0.003). The mean of the women's somatization scores with entering menopausal period naturally was higher than individuals with surgical menopausal period.

Table 11. ***Comparison of subscale of menopausal symptoms scale women's psychological complaints scores between with entering the menopausal period naturally and surgical menopausal period of women***

	Psychological Complaints	
	m±sd	t (p)
Entering the Menopausal	8.57±3.59	
Period Naturally		2.781
Surgical Menopausal	6.59±3.18	(0.007)

P<0.05 for significant

The mean of the women's psychological complaints of individuals with entering menopausal period naturally and surgical menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's mean psychological complaints scores of individuals with entering menopausal period naturally and surgical menopausal period (t=2.781, p=0.007). The mean of the women's psychological complaints with entering menopausal period naturally was higher than individuals with surgical menopausal period.

Table 12: Comparison of subscale of menopausal symptoms scale women's urogenital complaints scores between with entering the menopausal period naturally and surgical menopausal period of women

	Urogenital Complaints	
	m±sd	t (p)
Entering the Menopausal	5.58±2.63	
Period Naturally		3.606
Surgical Menopausal	3.80±2.12	(0.000)

P<0.05 for significant

The mean of the women's urogenital complaints of individuals with entering menopausal period naturally and surgical menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's mean urogenital complaints scores of individuals with entering menopausal period naturally and surgical menopausal period (t=3.606, p=0.000). The mean of the women's urogenital complaints with entering menopausal period naturally was higher than individuals with surgical menopausal period.

Table 13. ***Comparison of women's sex drive scores between with menopausal period and non-menopausal period of women***

	Sex drive	
	m±sd	t (p)
Menopause	3.72±1,37	4,32
Non-Menopause	2,54±1.36	(0,92)

P<0.05 for significant

The mean of the women's sex drive score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was no statistical significant difference between the mean of the participant's sex drive score of individuals with menopausal period and non-menopausal period. (t=4.32, p=0.93).

Table 14. ***Comparison of women's sexually aroused level between with menopausal period and non-menopausal period of women***

	Sexually aroused	
	m±sd	t (p)
Menopause	3.42±1,22	3,73
Non-Menopause	2,50±1.30	(0,56)

P<0.05 for significant

The mean of the women's sexually aroused score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was

no statistical significant difference between the mean of the participant's sex drive score of individuals with menopausal period and non-menopausal period. (t=3.73, p=0.56).

Table 15. ***Comparison of women's sexually aroused level between with menopausal period and non-menopausal period of women***

	vagina become moist or wet during sex m±sd	t (p)
Menopause	3.54±1,23	5,51
Non-Menopause	2,20±1.20	(0,70)

P<0.05 for significant

The mean of the women's vagina become moist or wet during sex score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was no statistical significant difference between the mean of the participant's sex drive score of individuals with menopausal period and non-menopausal period. (t=5.51, p=0.70).

Table 16. ***Comparison of women's orgasm score between with menopausal period and non-menopausal period of women***

	Orgasm score	
	m±sd	t (p)
Menopause	3.64±1,57	4,48
Non-Menopause	2,56±1.25	(0,48)

P<0.05 for significant

The mean of the women's orgasm score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was no statistical significant difference between the mean of the women's orgasm score of individuals with menopausal period and non-menopausal period. (t=4.48, p=0.48).

Table 17. ***Comparison of women's orgasm satisfying between with menopausal period and non-menopausal period of women***

	Orgasm Satisfy	
	m±sd	t (p)
Menopause	3.16±1,28	4,48
Non-Menopause	2,14±1.03	(0,10)

P<0.05 for significant

The mean of the women's orgasm satisfying score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was

no statistical significant difference between the mean of the women's orgasm satisfying of individuals with menopausal period and non-menopausal period. (t=4.48, p=0.10).

Table 18. ***Comparison of women's frequency of sexual intercourse between with menopausal period and non-menopausal period of women***

	Frequency of sexual intercourse	
	m±sd	t (p)
Menopausal	4.40±1.16	
Non-menopausal	4.49±0.88	-0.433
		(0.66)

P<0.05 for significant

The mean of the women's frequency of sexual intercourse score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was no statistical significant difference between the mean of the women's frequency of sexual intercourse of individuals with menopausal period and non-menopausal period. (t=-0.433, p=0.66).

Table 19. ***Comparison of women's communication satisfaction on sexual activity scores between with menopausal period and non-menopausal period of women***

	communication satisfaction on sexual activity scores m±sd	t (p)
Menopausal	4.47±1.73	
Non-menopausal	5.22±1.83	-2.099 (0.038)

P<0.05 for significant

The mean of women communication satisfaction on sexual activity scores of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was no statistical significant difference between the mean of the women's communication satisfaction on sexual activity score of individuals with menopausal period and non-menopausal period. (t=-2.099, p=0.038).

Table 20.*Comparison of women's sexual satisfaction between with menopausal period and non-menopausal period of women*

	Sexual Satisfaction	
	m±sd	t (p)
Menopausal	10,59±2.25	
Non-menopausal	10.97±1.73	-0.944
		(0.348)

P<0.05 for significant

The mean of the women's sexual satisfaction score of individuals with menopausal period and non-menopausal period of women were compared by Independent sample t-test. There was no statistical significant differen1ce between the mean of the women's sexual satisfaction score of individuals with menopausal period and non-menopausal period. (t=-0,944, p=0.348).

Table 21.*Comparison of women's avoidance from sexual activity scores between with menopausal period and non-menopausal period of women*

	Avoidance From Sexual Activity	
	m±sd	t (p)
Menopausal	7,21±3.02	
Non-menopausal	5.05±2.27	4.037
		(0.000)

P<0.05 for significant

The mean of the women's avoidance from sexual activity scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's mean avoidance from sexual activity scores of individuals with menopausal period and non-menopausal period (t=4.037, p=0.000). The mean of the women's avoidance from sexual activity scores with menopausal period was higher than individuals with non-menopausal peri

Table 22. ***Comparison of women's sensation on sexual activity scores between with menopausal period and non-menopausal period of women***

	Sensation on sexual Activity	
	m±sd	t (p)
Menopausal	10.02±2.20	
Non-menopausal	11.36±1.89	-2.809
		(0.006)

P<0.05 for significant

The mean of the women's sensation on sexual activity of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's mean sensation on sexual activity scores of individuals with menopausal period and non-menopausal period (t=4.037, p=0.000). The mean of the women's sensation on sexual activity scores with non-menopausal period was higher than individuals with menopausal period.

Table 23. ***Comparison of women's vaginismus score between with menopausal period and non-menopausal period of women***

	Vaginismus	
	m±sd	t (p)
Menopausal	8.20±2.34	
Non-menopausal	10.93±6.86	-2.667
		(0.009)

P<0.05 for significant

The mean of the women's vaginismus score of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's vaginusmus scores of individuals with menopausal period and non-menopausal period (t=-2.667, p=0.009). The mean of the women's vaginusmus scores with non-menopausal period was higher than individuals with menopausal period.

Table 24.*Comparison of women's orgasm disorder score between with menopausal period and non-menopausal period of women*

	Orgasm Disorder	
	m±sd	t (p)
Menopausal	9.30±2.03	
Non-menopausal	10.68±1.54	-3.821
		(0.000)

P<0.05 for significant

The mean of the women's orgasm disorder score of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's orgasm disorder scores of individuals with menopausal period and non-menopausal period (t=-3.821, p=0.000). The mean of the women's orgasm disorder scores with non-menopausal period was higher than individuals with menopausal period.

Table 25. ***Comparison of women's somatization scores between with menopausal period and non-menopausal period of women***

	Somatization	
	m±sd	t (p)
Menopausal	26.15±8.12	
Non-menopausal	18.23±6.73	5.308
		(0.000)

P<0.05 for significant

The mean of the women's somatization scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There were statistical significant differences between the mean of the women's somatization scores of individuals with menopausal period and non-menopausal period (t=5.308, p=0.000). The mean of the women's somatization scores with menopausal period was higher than individuals with non- menopausal period.

Table 26. ***Comparison of women's obsessive compulsive symptoms scores between with menopausal period and non-menopausal period of women***

	Obsessive-Compulsive Symptoms	
	m±sd	t (p)
Menopausal	19.40±6.26	
Non-menopausal	15.08±5.44	3.681
		(0.000)

P<0.05 for significant

The mean of the women's obsessive compulsive symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's obsessive compulsive symptoms scores of individuals with menopausal period and non-menopausal period (t=3.681, p=0.000). The mean of the women's obsessive compulsive symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 27.*Comparison of women's interpersonal sensitivity symptoms scores between with menopausal period and non-menopausal period of women*

	Interpersonal Sensitivity Symptoms	
	m±sd	t (p)
Menopausal	16.35±6.29	
Non-menopausal	12.60±5.17	3.255
		(0.002)

P<0.05 for significant

The mean of the women's interpersonal sensitivity symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's interpersonal sensitivity symptoms scores of individuals with menopausal period and non-menopausal period (t=3.255, p=0.002). The mean of the women's interpersonal sensitivity symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 28. ***Comparison of women's depression symptoms scores between with menopausal period and non-menopausal period of women***

	Depression Symptoms	
	m±sd	t (p)
Menopausal	27.17±9.46	
Non-menopausal	19.34±7.46	4.593
		(0.000)

P<0.05 for significant

The mean of the women's depression symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's depression symptoms scores of individuals with menopausal period and non-menopausal period (t=4.593, p=0.000). The mean of the women's depression symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 29. ***Comparison of women's anxiety symptoms scores between with menopausal period and non-menopausal period of women***

	Anxiety Symptoms	
	m±sd	t (p)
Menopausal	17.96±7.12	
Non-menopausal	12.47±4.35	4.648
		(0.000)

P<0.05 for significant

The mean of the women's anxiety symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's anxiety symptoms scores of individuals with menopausal period and non-menopausal period (t=4.648, p=0.000). The mean of the women's anxiety symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 30. ***Comparison of women's anger-hostility symptoms scores between with menopausal period and non-menopausal period of women***

	Anger-Hostility	
	m±sd	t (p)
Menopausal	9.75±4.05	
Non-menopausal	7.82±3.36	2.594
		(0.011)

P<0.05 for significant

The mean of the women's anger-hostility symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's anger-hostility symptoms scores of individuals with menopausal period and non-menopausal period (t=2.594, p=0.011). The mean of the women's anger-hostility symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 31. ***Comparison of women's psychotism symptoms scores between with menopausal period and non-menopausal period of women***

	Psychotism	
	m±sd	t (p)
Menopausal	14.82±5.43	
Non-menopausal	11.51±3.70	3.554
		(0.01)

P<0.05 for significant

The mean of the women's psychotism symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's psychotism symptoms scores of individuals with menopausal period and non-menopausal period (t=3.554, p=0.01). The mean of the women's psychotism symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 32.*Comparison of women's phobia symptoms scores between with menopausal period and non-menopausal period of women*

	Phobia	
	m±sd	t (p)
Menopausal	9.89±4.72	
Non-menopausal	7.46±2.02	3.344
		(0.001)

P<0.05 for significant

The mean of the women's psychotism symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's psychotism symptoms scores of individuals with menopausal period and non-menopausal period (t=3.554, p=0.01). The mean of the women's psychotism symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 33. ***Comparison of women's paranoid thoughts symptoms scores between with menopausal period and non-menopausal period of women***

	Paranoid Thoughts	
	m±sd	t (p)
Menopausal	10.31±4.30	
Non-menopausal	8.48±3.12	2.424
		(0.017)

P<0.05 for significant

The mean of the women's paranoid thoughts symptoms scores of individuals with menopausal period and non-menopausal period were compared by Independent sample t-test. There was statistical significant differences between the mean of the women's paranoid thoughts symptoms scores of individuals with menopausal period and non-menopausal period (t=2.424, p=0.017). The mean of the women's paranoid thoughts symptoms scores with menopausal period was higher than individuals with non- menopausal period.

Table 34.*Correlation between Subscales of Women Sexual Satisfaction Score and Menopausal Symptoms Score*

	Menopausal Symptoms	
Satisfaction	p= 0.117	r=0.158
Communication	p= 0.032	r=0.214**
Frequency	p= 0.053	r=0.194
Avoidance	p= 0.000	r=-0.400*
Sensation	p= 0.009	r=0.259
Vaginismus	p= 0.008	r=0.264
Anorgasmia	p= 0.000	r=0.343

Weak relation (r=0-0.3), Average relation (r=0.3-0.7)*, Strong relation (r=over 0.7)**

There was statistically significant between subscales of women sexual satisfaction score and menopausal symptoms score according to Pearson correlation analysis. There was weak correlation between satisfaction, frequency, sensation, vaginismus and anorgasmia subscales of women sexual satisfaction score and menopausal symptoms score. While these subscales of women sexual satisfaction scores were increased menopausal symptoms were decreased.

Table 36.*Correlation between Subscales of Menopausal Symptoms Score and Menopause*

	Menopause	
Somatization	p= 0.000	r=-0.593*
Psychological Complaints	p= 0.000	r=-0,517*
Urogenital Symptoms	p= 0.000	r=-0.604**

Weak relation (r=0-0.3), Average relation (r=0.3-0.7)*, Strong relation (r=over 0.7)**

There was statistically significant between subscales of women menopausal symptoms score and menopausal period score according to Pearson correlation analysis. There was average weak correlation between somatization and psychological complaints subscales of menopausal symptoms scale score and entering menopausal period. While these subscales of women menopausal symptoms scale scores were increased menopausal symptoms were decreased.

Table 37.*Correlation between Subscales of SCL-R 90 Score and Menopausal Symptoms Score*

	Menopausal Symptoms	
Somatization	p= 0.000	r=-0.480*
Obsessive-Compulsive	p= 0.000	r=-0.347*
Interpersonal Relations	p= 0.000	r=-0.311*
Depression	p= 0.000	r=-0.421*
Anxiety	p= 0.000	r=-0.416*
Hostility	p= 0.000	r=-0.246*
Phobia	p= 0.001	r=-0.326*
Paranoid Thoughts	P=0.016	r=-0.241*
Psychotism	P= 0.000	r=-0.344*

Weak relation (r=0-0.3), Average relation (r=0.3-0.7)*, Strong relation (r=over 0.7) **

There was statistically significant correlation between subscales of SCL-R 90 score and menopausal symptoms score according to Pearson Correlation Analysis. There was negative weak correlation between all subscales of SCL-R 90 score and menopausal symptoms score. While menopausal symptoms scores were increased subscales of SCL-R 90 scores were decreased.

5. DISCUSSION

This work indicates to analyze the effects of menopause on women's mental health and sexual life. In recent years, studies about menopause were increased. There are many social, biological (hormones etc.) and psychological factors affecting menopause. Also, menopause is affecting to sexual satisfaction. Nevertheless the less study was reported about menopause effects on sexual satisfaction. In this research we are discuss the factors of affecting the menopause.

Regular sex life with these changes is less common in women in menopausal period. ''I entered the menopause, but not because of the idea that a reduction in sexual desire'' thought trying to active sex life. This work showed that there are no connection between menopause and sexuality. Menopausal symptoms scores and Anorgasmia subscores have relationship. However, menopausal period women, have painful sexual satisfaction because they tried to prove that they lose their femininity. There is one research support of this work. Dennestein (2005, 174) indicated that, menopausal period women, 71% of European countries are continuing have active sex life and 34% decrease in sexual desire that the present opinion.

Varma (2006, 44) declared that, one of the most common symptoms experienced in menopausal women have found that it is sexual desire. Altınsoy (2004, 19) indicated decreased sexual interest, feel pain and feels dryness during sex. Freedman (2005, 259), examined that sexual dysfunction effects on menopausal symptoms. In a work conducted by Brazier et al., (1998, 206) was determined during menopause occurring bleeding, vaginal dryness. Dennerstein et al., (2001, 98) reported that, aspects of female sexual functioning decline with both age and the

menopausal transition. A decrease in excitability and capacity for orgasm; it may cause vaginal dryness and loss of lubrication. The frequency of sexual activities and libido are decrease mostly in the women with postmenopausal period. Therefore, sexual life is an important in relationship. Some menopausal symptoms especially, vaginal dryness, sexual arousal, orgasm level and sex drive symptoms significantly difference between the participants of entering menopausal period and non-entering menopausal period. However, some research supported this work. Goldstein (2000, 199) examined that, menopausal period is effective on avoidance of sexual activity and sensation on sexual activity. Dennerstein (2001, 55) found that, after the menopause, painful sexually arousal is normal because of this reason women have orgasm disorder.

In this work were substantive differences menopausal symptoms of between entering menopausal period and non-entering menopausal period of women. Menopause is the effects of hormones in women body causes a lot of changes such as hot flashes. In this work was confirmed this hypothesis. Kalarhouid et al.,(2011,138)examined that, the most common symptoms during menopause: depression, anxiety, tension, irritability, restlessness, depressed to remember events more self-dislike, self-esteem and loss of life decrease in enjoyment, lack of concentration, memory problems, difficulty remembering, irritability, crying for no reason, no reason can be listed as like as fear or panic. Gold (2002, 170) ascertained that, a somatic symptom during sleep disorder is very common disorder in the menopausal transition period. The most common sleep-related disorders complaints of difficulty in falling asleep, frequent awakenings, and in falling back asleep the withdrawal difficulties also it is shown that hot flashes to be associated with sleep disorder. Perez et al. (1998, 134) ascertained that, hot flashes is the symptoms are important in women with postmenopausal period. Cawood and Bancroft (1996, 88) ascertained that hot flashes, night sweats, vaginal dryness, and reduced interest in sex were each significantly

correlated with menopausal stage, with post-menopausal women reporting like worst symptomatology. Abraham (2002, 261) showed that also menopausal flushing, changes in blood pressure, the estrogen deficiency depending on vaginal dryness, decreased clitoral stimulation, painful sexual intercourse, itching of genitals, increased appetite and loss of weight. Roberts (2007, 234) stated that urogenital symptoms: such as vaginal dryness, itching and dyspareunia are caused by physiological responses to low concentrations of estrogen and androgens. There are some factors effects on hot flashes such as obesity, alcohol, hot drinks. Hot flashes are the classic symptoms of estrogen deficiency. Ertemür (2009, 126) showed that menopause symptoms of hot flashes is most common symptoms and then, palpitations, headache and changes in bowel function of the symptoms of menopause symptoms such as irritability. Similarly, in our work, the most common symptoms are hot flashes.

This work introduced there were connection between menopause and psychological symptoms. The appearance of these symptoms there is something to be expected. During the menopausal period changes hormones can be effect on psychological symptoms such as somatization, depression, anxiety etc. Gath (1987, 136) not found a significant connection between depression-anxiety subtest between menopause and psychological symptoms. Ballinger (1983, 79) showed there was no relationship any psychiatric table and menopausal symptoms. But there are some studies in the literature presenting opposite results. Rubinow et al.,(2012,128) showed menopausal period of depression, anxiety, fatigue, forgetfulness, self-confidence and the reduction of signs and symptoms, such as decreased libido. Schmidnt (2001, 142) also examined the disorder mood menopause may has a risk factor for patients with a depressive episodes in the past. Terzioğlu (2011, 87) showed that regular menstruation can lead to fertility and femininity is an indication, because of this reason menopause like the loss of the femininity. This situation can

be cause on depression on menopausal period. Swartzmann, Edelberg, and Kemmann (1990,56) rejected this cause assumption when they found that women were not more likely to announce hot flashes following several stressors than they were at the beginning of a session to elicit a stress response. Krononberg (1994, 232) demonstrated that, the mood changes in menopausal vasomotor symptoms or other physical symptoms are secondary symptoms. Hunter (1996, 87) determined that social values can be effective in psychiatric symptoms. This was called cultural differences. Solmuş (2014,110) showed that trying to cope with the symptoms of menopause as a woman in society menopausal / some negative attitudes towards older women also added women 's self-esteem and self - confidence are falling heard that perceptions are affected negatively. Taylor (2016,55) examined that, menopause, women experience a number of emotional problems and mood swings, including anger, in addition to physical changes. In this work also showed that, anger and hostility symptoms and anxiety symptoms were high during menopausal period.

Varma et al., (2005, 82) examined that, women have low menopausal symptoms on surgical menopause. In this study it is also showen that, there are significant differences between menopausal symptoms of natural and surgical menopause. If surgical menopause performed on early age, menopause symptoms may not be appear. And also, menopause symptoms are high in natural menopause because of these active hormones. There are supports to my study/research from another sources

6. CONCLUSION AND RECOMMENDATIONS

Consequently compared many studies about menopause, there presented different results from each other. This study is generally consistent with other studies. Menopause is a natural, but the biological, psychological and psychosocial factors may cause distress to some women in this phase of life. It is important for every health-care professional to understand that these factors are inter-related and sometimes could be the reason for a patient's difficulties. Menopause, viewed as part of aging, intricately relates the biological, cultural, and social aspects of a woman's life. A comprehensive assessment of women in menopause would enable nurses to identify any association between the many inter-relating factors involved in menopause, and thus assist each patient on an individual basis. Also the present studies contribute to available knowledge and broaden the understanding of the sexuality. Sexuality is an important part of other physical and emotional health. But there are women who find that their sex lives have become unsatisfying at menopause and are very unhappy about this. Female body image of menopause will disappear together, to hear the concerns of female function will end. Women who think that lose having sexual attractiveness of female sexuality with menopause. Menopause can be affect a woman's sexual life, physical and anatomical changes and also by psycgological symptoms.

This study can say some suggestions for clinicians. Clinicians should examine to giving women the opportunity to talk about menopausal symptoms and sexual problems are a fundamental part of health care and may improve their quality of life.

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Appendix 1

BÖLÜM 1.

Sosyo-demografik Bilgi Formu

Yaşınız: _____ **Şu an yaşadığınız yer:**_____

Medeni Durumunuz: _____ (evli, bekar, boşanmış, dul)

Mesleğiniz: _____

Çocuğunuz var mı? Var ( ) Yok ( ) Var ise sayısı: _____

Eğitim Durumunuz:

Okuma yazma bilmiyor ( ) Okuma yazma biliyor ( )

İlkokul mezunu ( ) Ortaokul mezunu ( )

Lise mezunu ( ) Üniversite mezunu( )

Yüksek lisans/Doktora ( )

Kiminle yaşıyorsunuz? Yalnız ( ) Ailesiyle ( ) Diğer ( )

Herhangi bir fiziksel hastalığınız var mı?

Evet (belirtiniz:_____) Hayır ( )

Varsa, bunun için şu an bir tedavi görüyor musunuz?

Evet (belirtiniz:_____) Hayır ( )

Herhangi bir psikiyatrik rahatsızlığınız var mı?

Evet (belirtiniz:_____) Hayır ( )

Varsa, bunun için şu anda bir ilaç kullanıyor musunuz?

Evet (belirtiniz:_____) Hayır ( )

Herhangi bir madde kullanımınız var mı ? (Alkol,Sigara

Evet (belirtiniz:_____) Hayır ( )

Menopoz dönemine girdiniz mi ?

Evet (belirtiniz)_____) Hayır( )

Kaç yaşında menopoza girdiniz ?

a) 35 b) belirtiniz_____

Menopoz ile ilgili herhangi bir ilaç kullandınız mı ?

Evet ( ) Hayır ( )

Doğal yollarla mı menopoza girdiniz ?

Evet ( ) Hayır (belirtiniz) _____

Ailenizde (anne, kardeş, teyze, hala.vb) 40 yaşından önce adetten kesilen bir kişi var mı?

Evet ( ) Hayır ( )

Menopoz döneminde hormon kullandınız mı?

Evet ( ) _____(ay/yıl) Hayır ( )

Son 6 ay içinde sizi etkileyen yaşam olayı var mı ?

Evet ( ) Hayır ( )

Appendix 2

BÖLÜM 2.

Psikolojik Belirti Tarama Listesi (SCL-90-R)

AÇIKLAMA: Aşağıda zaman zaman herkeste olabilecek yakınmaların ve sorunların bir listesi vardır. Lütfen her birini dikkatle okuyunuz. Sonra bu durumun bugün de dahil olmak üzere son üç ay içerisinde sizi ne ölçüde huzursuz ve tedirgin ettiğini gösterilen şekilde numaralandırarak işaretleyiniz.

Hiç: **0**

Çok az : **1**

Orta derecede: **2**

Oldukça fazla: **3**

İleri derecede: **4**

1. ( ) Baş ağrısı
2. ( ) Sinirlilik ya da içinizin titremesi
3. ( ) Zihinden atamadığınız tekrarlayan,hoşa gitmeyen düşünceler
4. ( ) Baygınlık ya da baş dönmesi
5. ( ) Cinsel arzu ve ilginin kaybı
6. ( )Başkaları tarafından eleştirilme duygusu
7. ( ) Herhangi bir kimsenin düşüncelerinizi kontrol edebileceği fikri
8. ( )Sorunlarınızdan pek çoğu için başkalarının suçlanması gerektiği duygusu
9. ( ) Olayları anımsamada güçlük.
10. ( ) Dikkatsizlik ya da sakarlıkla ilgili düşünceler

11.( ) Kolayca gücenme,rahatsız olma hissi

12.( )Göğüs ya da kalp bölgesinde ağrılar

13.( ) Caddelerde veya açık alanlarda korku hissi

14.( )Enerjinizde azalma veya yavaşlama hali

15.( ) Yaşamınızın sonlanması düşünceleri

16.( ) Başka kişilerin duymadıkları sesleri duyma

17.( ) Titreme

18.( ) Çoğu kişiye güvenilmemesi gerektiği hissi

19.( ) İştah azalması

20.( ) Kolayca ağlama

21.( ) Karşı cinsten kişilerle utangaçlık ve rahatsızlık hissi

22.( ) Tuzağa düşürülmüş ve ya yakalanmış olma hissi

23.( ) Bir neden olmaksızın aniden korkuya kapılma hissi

24.( ) Kontrol edilmeyen öfke patlamaları

25.( ) Evden dışarı yalnız çıkma korkusu

26.( ) Olanlar için kendisini suçlama

27.( )Belin alt kısmında ağrılar

28.( )İşlerin yapılmasında erteleme duygusu

29.( ) Yalnızlık hissi

30.( ) Karamsarlık hissi

31.( ) Her şey için çok fazla endişe duyma

32.( ) Her şeye karşı ilgisizlik hali

33.( ) Korku hissi

34.( )Duygularınızın kolayca incitilebilmesi hali

35.( )Diğer insanların sizin özel düşüncelerinizi bilmesi

36.( )Başkalarının sizi anlamadığı veya hissedemeyeceği duygusu

37.( )Başkalarının sizi sevmediği ya da dostça olmayan davranışlar gösterdiği hissi

38.( ) İşlerin doğru yapıldığından emin olmak için çok yavaş yapmak

39.( ) Kalbin çok hızlı çarpması

40.( ) Bulantı ve midede rahatsızlık hissi

41.( ) Kendini başkalarından aşağı görme

42.( ) Adale(kas) ağrıları

43.( ) Başkalarının sizi gözlediği ve ya hakkınızda konuştuğu hissi

44.( ) Uykuya dalmada güçlük

45.( ) Yaptığınız işleri bir ya da birkaç kez kontrol etme

46.( )Karar vermede güçlük

47.( ) Otobüs, tren,metro gibi araçlarla yolculuk etme korkusu

48.( )Nefes almada güçlük

49.( )Soğuk ve ya sıcak basması

50.( )Sizi korkutan belirli uğraş,yer ve ya nesnelerden kaçınma durumu

51.( )Hiçbir şey düşünmeme hali

52.( )Bedeninizin bazı kısımlarında uyuşma, karıncalanma olması

53. ( ) Boğazınıza bir yumru takınmış hissi

54.( ) Gelecek konusunda ümitsizlik

55.( )Düşüncelerinizi bir konuya yoğunlaştırmada güçlük

56.( )Bedeninizin çeşitli kısımlarında zayıflık hissi

57.( )Gerginlik ve ya coşku hissi

58.( ) Kol ve bacaklarda ağırlık hissi

59.( )Ölüm ya da ölme düşünceleri

60.( )Aşırı yemek yeme

61.( )İnsanlar size baktığı ve ya hakkınızda konuştuğu zaman rahatsızlık duyma

62.( )Size ait olmayan düşüncelere sahip olma

63.( )Bir başkasına vurmak, zarar vermek,yaralamak dürtülerinin olması

64.( )Sabahın erken saatlerinde uyanma

65.( )Yıkanma, sayma, dokunma gibi bazı hareketleri yineleme hali

66.( )Uykuda huzursuzluk, rahat uyuyamama

67.( )Bazı şeyleri kırıp dökme hissi

68.( )Başkalarının paylaşıp kabul etmediği inanç ve düşüncelerin olması

69.( )Başkalarının yanında kendini çok sıkılgan hissetme

70.( )Çarşı, sinema gibi kalabalık yerlerde rahatsızlık hissi

71.( ) Her şeyin bir yük gibi görünmesi

72.( )Dehşet ve panik nöbetleri

73.( )Toplum içinde yer , içerken huzursuzluk hissi

74.( )Sık sık tartışmaya girme

75.( )Yalnız bırakıldığınızda sinirlilik hali

76.( )Başkalarının sizi başarılarınız için yeterince takdir etmediği duygusu

77.( )Başkalarıyla birlikte olunan durumlarda bile yalnızlık hissetme

78.( )Yerinizde duramayacak ölçüde rahatsızlık hissetme

79.( )Değersizlik duygusu

80.( )Size kötü bir şey olacakmış hissi

81.( )Bağırma ya da eşyaları fırlatma

82.( )Topluluk içinde bayılacağınız korkusu

83.( )Eğer izin verirseniz insanların sizi sömüreceği korkusu

84.( )Cinsiyet konusunda sizi çok rahatsız eden düşüncelerin olması

85.( )Günahlarınızdan dolayı cezalandırılmanız gerektiği düşüncesi

86.( )Korkutucu türden düşünce ve hayaller

87.( )Bedeninizde ciddi bir rahatsızlık olduğu düşüncesi

88.( )Başka bir kişiye karşı asla yakınlık duymama

89.( )Suçluluk duygusu

90.( )Aklınızda bir bozukluğun olduğu düşüncesi

Appendix 3

BÖLÜM 3.

Golombok-Rust Cinsel Doyum Ölçeği- Kadın Formu

Aşağıda cinsel yaşamla ilgili sorular yer almaktadır. Her soru için "hiçbir zaman", "nadiren", "bazen", "çoğu zaman", "her zaman" şeklinde beş cevap şıkkı yer almaktadır. Sizden istenen kendi cinsel yaşamınızı göz önünde bulundurarak soruları cevaplamanızdır. Cevaplandırırken;

1. Her soruyu dikkatle okuyunuz.
2. Soruları durumun son zamanlarda ne kadar sıklıkla ortaya çıktığını düşünerek cevaplayınız.
3. Söz konusu durumun ne kadar sıklıkla ortaya çıktığına karar verdikten sonra ilgili sorunun size uyan seçeneğini "X" işareti koyarak belirtiniz.

		Hiçbir zaman	Nadiren	Bazen	Çoğu zaman	Her zaman
1	Cinsel yaşama karşı ilgisizlik duyar mısınız?					
2	Eşinize, cinsel ilişkinizle ilgili nelerden hoşlanıp, nelerden hoşlanmadığını sorar mısınız?					
3	Bir hafta boyunca cinsel ilişkide bulunmadığınız olur mu? (Adet günleri, hastalık gibi nedenler dışında)					
4	Cinsel yönden kolaylıkla uyarılır mısınız?					
5	Sizce, sizin ve eşinizin ön sevişmeye (öpme, okşama vb.) ayırdığınız zaman yeterli mi?					
6	Kendi cinsel organınızın eşinizin cinsel organının giremeyeceği kadar dar olduğunu düşünür müsünüz?					
7	Eşinizle sevişmekten kaçınır mısınız?					
8	Cinsel ilişki sırasında doyuma (orgazma) ulaşır mısınız?					
9	Eşinize sarılıp, vücudunu okşamaktan zevk alır mısınız?					
10	Eşinizle olan cinsel ilişkinizi tatminkâr buluyor musunuz?					
11	Gerekirse rahatsızlık ve acı duymaksızın, parmağınızı cinsel organınızın içine sokabilir misiniz?					

		Hiçbir zaman	Nadiren	Bazen	Çoğu zaman	Her zaman
12	Eşinizin cinsel organına dokunup okşamaktan rahatsız olur musunuz?					
13	Eşiniz sizinle sevişmek istediğinde rahatsız olur musunuz?					
14	Sizin için doyuma (orgazm) ulaşmanın mümkün olmadığını düşünür müsünüz?					
15	Haftada iki defadan fazla cinsel birleşmede bulunur musunuz?					
16	Esinize cinsel ilişkinizle ilgili olarak nelerden hoşlanıp nelerden hoşlanmadığınızı söyleyebilir misiniz?					
17	Esinizin cinsel organı, sizin cinsel organınıza rahatsızlık vermeden girebilir mi?					
18	Eşinizle olan cinsel ilişkinizde sevgi ve şefkatin eksik olduğunu hisseder misiniz?					
19	Eşinizin cinsel organınıza dokunup okşamasından zevk alır mısınız?					
20	Eşinizle sevişmeyi reddettiğiniz olur mu?					
21	Ön sevişme sırasında esiniz klitorisinizi uyardığında doyuma (orgazma) ulaşabilir misiniz?					
22	Sevişme boyunca sadece cinsel birleşme için ayrılan süre sizin için yeterli mi?					
23	Sevişme sırasında yaptıklarınızdan tiksinti duyar mısınız?					
24	Kendi cinsel organınızın, esinizin cinsel organının derine girmesini engelleyecek kadar dar olduğunu düşünür müsünüz?					
25	Eşinizin sizi sevip okşamasından hoşlanır mısınız?					
26	Sevişme sırasında cinsel organınızda ıslaklık olur mu?					
27	Cinsel birleşme anından hoşlanır mısınız?					
28	Cinsel birleşme anında doyuma (orgazma) ulaşır mısınız?					

Appendix 4

Bölüm 4

Menopoz Semptomları Değerlendirme Ölçeği

MENOPOZ SEMPTOMLARINI DEĞERLENDİRME ÖLÇEĞİ (MRS)

Sevgili hanımlar. Menopoz semptomlarını değerlendirme ölçeğimizde belirtilen yakınmalarından yaşadıklarınız varsa lütfen bu yakınmaları ne düzeyde yaşadığınızı ölçeğimiz üzerinde işaretleyiniz. Şikayetinizin olmadığı yakınmalar için "hiç yok" seçeneğini işaretleyiniz.

YAKINMALAR:	Hiç yok	Hafif	Orta	Şiddetli	Çok şiddetli
Puanlar =	0	1	2	3	4
1. Sıcak basması, terlemeler (Terleme nöbetleri)	☐	☐	☐	☐	☐
2. Kalp rahatsızlıkları (Normalde hissetmediğiniz şekilde kalpte sıkışma, tekleme, çarpıntı hissi)	☐	☐	☐	☐	☐
3. Uyku sorunları (Uykuya dalmada güçlük, uzun süre uyuyamama, erken uyanma)	☐	☐	☐	☐	☐
4. Keyifsizlik hali (Kendini kötü, üzgün, ağlamaklı hissetme, isteksizlik, ruh halinde değişiklik)	☐	☐	☐	☐	☐
5. Sinirlilik (Sinirliklik, gerginlik ve çabuk öfkelenme hissi)	☐	☐	☐	☐	☐
6. Endişe (İçsel huzursuzluk, panik hissi)	☐	☐	☐	☐	☐
7. Fiziksel ve zihinsel yorgunluk (Gün içinde yaptığı işlerde azalma, hafızada zayıflama, konsantrasyon zorluğu, unutkanlık))	☐	☐	☐	☐	☐
8. Cinsel sorunlar (Cinsel istekte, cinsel ilişkide ve tatmin olmada değişiklik)	☐	☐	☐	☐	☐
9. İdrar sorunları (İdrar yaparken güçlük, sık idrara çıkma, idrar kaçırma)	☐	☐	☐	☐	☐
10. Vajinada (haznede) kuruluk (Vajinada kuruluk ve yanma hissi, cinsel birleşmede zorlanma)	☐	☐	☐	☐	☐
11. Eklem ve kas rahatsızlıkları (Eklemlerde ağrı, romatizmal şikayetler)	☐	☐	☐	☐	☐

Appendix 5

ARIZONA CİNSEL YAŞANTILAR ÖLÇEĞİ

KADIN FORMU

Lütfen her madde için BUGÜN de dahil olmak üzere GEÇEN HAFTAKİ durumunuzu isaretleyiniz.

1. Cinsel açıdan ne kadar isteklisiniz?

1	2	3	4	5	6
Oldukça İstekli	Çok İstekli	Biraz İstekli	Biraz İsteksiz	Çok İsteksiz	Tamamen İsteksiz

2. Cinsel açıdan ne kadar kolay uyarılırsınız (tahrik olursunuz)?

1	2	3	4	5	6
Oldukça Kolay	Çok Kolay	Biraz Kolay	Biraz Zor	Çok Zor	Oldukça Zor

3. Cinsel organınız ilişki sırasında ne kadar kolay ıslanır veya nemlenir ?

1	2	3	4	5	6
Oldukça Kolay	Çok Kolay	Biraz Kolay	Biraz Zor	Çok Zor	Asla

4. Ne kadar kolay orgazm olursunuz ?

1	2	3	4	5	6
Oldukça kolay	Çok Kolay	Biraz Kolay	Biraz Zor	Çok Zor	Asla Boşalamam

5. Orgazmınız tatmin edici midir ?

1	2	3	4	5	6
Oldukça Tatmin Edici	Çok Tatmin Edici	Biraz Tatmin Edici	Çok Tatmin Etmiyor	Pek Tatmin Etmiyor	Orgazma Ulaşamam

Appendix 6

ARAŞTIRMA AMAÇLI ÇALIŞMA İÇİN AYDINLATILMIŞ ONAM FORMU

Menopozun Kadınların Ruh Sağlığına ve Cinsel Yaşamlarına Etkisinin İncelenmesi ile ilgili yeni bir araştırma yapmaktayız. Araştırmanın ismi "Menopozun Ruh Sağlığına ve Kadınların Cinsel Yaşamlarına Etkisinin İncelenmesi dir.

Sizin de bu araştırmaya katılmanızı öneriyoruz. Bu araştırmaya katılıp katılmamakta serbestsiniz. Çalışmaya katılım gönüllülük esasına dayalıdır. Kararınızdan önce araştırma hakkında sizi bilgilendirmek istiyoruz. Bu bilgileri okuyup anladıktan sonra araştırmaya katılmak isterseniz formu imzalayınız.

Bu araştırmayı yapmak istememizin nedeni, Menopozun Ruh Sağlığına ve Kadınların Cinsel Yaşamlarına Etkisinin incelenmesidir. Yakın Doğu Üniversitesi Psikoloji Anabilim Dalı Uygulamalı Klinik Psikoloji Yüksek Lisans ortak katılımı ile gerçekleştirilecek bu çalışmaya katılımınız araştırmanın başarısı için önemlidir.

Eğer araştırmaya katılmayı kabul ederseniz. Araştırmaya katılacak olan katılımcılarda aranacak olan özellikler, Türkiye Cumhuriyeti, Antalya ilinde yaşıyor olmaları, 45-60 yaş arası kadınların ve ana dillerinin Türkçe olması gerekmektedir. Bu araştırma toplamda üç ölçek kullanılacaktır. Bu ölçekler Sosyodemografik Bilgi Formu, Menopoz Semptomları Değerlendirme Ölçeği,Belirti Taram Listesi (SCL-90) ve Golombok-Rust Cinsel Doyum Ölçeğidir.

Bu çalışmaya katılmanız için sizden herhangi bir ücret istenmeyecektir. Çalışmaya katıldığınız için size ek bir ödeme de yapılmayacaktır.

Sizinle ilgili tıbbi bilgiler gizli tutulacak, ancak çalışmanın kalitesini denetleyen görevliler, etik kurullar ya da resmi makamlarca gereği halinde incelenebilecektir.

Bu çalışmaya katılmayı reddedebilirsiniz. Bu araştırmaya katılmak tamamen isteğe bağlıdır ve çalışmanın herhangi bir aşamasında onayınızı çekmek hakkına da sahipsiniz.

Appendix 7

(Katılımcının / Hastanın Beyanı)

Sayın Psikolog Seren Akman tarafından Psikoloji Anabilim Dalı Uygulamalı Klinik Psikoloji Yüksek Lisans Anabilim Dalları'nda 'Menopozun Ruh Sağlığına ve Kadınların Cinsel Yaşamlarına Etkisinin İncelenmesi'konusunda bir araştırma yapılacağı belirtilerek bu araştırma ile ilgili yukarıdaki bilgiler bana aktarıldı. Bu bilgilerden sonra böyle bir araştırmaya "katılımcı" olarak davet edildim.

Eğer bu araştırmaya katılırsam araştırmacı ile aramda kalması gereken bana ait bilgilerin gizliliğine bu araştırma sırasında da büyük özen ve saygı ile yaklaşılacağına inanıyorum. Araştırma sonuçlarının eğitim ve bilimsel amaçlarla kullanımı sırasında kişisel bilgilerimin ihtimamla korunacağı konusunda bana yeterli güven verildi.

Projenin yürütülmesi sırasında herhangi bir sebep göstermeden araştırmadan çekilebilirim. (Ancak araştırmacıları zor durumda bırakmamak için araştırmadan çekileceğimi önceden bildirmemim uygun olacağının bilincindeyim).

Araştırma için yapılacak harcamalarla ilgili herhangi bir parasal sorumluluk altına girmiyorum. Bana da bir ödeme yapılmayacaktır.

Bu araştırmaya katılmak zorunda değilim ve katılmayabilirim. Araştırmaya katılmam konusunda zorlayıcı bir davranışla karşılaşmış değilim.

Bana yapılan tüm açıklamaları ayrıntılarıyla anlamış bulunmaktayım. Adı geçen bu araştırma projesinde "katılımcı" olarak yer alma kararını aldım. Bu konuda yapılan daveti büyük bir memnuniyet ve gönüllülük içerisinde kabul ediyorum.

Bu konuda ek bilgi alma ihtiyacım olursa 2236464 (iç hat 254) telefon numarasından Yakın Doğu Üniversitesi Psikoloji Bölüm Başkanlığına ulaşabileceğim bilgisi bana verilmiştir.

İmzalı bu form kâğıdının bir kopyası bana verilecektir.

Katılımcı

Adı, soyadı:

Adres:

Tel.

İmza:

Appendix 8

BİLGİLENDİRME FORMU:

Bu çalışma Yakın Doğu Üniversitesi Klinik Psikoloji Yüksek Lisans Öğrencisi Psk. Seren Akman tarafından Prof. Dr. Mehmet Çakıcı danışmanlığında yürütülen bir tez çalışmasıdır. Bu tez çalışması, Menopozun Ruh Sağlığına ve Kadınların Cinsel Yaşamlarına Etkisini incelemeyi amaçlamaktadır.

Daha önce de belirtildiği gibi size ait bilgiler kesinlikle gizli tutulacaktır ve elde edilen bilgiler sadece bilimsel araştırma ve yazılarda kullanılacaktır. Çalışmanın sonuçlarını öğrenmek ya da bu araştırma hakkında daha fazla bilgi almak için aşağıdaki iletişim bilgilerinden araştırmacıya ulaşabilmeniz mümkündür. Bu araştırmaya katıldığınız için teşekkür ederiz.

Psk. Seren Akman

Klinik Psikolojisi Yüksek Lisans Programı Öğrencisi,

Yakın Doğu Üniversitesi

Lefkoşa

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Appendix 9

CURRICULUM VITAE

1. PERSONAL INFORMATION

NAME, SURNAME: **DATE OF BIRTH, PLACE:**	Seren Akman 04.11.1990, Antalya
JOB: **TELEPHONE:** **E-MAIL:**	Psychologist 0 533 823 19 56 seren_akman@hotmail.com

2. EDUCATION

YEAR	DEGREE	UNIVERSITY	EDUCATION AREA
2009-2013	3.00	Eastern Mediternean University	Psychology (undergraduate)
2013-		Near East University	Applied (Clinical) Psychology. (Postgraduate).

3. PROFESSIONAL EXPERIENCE

PERIOD OF DUTY	TITLE	FIELD	PLACE of WORK
2014-2015	Intern Clinical Psychologist	Clinical Psychology	Akdeniz Üniversitesi Hastanesi
2014-2015	Intern Clinical Psychologist	Clinical Psychology	SATED Therapium

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"Proceedings of the 16th Annual Congress of the European Society for Sexual Medicine and the 12th Congress of the European Sexology Federation, Istanbul, Turkey, January 29-February 1, 2014 : Podium Sessions - ESSM", Journal of Sexual Medicine, 2014.

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