Saúde e Pesquisa
DOI: 10.17765/2176-9206.2022v15n2.e10364

Symptoms and understandings of women in menopause in a metropolitan area of brazilian northeast: a quanti-qualitative study

Sintomas e compreensões de mulheres na menopausa em área metropolitana do Nordeste brasileiro: estudo quantiqualitativo

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ABSTRACT
Objective: To evaluate what women feel and how they understand the menopause period in a metropolitan area of the Brazilian Northeast. Method: A mixed study with 417 women aged 40 to 60 years that used a script of socioeconomic, gynecological/obstetrical, morbidity, medication, and sexuality questions, as well as the Female Sexual Function Index and Menopause Rating Scales. Results: Menopause, observed in 56.6% of women with a mean age of 50.4±5.7 years, had severe associated symptoms (shortness of breath, sweat, heat and anxiety); 52.5% had doubts or lack of knowledge about menopause, and 44.6%, reduction in sexual function, which correlated negatively with age (r= -0.208; p<0.001). Sexual dysfunction is almost twice as high in menopausal women as in premenopausal women (OR=1.81; p=0.036). Conclusion: The sexuality of women with sexual issues or dysfunctions due to menopause may be permeated by emotional and psychological inhibitions.

Keywords: Menopause. Sexuality. Hot flashes. Women's health.

RESUMO
Objetivo: Avaliar como as mulheres em área metropolitana do Nordeste brasileiro sentem e compreendem a menopausa. Método: Estudo misto, com 417 mulheres de 40 a 60 anos no qual se utilizou um roteiro de questões socioeconômicas, ginecológicas/obstétricas, morbidades, medicações e sexualidade, além do *Female Sexual Function Index* e *Menopause Rating Scale*. Resultados: A menopausa, constatada em 56,6% das mulheres com média de idade de 50,4±5,7 anos, teve sintomatologia associada severa (falta de ar, suor, calor e ansiedade); 52,5% apresentaram dúvidas ou falta de conhecimento sobre a menopausa, e 44,6%, redução na função sexual, que se correlacionou negativamente com a idade (r= -0,208; p<0,001). A disfunção sexual é quase duas vezes maior nas mulheres em menopausa do que naquelas em pré-menopausa (OR=1,81; p=0,036). Conclusão: A sexualidade das mulheres com dificuldades ou disfunções sexuais por causa da menopausa pode estar permeada por inibições emocionais e psicológicas.

Palavras-chave: Menopausa. Sexualidade. Fogachos. Saúde da mulher.

Received in September 23, 2020
Accepted on January 28, 2021

INTRODUCTION

Female aging is a period marked by the mismatch and conflicts between the timeless unconscious and the body in the context of temporality[1]. In this process, menopause is characterized by the definitive interruption of menstrual cycles due to hypoestrogenism. It is often accompanied by physical and psychosocial signs and symptoms that need control and evaluation to ensure the quality of life during female aging[2].

Female sexual function is the product of overlapping of the desire phases: arousal, orgasm, and resolution, being associated with multiple biological, psychological, sociocultural, economic, and interpersonal factors. To that end, menopausal hormonal changes can influence interpersonal relationships and female well-being[3].

Menopause begins earlier in Latin American women (43.8 to 53 years), and its clinical manifestations are perceived and understood differently, according to the subjectivity of each person[4,5]. With this and other findings in mind, the clinical assessment of the intensity of menopausal symptoms has been the subject of study in several countries[5, 6].

With the increase in the life expectancy of the world's population, women experience menopause and onwards for longer, thus becoming relevant to evaluate and monitor the symptoms, signs, and understandings of climacteric women in the women's health and care service spaces. Because of this importance, the Family Health Units (FHU) of the Brazilian Public Health System included programs and reference Centers for women's health through the incorporation of public policies[7] since it understands that the process of evolution/transition occurs from the conception of maternal-child care to an understanding of integral care[8], including care for the climacteric woman.

From this perspective, integral care makes it possible to understand menopausal women in a clinical and preventive approach through the action of the multiprofessional team to identify care and outline preventive actions, self-care, and thus promote health to alleviate/minimize possible discomforts and aggravations. Therefore, health promotion assistance to women must be focused on care in all life cycles to meet their basic health needs and promote quality of life[9, 10].

Current population-based studies on menopause have focused on symptoms and repercussions of the symptomatology in a quantitative way[11,12] or the association between this event, comorbidities, and/or quality of life[13,14]. However, broadening the analytical horizon on the multidimensional aspects of aging women and their associations, as well as the resignifications

established in menopause, can help in the reflection and analysis of the experience of women in this transition between the reproductive and non-reproductive period of women's life, considering a comprehensive attention[8].

Given the above, this study aimed to quantifiably evaluate what women feel and how they understand menopause in the metropolitan area of Northeast Brazil.

METHOD

It is a study with a mixed (quanti-qualitative), cross-sectional, population-based approach, with women aged 40 to 60 years, treated in Women's Health Reference Units in the city of Aracaju, State of Sergipe (SE), Brazil.

The Human Development Index of Aracaju is 0.770, and the population is 571,149 inhabitants, of which 97,463 are women aged between 40 and 60 years[15]. The Primary Care Network consists of 43 Family Health Units, of which the units Dona Sinhazinha, Francisco Fonseca, and Carlos Fernandes are references in women's health, therefore chosen for this study[16].

The study population was composed of 8,497 women between 40 and 60 years of age registered in these reference units and eligible by the inclusion criteria described below.

Using the Barbetta method[17], adopting a 5% sample error, the sample size was defined in 382 registered women, adding 10% as a safety margin, totaling 420 women. Then, the sample was distributed proportionally by the three reference units according to the number of women registered in each, with FHU Dona Sinhazinha 16% of the total number of registrations; FHU Carlos Fernandes, 29%; and FHU Francisco Fonseca, 55%. However, after the start of data collection, five dropouts and two increases for interest in participating in the research were recorded, finishing the sample in 417 women, distributed as follows: FHU Dona Sinhazinha, 67 women; FHU Carlos Fernandes, 121; and FHU Francisco Fonseca, 229.

The study included women who lived in the coverage area and/or were referred to Family Health Units. Based on medical records, it also excluded those with psychiatric disorders and/or physiological conditions that limited communication capacity.

Data collection occurred according to the schedule of gynecological/obstetric visits in Family Health Units between March and November 2017. The eligible women, waiting for medical attention, were invited to participate in the survey, which took place individually, with a duration of approximately 60 minutes, in the obstetric gynecological office, behind closed doors, to feel comfortable answering the questions of the questionnaire.

The interview script, composed of 50 mixed questions, focused on: sociodemographic and behavioral aspects (smoking, alcoholism, etc.), gynecological/obstetric data, history of morbidities, medication use, sexuality (sexual life, perceptions, and attitudes/behaviors towards menopause). This script was previously validated by 12 independent evaluators, according to the criteria of relevance, clarity, objectivity, accuracy, vocabulary, and comprehensiveness (expertise method)[18].

Initially, the study conducted the recorded interviews; and only then did the women respond to instruments assessing sexual function and evaluating menopausal symptoms. The Female Sexual Function Index (FSFI) is an instrument that evaluates the dimensions-key to female sexual function in the last four weeks. FSFI informs about domains of sexual response: desire, arousal, lubrication, orgasm, satisfaction, and pain[19]. Individual scores are obtained by the sum of the items comprising each domain (simple score), which are multiplied by the factor of that domain and provide the weighted score. The final score (between 2 and 36) is obtained by summing the weighted scores of all domains.

O Menopause Rating Scales (MRS) is a validated instrument[20] composed of 11 questions distributed in three dimensions related to the severity of symptoms (somatovegetative, psychological and urogenital). Each symptom can be classified into the following grades: 0 – none/scarce; 1 – mild; 2 – moderate; 3 – severe; and 4 – very severe. The score by dimension is obtained through the sum of these symptoms, and the general classification corresponds to the total sum of the scores of the dimensions: none/scarce (0-4), mild (5-8), moderate (9-15), severe (> 16).

The study used descriptive statistics to characterize the quantitative data; the Mann-Whitney test to verify the differences between medians (two samples), and analysis of variance (Tukey's or Duncan's *post hoc* tests) (multiple comparisons). It used Pearson's linear correlation[21] and the odds ratio for the presence of menopause and sexual dysfunction to evaluate the association between variables. In all analyses, the study adopted Alpha equal to 5% and the software R Core Team 2017 and Statistica 7.1 (stat Soft Inc.).

For qualitative analysis of discursive responses, the study used the webQDA software (https://www.webqda.net). The procedures for content analysis, which only one interviewer processed, were: 1) literal transcription of the interviews; 2) vertical analysis: selection of the excerpts of each narrative that contained the main ideas of the themes explored and their categorization; 3) horizontal analysis: regrouping of the repeated ideas in the themes, forming the categories, which enabled the frequency analysis. Thus, it was

possible to interconnect the information of the discourses related to the symptoms and understanding of menopause[22]. The speeches were identified as E1, E2, and so on to ensure anonymity.

Each participant, previously and voluntarily, signed the term of free and informed consent, being guaranteed anonymity and freedom to withdraw consent at any time. The research was approved by the Research Ethics Committee of Tiradentes University, with approval Opinion No. 1,813,269, CAAE 58431716.7.0000.5371.

RESULTS

Four hundred and seventeen women with a mean age of 50.4±5.7 years participated in the study, of which 236 (56.6%) were menopausal. The mean age of women in pre-menopause and menopausal women had significant differences (MW; Z = 12.71; $p < 0.001$).

In both groups (menopausal and premenopausal), 281 (67.4%) women claimed to be responsible for the financial support of their homes. Women who had marital and consanguineous relationships were the most financially dependent. A total of 216 women users of these Family Health Units, references in women's health, had only incomplete/complete elementary education (51,8%); 153 (36,7%), incomplete/complete high school, while only 23 (5.5%) had higher education level. Concerning financial income, the majority of women (269; 64%) claimed to have an average monthly income equal to or less than a minimum wage[*].

According to the MRS classification, 90.4% of the women presented symptoms, distributed in 233 (55.9%) severe, 107 (25.6%) moderate, and 37 (8.9%) mild. However, 40 (9.6%) women were asymptomatic or with poor symptoms. Among the climacteric symptoms, there was high severity related to shortness of breath, sweats, and heat (somatovegetative), and anxiety (psychological) — all of these standing out regarding the other severe/very severe symptoms (Table 1).

[*] Reference minimum wage (2017): R$937.00, or approximately US$282.83

Table 1. Occurrence and degree of intensity of symptoms related to menopause, according to their intensity in women of the FHUs Reference in Women's Health of Aracaju, Sergipe, 2017, according to the Menopause Rating Scales – MRS

		Degree of intensity*				
	Symptom	None/ Scarce n (%)	Mild n (%)	Moderate n (%)	Severe n (%)	Very Severe n (%)
Dimension of Somatovegetative Symptoms	Shortness of breath, sweats, heat	119 (28.5)	34 (8.2)	86 (20.6)	45 (10.8)	133 (31.9)
	Cardiac malaise	189 (45.3)	45 (10.8)	103 (24.7)	37 (8.9)	43 (10.3)
	Sleep problems	155 (37.2)	36 (8.6)	64 (15.3)	50 (12.0)	112 (26.9)
	Muscle and joint problems	140 (33.6)	40 (9.6)	65 (15.6)	67 (16.1)	105 (25.2)
Dimension of Psychological Symptoms	Depressive mood	156 (37.4)	52 (12.5)	80 (19.2)	53 (12.7)	76 (18.2)
	Irritability	103 (24.7)	47 (11.3)	93 (22.3)	71 (17.0)	103 (24.7)
	Anxiety	77 (18.5)	64 (15.3)	68 (16.3)	83 (19.9)	125 (30.0)
	Physical and mental exhaustion	129 (30.9)	61 (14.6)	80 (19.2)	62 (14.9)	85 (20.4)
Dimension of Urogenital Symptoms	Sexual problems	191 (45.8)	43 (10.3)	62 (14.9)	44 (10.6)	77 (18.5)
	Bladder problems	322 (77.2)	33 (7.9)	24 (5.8)	19 (4.6)	19 (4.6)
	Vaginal dryness	229 (54.9)	51 (12.2)	57 (13.7)	20 (4.8)	60 (14.4)

* According to the subscales of the MRS dimensions classification

The testimonies of the women culminated in the following terms related to conceptions and understandings about menopause: associations of menopause (hot flashes, clinical, psychological, and sexual manifestations, old age); doubts; ovarian aging; negative/positive assessments; hysterectomy. The most frequent units of meaning, reported by 384 women (80.2%), were related to the hot flashes: heat, sweat, cold, and fire. The study observed a panorama of doubts and/or lack of knowledge about menopause in a group of 212 women (52.5%), while only 20 (5%) reflected a positive assessment, such as: *It's good because you no longer menstruate* (E25); *It increases sexual desire* (E69); *It has not changed sexual desire* (E215) (Table 1).

Chart 1. Ideas and conceptions about menopause verbalized by the participants of the research in the FHUs Reference in Women's Health of Aracaju, Sergipe, 2017

Theme	Contents	Frequency n (%)*
Menopause is associated with hot flashes	Heat; cold; sweat; fire	324 (80.2)
Expressions of doubt about menopause; If she is menopausal; Lack of knowledge	I think; what is menopause? She doesn't understand anything; she doesn't know what it is She does not know whether or not she is in menopause period	212 (52.5)
Ovarian aging	End of menstruation; decreased menstruation; irregular menstruation; end of reproductive life; end of ovulation; loss of fertility; early menopause	147 (36.4)
Menopause is associated with clinical manifestations; Muscle, joint and sleep problems	Headaches; inflammation; nausea; intoxication; itching; malaise; various symptoms; dry skin; sinuses pain; colic, vaginal dryness; leg pain; bone pain; body pain; cramping; joint pain; decreased calcium; muscle pain; loss of ability; dizziness, shortness of breath, tachycardia Insomnia or drowsiness	102 (25.2)
Menopause is associated with psychological changes	Physical and mental exhaustion; nervousness; impatience; irritability; anxiety; stress; depression; bad mood; feeling of sadness; anguish; mental problems; aggressiveness; phobia; worry	91 (22.5)
Negative valuation	Disease; horrible; scary; bad, causes disorders; annoying; nauseous; strange; a loss; discomfort; causes health problems, the woman becomes fragile; worse thing; difficult; traumatic; sad; seven-headed bug; total weakening; uncomfortable; does not want to enter menopause period; fear of aging	90 (22.3)
Hormonal and metabolic changes Hormonal replacements	Decrease of hormones; lack of knowledge; hormonal change; transforms the body; has to take medicine; has to use hormones; has to go under treatments	77 (19.0)
Menopause is associated with sexual problems	Decreased sexual desire; loses sexual desire; changes sexual desires; woman gets cold; end of sex life; sexual pleasure decreases; decreased orgasm, loss of pleasure	39 (9.7)
Menopause is attributed to old Age/Aging	When old age comes; when old age comes	33 (8.2)
Positive feedback	It is not a disease; it is good because you do not menstruate; important period; it is good for the woman; it is good; increases sexual desire; it did not change sexual desire; important to have knowledge on the subject; it is good to know	20 (5.0)
Hysterectomy anticipating menopause	Hysterectomy anticipates menopause; removal of the uterus leaves the woman cold; uterus serves to generate child and disease; hysterectomy changes sex life	14 (3.5)

*Some verbalizations contained more than one idea/content.

Another important theme that emerged in the interviews was the "lack of medical guidance" in a care space that is a reference in women's health. About this, 15 (3.6%) participants reported that doctors do not ask, explain, or guide about menopause,

as shown in the following statements. In contrast, two women received guidance on the use of natural medicines (BlackBerry tea).

> *I do not understand anything and do not dare to ask the doctors.* (E214)
> D*octors never asked anything.* (E32)

Regarding the degree of severity of symptoms among menopausal and premenopausal women, the means of the scores of the three dimensions were higher for the former. The dimensions of somatovegetative and urogenital symptoms showed a significant difference between the two groups of women, which did not occur in the psychological (Figure 1a, b, and C). However, the mean total scores reached values referring to "severe" symptoms in both groups (menopausal: 19.1±9.7; premenopausal: 16.4±9.8), although they had a significant difference between them (figure 1D).

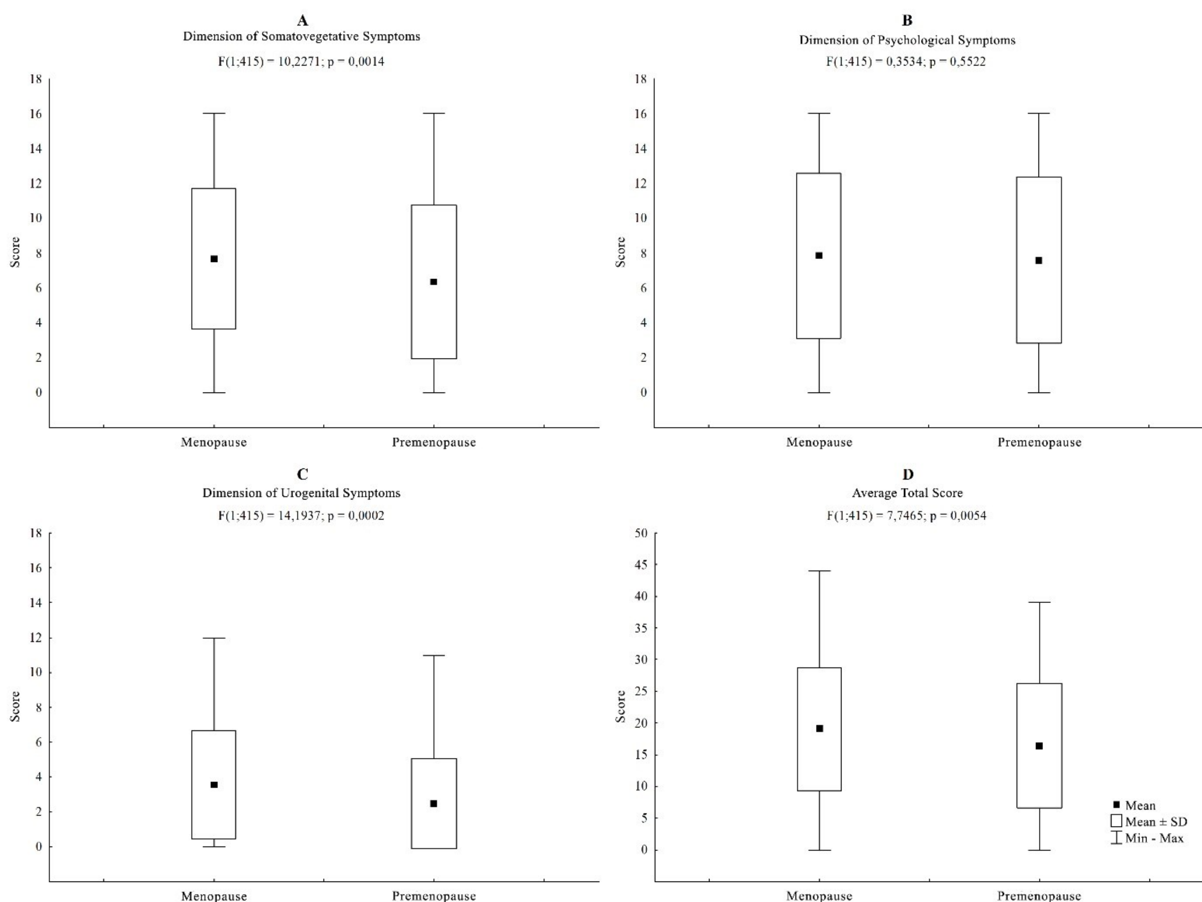

Figure 1. Mean scores of symptom severity of the analyzed dimensions and the mean total score among women with menopause and those who are not yet in menopause (premenopause), from the FHUs Reference in Women's Health, Aracaju, Sergipe, 2017, according to the Menopause Rating Scales - MRS. ANOVA with Turkey's *post hoc* test.

When MRS questions are analyzed separately, the study observes that the highest mean scores relate to psychological symptoms in both groups of women. The somatovegetative symptoms that presented most expressively in menopausal and premenopausal women were shortness of breath, sweating, heat, and muscle/joint issues, while among the urogenital symptoms, sexual problems and vaginal dryness stood out, shown in Figure 2 and following reports:

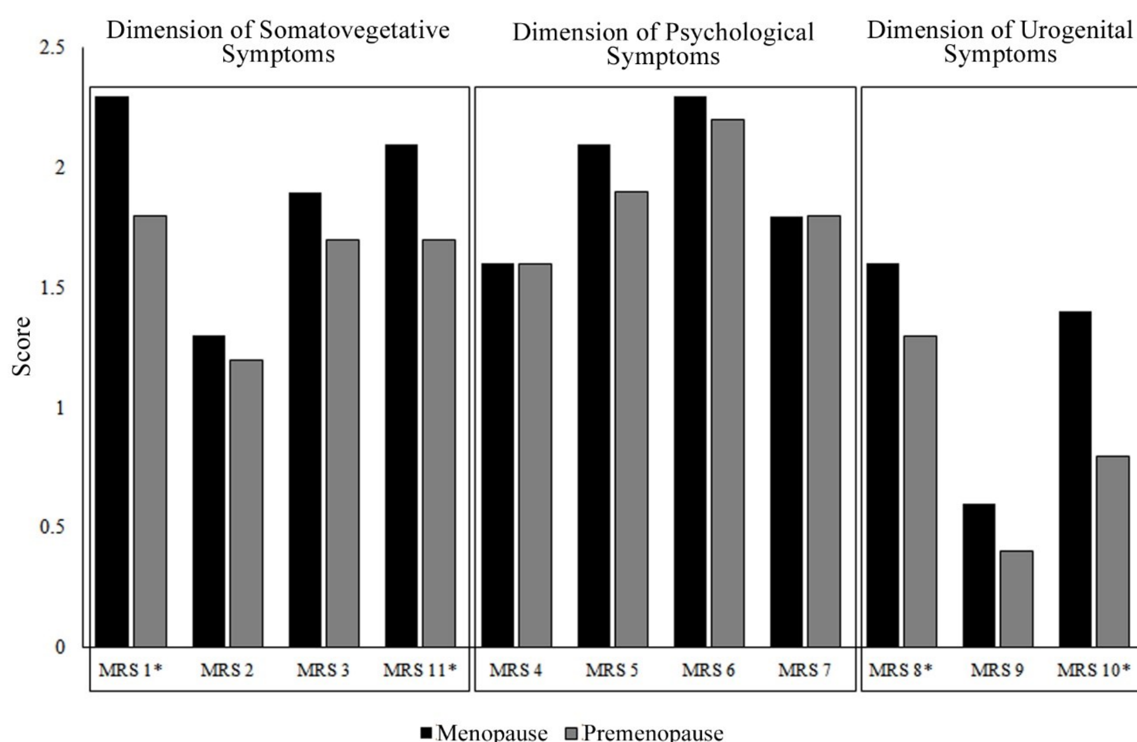

Figure 2. Differences between mean scores by symptom domain between groups of women in menopause and those who are not yet in menopause, FHUs Reference in Women's Health from Aracaju, Sergipe, 2017, according to the Menopause Rating Scale - MRS.
MRS 1: shortness of breath, sweats, heat; MRS 2: cardiac malaise; MRS 3: Sleep Problems; MRS 11: muscle and joint problems; MRS 4: depressive mood; MRS 5: irritability; MRS 6: anxiety; MRS 7: physical and mental exhaustion; MRS 8: sexual problems; MRS 9: bladder problems; MRS 10: vaginal dryness. *Means with significant differences – Mann Whitney U test.

> *[...] That's when you turn 40, around it... I think the hands warms up, my hand warms up a lot, [...] too much heat, that's all.* (E1)
> *It's like a cold, I don't know, pain in the body, others feel more hot flashes, others do not feel. I see a lot like that from people who talk about heat, who feel a lot of heat.* (E8)
> *Girl, suddenly I'm sweating and suddenly the sweat goes away like this, it hurts my bones afterwards.* (E16)

The following statements show anxiety and irritability in this menopause period. The unhealthy clinical picture of long duration and prolonged recovery is

associated with a negative assessment of climacteric. Most women, during routine consultations, tend to report only somatic symptoms or do not have access to spaces of psychosocial care and attention:

> *Boy, menopause is what I'm feeling: heat, irritation, impatience, anxiety.* (E132)
> *A lot of things, a lot of bad things. I feel unwillingness, lack of desire, bad mood, too much heat, fatigue, anxiety, anguish, too much headache.* (E59)

When asked what they understood by menopause, most women associated it with illness. It was also observed verbalizations about the non-association — *[...] I do not believe it is a disease, I feel hot, but the normal [...]* (E101) — in spite of presenting severe symptoms (MRS).

Although there were no significant differences between the means in the psychological dimension, some women who reported being depressed and not using specific medications had higher means than those taking antidepressants/tranquilizers (2.1±1.0 and 2.6±1.1 respectively; $p < 0.001$). Women users and non-users of medicines revealed psychological symptoms, with the most severe intensity in the second.

The menarche[a] of the women studied occurred, on average, at 13.1±1.8 years of age, while the sexarche[b] occurred at 18.8±4.3 years (between 10 and 39 years). All of the answered questions related to sexual activity, however, 172 (41.2%) women reported they did not have sexual relations and explained the reasons. Based on these reasons, the study identified three themes: Personal/relational issues; Sexual and health changes; Old age problems (Figure 3). The main reasons reported were: having no partner, lack of interest, and sexual desire:

> *Because I don't want any more, I'm sick.* (E159)
> *It changes the sexual desire, excitement, changes for the worse, the desire diminishes..."* (E293)
> *I never felt pleased with my husband when he was alive [...]. To this day, my pleasure is always alone. I masturbate and I feel pleasure alone...* (E269)

[a] First menstruation

[b] First sexual intercourse

Themes	Content	Frequency
Personal/ Relationship issues	Do not have a partner	45 (26,2%)
	Do not informed why	34 (19,8%)
	Divorced	18 (10,5%)
	Widow	13 (7,6%)
	Not married	6 (3,5%)
	Single	4 (2,3%)
	Virgin	3 (1,7%)
	Husband's poor health	3 (1,7%)
	Fear of contracting STIs	2 (0,6%)
Sexual/Health changes	No sexual interest/desire	38 (22,1%)
	Never had the opportunity to have sex	1 (0,6%)
	Don't like to have sex	1 (0,6%)
	Have pain and bleeding after intercourse	1 (0,6%)
	Blader fistula caused by hysterectomy surgery	1 (0,6%)
Old age problems	Husband's old age	1 (0,6%)
	Feel old	1 (0,6%)

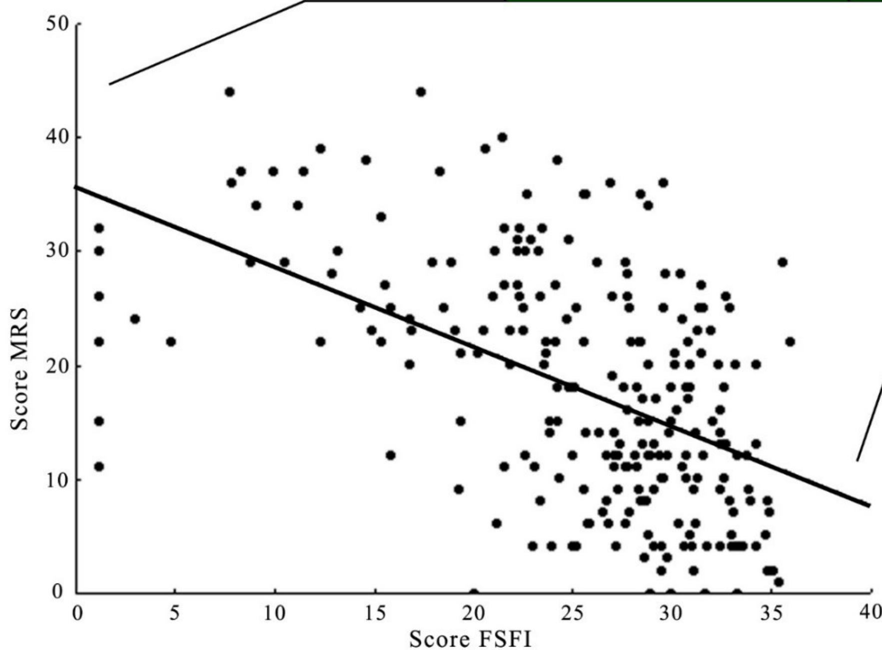

Figure 3 - Correlation between menopausal symptoms (MRS) and sexual function (FSFI) scores, with the declared reasons for the absence of sexual activity, in women in Family Health Units Reference in Women's Health in Aracaju, Sergipe, 2017. Reporting frequency: high (red), medium (yellow), low (green). Pearson's linear correlation.

A though there were no statistically significant differences, women who started sexual life later reported mild symptoms in menopause, according to MRS ($p = 0.383$ – ANOVA with Duncan's *post hoc* test). Among the participants, 55.4% reported having sexual intercourse in the last four weeks, with a frequency of 2.0±1.5 sexual intercourse/week. In a context in which 73.7% of women reported having one to four sexual intercourse/week, 44.6% had female sexual dysfunction, finding that, as the woman ages, there is a reduction in sexual function ($r = -0.208$; $p < 0.001$).

Among sexually active women, the correlation between the scores of both

instruments used (FSFI and MRS) was inversely proportional and significant (r = -0.507; p < 0.001), that is, as the severity of menopausal symptoms increases, there is a reduction in female sexual function, as also demonstrated in the following statements:

> *I think it's that phase where the woman stops menstruating, loses her hormones, she also loses her stimulus, her sexual desire. She has less desire for sex, her body changes.* (E33)
> *It has that little heat, that annoying heat, it has the dryness in the vagina, the sexual appetite changes a little bit, it is not the same thing, you don't lose it completely, but it changes.* (E14)

Although the study significantly detected sexual dysfunction in both menopausal women (52.3%) and premenopausal women (37.7%), the first group presented a ratio of almost twice as likely as the second to develop dysfunction (OR = 1.81; p = 0.036; 1.07 ≤ μ ≤ 3.06).

Women with absence/scarcity of menopausal symptoms generally have higher mean FSFI scores than those with moderate or severe symptoms (Table 2).

Table 2. Comparison of the scores of the domains of the Female Sexual Function Assessment Scale (FSFI) between the symptom groups of the Menopause Rating Scale (MRS) of menopausal women of the FHUs Reference in Women's Health of Aracaju, Sergipe, 2017

	MRS symptom groups				
	None/Scarce Mean (SD)	Mild Mean (SD)	Moderate Mean (SD)	Severe Mean (SD)	Value of *p*
Desire	4.2±0.7 [a]	4.0±0.8 [a]	3.5±1.2 [ab]	3.0±1.3 [b]	< 0.001
Excitation	4.5±0.9 [a]	4.2±0.8 [a]	3.9±1.4 [ab]	3.1±1.5 [b]	< 0.001
Lubrication	5.6±1.1 [a]	4.7±1.2 [ab]	4.5±1.6 [ab]	3.5±1.9 [b]	< 0.001
Orgasm	5.3±0.8 [a]	5.1±0.7 [ab]	3.9±1.7 [bc]	3.3±1.8 [c]	< 0.001
Satisfaction	5.8±0.4 [a]	4.7±1.8 [ab]	4.8±1.7 [ab]	3.8±2.1 [b]	< 0.001
Pain	5.5±1.4 [a]	5.5±0.8 [a]	5.2±1.5 [a]	4.2±2.1 [a]	< 0.001

Note: means with the same letter are not significantly different. ANOVA with Duncan's *post hoc* test.

DISCUSSION

Monitoring the health and well-being of women, especially those who are going through the climacteric, requires the integrated analysis of instruments and methodologies sensitive and valuable to intervention policies in response to women's demands on the climacteric transition and menopause, as demonstrated in the findings of this study.

Regarding the high prevalence of symptoms in menopause, the results coincide with the findings in a study conducted in the State of Rio Grande do Sul, Brazil, with 100 women between 52 and 68

years, in which 91% of the participants presented symptoms. Concerning the degree of intensity of the symptoms, the moderate (36%) was highlighted in each of the domains of MRS and somatovegetative symptomatology (80%), unlike the present study, in which found a higher prevalence in severe degree and psychological symptoms[23].

The arguments of "discomfort" in women from that State were associated with their symptoms detected by MRS, which presented statistical differences between the groups studied. The most frequent symptoms of menopause of severe and very severe intensity were anxiety (49.9%) and irritability (41.7%), followed by somatovegetative (Table 2). In women from the State of Sergipe, the symptomatic triad shortness of breath-sweat-heat (71.5%) presented varying intensity from mild to severe. These are classic clinical manifestations of the transition to menopause and can occur even in premenopause and with a frequency of 2.9 hot flashes/day[24]. When night sweating is frequent and intense, it can disturb sleep generating fatigue and irritability and influencing the incidence of psychological symptoms[25].

The significance of menopause for women in this study is mainly associated with hot flashes (heat, sweat, cold, fire), the absence of menstruation, and hormonal changes. A qualitative research study[26] in virtual environments on verbalizations analysis of menopausal women observed that vasomotor symptoms (hot flashes) were the most prominent in the narratives of internet users.

When comparing the results of the present study with signs and symptoms experienced by Colombians, it identified that women entering postmenopausal period are more likely to have hot flashes because there is a reduction in estrogen levels, modifications in the release of gonadotropins, as well as in their interrelationship with the brain's thermoregulation center. These mechanisms also explain the hot flashes that occur in premenopause or menopause since this symptom, in general, is present in women who are still menstruating or who are in the climacteric stage[27].

Menopause is seen as negative to the extent that participants associate it with physiological changes, such as malaise, and psychological changes, such as agony, nervousness, stress - changes that interfere with their interpersonal relationships. The study observed that, during this phase, women may have limited tolerance and increased irritability[28]. In a study conducted with climacteric women in the State of Paraná[29], the participants also noticed emotional and psychic changes related to menopause, confirming the most frequent as anxiety (81.25%) and irritability (75%). In the present study, menopausal women were neither more nor less irritated, anxious or depressed than those in premenopause.

A study conducted with Swedish women showed that the most frequently reported psychological symptoms were physical and mental exhaustion, decreased concentration, inner tension, and, particularly, anxiety[24]. The high frequency of anxiety and irritability found in the present study, although not necessarily pathological, requires early diagnosis and primary care for these menopausal women[30] since most of those interviewed here tend to report, during routine consultations, only somatic symptoms.

In multiethnic cultures, such as the Brazilian, the loss of elements of female appreciation (physical beauty, opportunities, and motherhood) favors feelings of devaluation, failure, sadness, mental exhaustion, and depression. The frequency of users from the State of Sergipe who used antidepressants/tranquilizers ranged from 16.1% (menopause) to 18.8% (premenopause), and 46.5% did not have a depression diagnosis but already used palliative drugs that only alleviate the emotional aspects. The perception of aging and the intensification of symptoms due to hypoestrogenism, combined with the growth of children or death of the spouse, imply emotional adjustments and lifestyle changes[12].

Some women from Sergipe have related the occurrence of muscle and joint pain (lower limbs) to menopause, considering it as a disease along with the fatigue proper of aging. Approximately 60% of these women had a risk age profile for osteoarthritis and fibromyalgia. Such inflammatory problems may not be caused by hypoestrogenism but are intensified and take on new meaning with menopause[31].

Despite few urogenital symptoms (vaginal dryness), it is essential to intensify attention to the sexual health of these women[11], for this is one of the pillars of good female living. In general, women have to deal with many physical and physiological changes due to aging and hypoestrogenism symbolized by menopause, which together can compromise their perception of self-image, self-esteem and libido, and cause sexual dysfunctions[24].

A study conducted in the city of Vitória da Conquista, State of Bahia (BA), with 20 women in climacteric, found a correlation of sexual function with quality of life in the physical and environmental domains, as well as a higher average quality of life for women who did not present sexual dysfunction[32]. Based on this, sexual dysfunction impairs the quality of life by compromising the sensation of sexual desire, orgasm, and excitement, in the same way as that found in the present study.

Menopausal women face, secondary to their aging, the loss of sexual desire and a new significance of their sexuality. The problem of the transition to menopause may lie in this identification of the sign woman as the object of procreation and the inability

to transcend the physical metamorphosis (new body) to a new psychosocial sphere[33].

The study observed a lack of knowledge — *I don't understand anything* (E25) —, doubts about “being” or “not being” in menopause period, or apparent difficulty in coping with the disturbing and misunderstood signs/symptoms of the transition to menopause, a situation similar to the findings of another study with 14 women in the north of the State of Minas Gerais[34]. The lack of information may be related to low income and low level of education, irregular frequency of gynecological visits, and age[35].

In this transition phase, it is necessary the implementation of organized dynamic education to provide autonomy for women in decision-making in the different needs throughout this period to contribute to their health care[36]. In this scenario, the importance of the health professional is remarkable, exposing enlightening information about sexuality to mitigate myths and taboos about the subject and establish a link that allows reporting their doubts and fears[37], a situation that did not occur with some women in the present study during medical visits.

Women from Sergipe also mentioned menopausal treatments, suggesting that these professionals did not have enough time or were unwilling to clarify/discuss doubts, leaving them more insecure and confused. A study conducted in Iran revealed the need for dialogue/information spaces for women to understand their bodily transformations and establish a neutral attitude towards menopause[38]. However, despite the obstacles in women-doctor communication, integrative and complementary practices policies are inserted[16] with the indication of teas and other natural products.

Some women related menopause to old age and conceptions of biological reproduction, reproducing the negative meanings (prejudices, myths, fears) circulating in the popular imagination and sociocultural patterns. Hormonal changes can cause loss of physical attributes, while women feel old, discarded, and have low self-esteem[39]. Positive and libertarian expressed feelings about menopause reflect, in some cases, vivacity, resilience, and new/old bodily and sexual discoveries, essential to cope with the psychological state of this period[40].

Sexual dysfunction, accentuated by menopause, can be triggered by hormonal and psychosocial factors, family problems, or sexual difficulties of the partner[39]. A previous study in Sergipe[41] indicated 21.9% of sexual dysfunction in young women exposed to work stressors (environment, career, and competition). However, in the northeastern scenario, a review study observed a variation between 31.2% and 79.3% of women affected by sexual dysfunction[42]. In the United States, a survey of 31,531 women over 18 years of age presented a prevalence of 43% of sexual

dysfunction, predominating in menopausal women[43], similar to the present study.

At this stage, sexual life needs to be understood in the context in which the woman is inserted, considering previous sexual experiences and their social, religious, cultural, and other characteristics, and not restricting her only to the satisfaction of her partner and reproduction. A North American study of a thousand postmenopausal women between 55 and 65 years old showed that vaginal discomfort caused most of the women interviewed to avoid intimacy (58%), suffer the loss of libido (64%), and report pain associated with sex (64%)[44].

Since during menopause, in the case of healthy women, the type of sexual response can be changed: it becomes slower and less intense due to the reduction of estrogen, which favors sexual dysfunction (SD), especially impairment in the area of sexual desire and interest[45]. Latin American Studies[11,46] have disclosed a higher prevalence of sexual dysfunction, always with some negative impact on the well-being and interpersonal relationships of women since the low sexual function increases significantly with age in a disconcerting and distressing way by causing changes in desire and arousal. Women from Sergipe are older in menopause, feel less desire/excitement/satisfaction, have less lubrication, and have more pain during sex. These sexual difficulties are associated with females aged over 45 years and various physiological changes[47].

The FSFI instrument was efficient in the early screening of sexual difficulties that must be clinically evaluated later. It observed a better sexual function in women with mild menopause, while sexual dysfunction was more frequent among women with severe symptoms recurrent in menopause or premenopause. Qualitative screening also identified issues of interpersonal relationships and lack of interest/sexual desire influencing sexual function, but not a direct relationship with the aging of sexual partners.

Because they are women served in Women's Health Reference Units, this sector and the multiprofessional team are essential for the knowledge building of general aspects and changes during the climacteric period. The objective is to provide an appropriate and timely assessment and care planning to the biopsychosocial needs manifested and expressed by women, emphasizing the promotion of healthy lifestyles.

CONCLUSION

The results indicate a demand for the implementation of psychosocial attention strategies focusing on psychoemotional and sexual aspects of menopausal women in the face of their singularities. They, as female individuals, feel hot flashes and have many doubts, which is why it is essential to have

access to qualified information so that they better understand the transformations inherent in the period from climacteric to menopause and be able to contemplate such phases integrated into their life and not as symbols of old age, unproductivity, end of menstruation or sexuality. Thus, in the context of primary care, it is essential to produce and strengthen reflections in the health promotion field, through unique strategies, on the possible bodily transformations arising from the transition phase to menopause. It is also necessary to encourage women to change their lifestyles to replenish and improve their mental and physical health to minimize the negative view about aging and menopause. The sexuality of women with sexual difficulties and/or dysfunctions caused by menopause may be permeated by emotional and psychological inhibitions.

FINANCIAL SUPPORT

This work was carried out with the support of the Coordination for the Improvement of Higher Education Personnel Foundation - Brazil (CAPES) - Financing Code 001.

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