

Psychological Capital and Prevailing Menopausal Symptoms among Middle-Aged Women

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Abstract

Background: Menopause is a complicated physiological process that marks the end of a woman's normal reproductive life, **Aim of the study:** Determine the correlation between psychological capital and prevailing menopausal symptoms among the middle-aged women. **Method:** Descriptive correlational design was used to determine the relationship between psychological capital and menopausal symptoms. Convenience sampling was utilized to recruit the 360 menopausal middle-aged women in Port Said, Egypt, from August to October 2021. **Results:** Majority of the participants are married, with a mean age of 52.01±9.881, housewife, Muslim, and obtained college degree. More than half of the participants had three gravida, with more than 3 children and with enough income for daily needs. Prevailing somatic symptom is joint and muscle discomfort in all phases of menopausal stages. While psychological and urogenital symptoms vary according to menopausal stages. It was also observed that there are significant relations between all menopausal symptoms with premenopausal versus perimenopausal and premenopausal versus post-menopausal (p-value = 0.005), except for sexual problems. There is a high negative correlation between all menopausal symptoms and domains of psychological capital (p value =0.01). **Conclusion:** Menopausal middle-aged women persistently experienced symptoms throughout menopausal stages. They have low psychological capital concerning hope, optimism, and resilience. The psychological capital turns out to be lower as the menopausal symptoms persisted across menopausal stages.

Keywords: Menopausal Symptoms, Middle-Aged, Psychological Capital.

Introduction:

Menopause often occurs in her middle years & is caused by a variety of factors, including hormonal changes and the 'cessation of ovarian follicular activity, and is characterized by the absence of menstrual flow for at least 12 months'. (Baral, 2019; Converso et al., 2019). Hot flashes, sleep problems, diminished physical strength, mood changes, and bladder irritation are some of the other

menopausal symptoms that which vary in terms of prevalence and gravity among individuals and various stages of the menopausal period (Hardy et al., 2018).

Women's menopausal lives are separated into three stages: The first is the menopausal transition period (pre-menopause), which is marked by irregular menstrual cycles and occurs between the ages of 45 and 49. Perimenopause is the second stage which lasts

around two years prior to menopause and up to two years beyond menopause, the initial biological and endocrine signs develop during this stage. The time after the last menstruation, regardless of whether it was a natural or artificially induced menopause, is known as postmenopausal stage. (Bromberger & Epperson, 2018; Makara-Studzińska et al., 2014).

According to (World Organization, 1996), In 2030, there will be 1.2 billion perimenopausal women, with almost 76 percent of them living in developing nations. As a result, the WHO has prioritized the treatment of perimenopausal women and increased women's quality of life in the twenty-first century. Menopausal symptoms have recently been highlighted for a better understanding of individual variances in symptom assessment, such as coping mechanisms, lifestyle choices, emotional status, and personality features. (Bauld & Brown, 2009; Weidner et al., 2020).

Menopausal symptoms have been shown in the literature to have a negative impact on women's personal lives, lowering their general subjective well-being and psychological condition. (Converso et al., 2019). The purpose of positive psychology, according to the authors, is to "begin catalysing a shift in psychology's focus from solely fixing the worst aspects of life to also cultivating positive traits." The authors emphasize the importance of "valuable subjective experiences" and "good individual attributes" in their conclusion. Psychological Capital is one facet of positive psychology (Kappagoda et al., 2014; Yuksel et al., 2019).

Recently, Psychological Capital (PsyCap) was defined as: 'an individual's positive psychological state of development that is characterized by having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; making a positive attribution (optimism) about succeeding now and in the future; persevering toward goals and, when necessary, redirecting paths to goals (hope) to succeed; and finally, if problems and challenges were encountered, being flexible to a certain situation (Resiliency) is a necessity to attain success' (Santisi et al.,

2020; Song et al., 2019). On the other hand, 'resilience is the human's capacity to overcome adversity, characterizing those people who, despite experiencing adverse situations, show healthy psychological development and can even become stronger as a consequence of such experiences.' Recent research revealed that great resilience lowers the effect of symptoms during menopausal period (Placido Llana, 2015; Oliva et al., 2019).

The four PsyCap components are state-like, which means they are flexible and may be altered by physiological and environmental circumstances, unlike the qualities associated with personality theory. As a result, rather of being permanent and fixed (as are trait-like variables), the PsyCap factors are more malleable. The relationship between each PsyCap component and physiological and environmental stressors will be inverted due to the positive nature of the PsyCap variables. That is, when PsyCap levels rise, the negative impacts of stress on performance, as well as the physiological signs linked to stress, will decrease (J. Chen, 2020; X. Chen et al., 2019).

Hence, the study sought to ascertain how psychological is linked to reported menopausal symptoms among middle-aged women. We hypothesized that higher means of psychological capital would be associated with fewer symptom reports in all stages of menopause.

The researchers' believed that no research is conducted yet in examining the relationship between psychological capital and menopausal symptoms. Certainly, menopausal symptoms affect individuals physically and psychologically as the symptoms vary from light to intense. Considering this, it is deemed important to understand its relationship with psychological capital, to give light among health care providers in assisting menopausal women to manage the prevailing symptoms and to design a program that will improve quality of life across menopausal stages.

Objectives of the Study:

The overall aim is to determine the correlation between psychological capital and

prevailing menopausal symptoms among the middle-aged women.

The objectives of study were:

a. Assess the prevailing menopausal symptoms among middle-aged women according to menopausal status.

b. Assess psychological capital in terms of hope, self-efficacy, resilience, and optimism.

c. Identify the correlation between reported menopausal symptoms and psychological capital among middle-aged women.

Method

Research Design

The research design of the current study was descriptive correlational design, this design is useful for describing how one phenomena is related to another in situations where the researcher has no control over the independent variables or the variables that are believed to cause or influence the dependent variable, such design was used in current study to ascertain how psychological capital is linked to prevailing menopausal symptoms among middle-aged women.

Research Setting

The social club in Port Said, Egypt, was chosen as the setting to carry out this research and gathered data on women's menopausal symptoms and psychological capital. It is associated with the Ministry of Youth and Sports and is one of the most well-known clubs in Port Said. The club offers a variety of social, sporting, and recreational activities to people of various ages and socioeconomic backgrounds.

Research subjects:

A total of 360 women who met the inclusion criteria (middle-aged 45 – 65 years old, experienced at least subtle changes in menstrual flow and length). The sample size was calculated using Raosoft with 95% confidence level at 5% margin of error (323), hence the women who participated were beyond the sample size (360). Women were recruited in the study using purposive sample. Those women who are pregnant or breastfeeding, hypertensive, diabetic, had heart disease, on cancer treatment, had mental illness, or had a drug or alcohol abuse history, and on hormonal therapy were all excluded from the study.

Tools of data collection:

An Arabic-language questionnaire consisting of four tools were used to collect the necessary data. **First tool** was the structured interview which developed by the researcher and contained demographic and obstetric information such as age, residence, religion, working status, educational level, marital status, number of gravida, parities, number of living children, and finally family income. **Second tool:** The women's menopausal stage which is categorized using Stages of Reproductive Aging Workshop (STRAW) categorization system (**de Kruif et al., 2016; Soules et al., 2001**). The menopausal stages was: 'No menstrual bleeding in the previous/last 12 months; postmenopausal. Menstruation in the previous/last 2- 12 months but not in the previous/last 2 months; late perimenopause, early perimenopause; increased irregularity of menses without skipping periods (7 days gap between the start of one cycle and the start of the next, observed after a previously regular cycle) and Perimenopause; small variations in cycle duration, mainly decreasing cycle length' (**Baral, 2019; Soules et al., 2001**).

Third tool was Menopause Rating Scale (MRS) instrument that has been widely used in most studies to assess the prevailing signs and symptoms of menopause among middle-aged women (**Rahman et al., 2010**). The present study used an Arabic version of the MRS, validated in a previous Egyptian study, also the reliability of MRS is indicated by Cronbach alpha coefficient of 0.868 (**Sweed et al., 2012**). MRS has 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 vaginal dryness. Subjects score each item from 0 (not present) to 4 (1–mild, 2–moderate, 3–severe, 4–extremely severe). The overall score of each subscale is the sum of the subscale's item scores. No or minor symptoms (0–4), mild (4–8), moderate (9–16), and severe (9–16) were the total severity scores (17).

Fourth tool was the 24-item Psychological Capital Questionnaire (PCQ) which used to measure psychological capital (**Luthans & Youssef-Morgan, 2017**). The PCQ comprises of four dimensions, hope, self-

efficacy, optimism, and resilience. Hope consists of items that assess a person's capacity to stick to a goal and reroute courses to achieve success. Efficacy determines the person's willingness to take on difficult activities and put out the effort required to accomplish. Resilience measures a person's capacity to persevere and bounce back when confronted with obstacles and adversities to achieve a specific goal. Finally, optimism evaluates a person's capacity to attribute positive attributes to their current and future success. PsyCap questionnaire was first translated into Arabic by experts in the field and verified by a linguist, and then double checks that version to English to ensure that the authenticity of the instrument was preserved in the translation. Cronbach alphas of 0.88, 0.89, 0.89, and 0.89, respectively, were used to evaluate the overall reliability of PsyCap constructs. The total PCQ score was employed in this study because it is more dependable than the individual subscales. High psychological capital was defined as score of more than 70%, moderate psychological capital as scores of 50% to 70%, and low psychological capital as score of less than 50%. A pilot study with 30 women who were excluded from the study subjects was conducted to measure the accuracy, time required to complete the questionnaire. Required modification were done based on the results of the pilot study.

Ethical Considerations and Data Collection

The Institute of Review Board (IRB) of Port Said University's college of nursing granted permission to undertake this study. The ethical committee consists of 5 members. The date approved was 09-01-2020. A cover letter that explained the nature, purpose, and objectives of the study, as well as the inclusion criteria were attached to the research questionnaire. Data collection took around three months (from March to Jun 2020). The researchers visited the club four times per week. On each visit the researchers interview about 6-7 woman. The inform consent that explains the participation is entirely voluntary, and that their personal information would be kept private and anonymous was provided. All those who agreed to take part in the current study affirmed their willingness to participate and that they had read and understood the content of it. Data that had been collected was stored in a password

protected file where only researchers have accessed it.

Statistical Analysis

Data were tallied, organized, and analysed using SPSS version 21. The normality of the data was first tested using the one-sample Kolmogorov–Smirnov test. Quantitative data were described using numbers and percentages. Continuous variables were presented as means \pm standard deviation. Pearson moment of correlation were used to measure the relationship between variables at p values of 0.005 and 0.001.

Results

Table (1) revealed that the mean age of the studied sample was 52.01 ± 9.88 years, 81.9% of them came from urban areas, and 96.9% were Muslim. Regarding working status, 61.4% of them were housewives. Moreover, this table showed that 63.6% of the studied sample had university and post graduate education and 86.1% of them were married. More than half of the studied subjects (52.5%) had more than three gravida, 24.2% had three gravida, while only 5% of them had one gravida. In respect to the number of parities, 48.3% of the studied subjects had more than three parities, 24.2% had three parities, while only 5.8% of them had one parity. According to the number of living children, 44.2% of the studied subjects had more than three children. Additionally, related family income, 87.5% of them had enough income.

Figure (1) showed that 44.2% of the studied subjects were in postmenopausal status, 38.9% were in peri-menopausal status, while only 16.9% of the studied subjects were in premenopausal stage.

Table (2) disclosed that 93.9% of the participants suffered from joint and muscular discomfort and 86.4% of them had sleeping problems. In terms of related psychological symptoms, 96.7% of them experienced physical and mental exhaustion and 96.5% of them suffered from anxiety. Similarly, 86.4% of them suffered from sexual problems and 83.3% of them endured bladder problems concerning urological symptoms. The results indicated that majority of the studied subjects had mild

menopausal symptoms including somatic, psychological, and urogenital.

Furthermore, table (3) shows that the prevailing somatic symptom is joint and muscle discomfort in all phases of menopausal stages. While psychological and urogenital symptoms vary according to menopausal stage.

It was also observed that there are significant relations between all menopausal symptoms with premenopausal versus perimenopausal and premenopausal versus postmenopausal (p -value ≤ 0.005), except for sexual problems, no significant relationship (p -

value=0.064) between premenopausal and postmenopausal stage was observed.

Table (4) exhibited that 41.9% of the studied subjects had low levels of hope and optimism, 36.7% had moderate self-efficacy, and 40% of them had low resilience. In general, the participants showed that 40.8% of them had a low level of psychological capital.

Table (5) revealed that there was a high negative correlation between all menopausal symptoms and domains of psychological capital (hope, self-efficacy, resilience, and optimism) at a p value <0.01 .

Table 1. Distribution of women according to their demographic characteristics (n=360)

Demographics characteristics	N	%
Age:		
45-50	177	49.2
51-55	55	15.3
56-60	58	16.1
61-65	70	19.4
Mean SD.	52.01±9.88	
Residence:		
Urban	295	81.9
Rural	65	18.1
Religion:		
Muslim	349	96.9
Christian	11	3.1
Working status:		
Housewife	221	61.4
Working	139	38.6
Educational level:		
Illiterate	5	1.4
Primary Education	25	6.9
Secondary Education	101	28.1
University or Post Graduate Education	229	63.6
Marital status:		
Married	310	86.1
Single	8	2.2
Widow	32	8.9
Divorced/ Separated	10	2.8
Number of gravida:		
Zero	24	6.7
One gravida	18	5
Two gravida	42	11.7
Three gravida	87	24.2
More than three gravida	189	52.5
Number of parity:		
Zero	22	6.1
One para	24	6.7
Two parities	54	15
Three parities	87	24.2
More than three parities	173	48
Number of living children:		
Zero	23	6.4
One child	25	6.9
Two children	56	15.6
Three children	97	26.9
More than three children	159	44.2
Family income:		
Enough for daily needs	315	87.5
Not enough for daily needs	45	12.5

Figure 1. Distribution of participants according to their menopausal status (n=360)

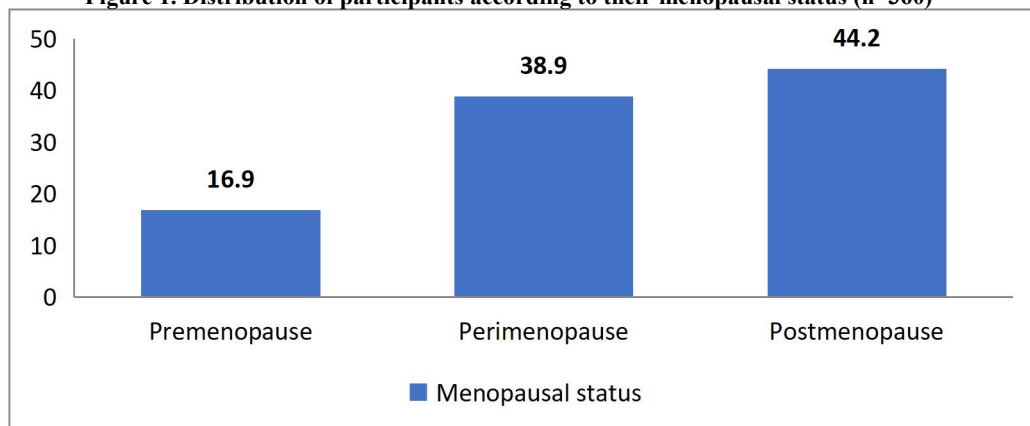


Table 2. Distribution of participants according to their Menopause Rating Scale (MRS) (n=360)

Menopause Rating Scale (MRS)	All (n =360) No - %	Mild	Moderate to Very Severe
Somatic			
Hot flushes, sweating	305 (84.7)	253(83)	52(17)
Heart discomfort	300(83.3)	258(86)	42(14)
Sleeping problems	311(86.4)	242(77.8)	69(22.2)
Joint and muscular discomfort	338(93.9)	275(81.4)	63(18.6)
Psychological			
Depressive mood	330(91.7)	302(91.5)	28(8.5)
Irritability	345(95.8)	276(80)	69(20)
Physical and mental exhaustion	348(96.7)	275(79)	73(21)
Anxiety	347(96.4)	277(79.8)	70(20.2)
Urogenital			
Sexual problems	311(86.4)	282(90.7)	29(9.3)
Bladder problems	300(83.3)	268(89.3)	32(10.7)
Dryness of vagina	285(79.2)	248(87)	37(13)

Table 3. Prevalence of menopausal symptoms according to menopausal stages (Premenopausal, Perimenopausal, and Post-Menopausal) (n=360)

MRS	Pre menopause (n =61)	Peri menopause (n =140)	Post menopause (n=159)	P value	
				Pre vs Peri	Pre vs Post
Somatic					
Hot flushes, sweating	55(90.2)	105(75)	130(81.7)	0.003**	0.005**
Heart discomfort	52(86.7)	118(84.3)	144(90.6)	0.000**	0.008**
Sleeping problems	56(91.8)	114(81.4)	148(93.1)	0.001**	0.007**
Joint and muscular discomfort	61(100)	126(90)	159(100)	0.002**	0.005**
Psychological					
Depressive mood	53(86.9)	128(91.4)	151(94.9)	0.001**	0.006**
Irritability	57(93.4)	138(98.6)	156(98.1)	0.000**	0.009**
Physical and mental exhaustion	59(96.7)	135(96.4)	152(95.6)	0.002**	0.011*
Anxiety	60(98.4)	139(99.3)	148(93.1)	0.000**	0.018*
Urogenital					
Sexual problems	58(95.1)	127(90.7)	125(78.6)	0.001**	0.064
Bladder problems	56(91.8)	105(75)	142(89.3)	0.003**	0.008**
Dryness of vagina	49(80.3)	102(72.9)	130(81.7)	0.003**	0.009**

Table 4. Respondents Psychological Capital State

Items	High		Moderate		Low	
	N	%	N	%	N	%
Hope	79	21.9	130	36.2	151	41.9
Self-efficacy	88	24.4	132	36.7	140	38.9
Resilience	101	28.1	115	31.9	144	40
Optimism	82	22.8	127	35.3	151	41.9
Total	87	24.2	126	35	147	40.8

*High > 70%; Moderate = 50% to 70%; Low < 50%.

Table 5. Correlation between Menopausal Symptoms and Psychological Capital

Menopausal Symptoms	Psychological Capital		Hope	Self-Efficacy	Resilience	Optimism	Total Score
Somatic	r.		-0.670	-0.590	-0.601	-0.723	-0.711
	p		<0.01**	<0.01**	<0.01**	<0.01**	<0.01**
Psychological	r.		-0.588	-0.623	-0.700	-0.823	-0.790
	p		<0.01**	<0.01**	<0.01**	<0.01**	<0.01**
Urogenital	r.		-0.579	-0.623	-0.665	-0.712	-0.744
	p		<0.01**	<0.01**	<0.01**	<0.01**	<0.01**
Total mean	r.		-0.600	-0.719	-0.712	-0.801	-0.650
	p		<0.01**	<0.01**	<0.01**	<0.01**	<0.01**

Discussion

Menopause affects a woman's health in all areas, including vasomotor, psychological, physical, and sexual aspects. The increase in symptoms threatens women's 'quality of life throughout the menopausal period' (Modoodi et al., 2020a).

It was found out that the mean age of women was 52.01±9.88 years. Less than one tenth of the population were in premenopausal stage, more than one third are in perimenopausal stage, and less than half of the population were in postmenopausal stage. Generally, the findings showed that women in postmenopausal notably showed inflated symptoms compared to premenopausal women except for other menopausal symptoms related to hot flashes, sweating, physical, mental exhaustion, sexual problems, and bladder problems. Furthermore, a significant relationship is noted amongst menopausal symptoms with pre versus peri and pre versus post-menopause except the sexual relations explanation could be that during premenopausal hormone levels are changing however during post-menopause, the levels of estrogen and progesterone are low but steady. Similarly, P. Chedraui et al. discovered that hormonal

variations triggered menopausal symptoms (Chedraui et al., 2007).

The findings of this study complement those of Maki & Santoro N et al., who found that 85 percent of peri-menopausal women suffer vasomotor symptoms (e.g., hot flashes and night sweats), which are the cardinal symptoms of menopause (Maki & Henderson, 2016; Santoro et al., 2015). Carpenter et al. discovered that hot flashes had an impact on work, social activity, leisure time, sleep, mood, attention, communication with others, sexual activity, general quality of life, and overall happiness (Carpenter et al., 2011).

It is remarkable to note that in the current study, 86.4 percent of the participants had sleep issues. This could be linked to the fact that most of them experienced hot flashes and sweating. In this regard, a study done by Murphy et al. found that sleep difficulties after menopause are linked to 'estrogen deficiency, as exogenous estrogen has been demonstrated to improve both subjective and objective sleep', as well as reduce hot flashes, increased Luteinizing Hormone (LH) levels during late menopause cause poor quality of sleep (Murphy & Campbell, 2007). In this context, Steiner et al. mentioned that in addition to

continuous variations in estrogen and progesterone levels, a decrease in melatonin and growth hormone among postmenopausal women was observed which influences fluctuation in their sleep pattern (Steiner et al., 2003).

In connection with psychological symptoms, the study revealed that depressive mood, irritability, physical and mental exhaustion, and anxiety were reported by most of the participants. This result has similar findings to the study conducted in Polish City (Olchowska-Kotala, 2015). A possible explanation for the results of the current study may be related to the regulatory changes in serotonin and norepinephrine because of the fluctuation in estrogen levels as it affects the psychological state. For the reason that estrogen aids in the regulation of serotonin and norepinephrine, as it decrease, it will influence via-a-vis the mentioned hormones (Liu et al., 2018). Another interpretation of the current findings could be linked to unfavorable attitudes concerning menopause, as well as women's beliefs about the physiological and role changes that come with aging. In this context other previous research studies indicated that there were link between 'negative views on menopause and the severity of menopausal symptoms' (e.g., vasomotor symptoms and fatigue) as well as psychological problems (Erbil, 2018; Gharaibeh et al., 2010). Varied cultures have quite different perspectives on menopause. In Japan, they had more favorable attitudes toward menopause than in Western countries (Barth Olofsson & Collins, 2000). There are notable factors affecting the extent to which menopausal women develop 'good or negative attitudes' regarding this life change (Smail et al., 2019). Menopause is referred to in Arabic as "sen al yaas," which translates to "the age of despair or hopelessness".

On the other hand, N. Santoro. 2015 mentioned that daytime weariness and sleepiness caused by insufficient sleep might lead to injury, depressive symptoms, and poor quality of life (Santoro et al., 2015). This result were congruent with the present study wherein the majority of the individuals suffered from hot flashes and had difficulty sleeping. According

to a study conducted in 2017 by Heidari et al., menopause is regarded as one of the growth stages in the life cycle of women, and it has a direct impact on women's 'quality of life and psychological well-being'. As a result, postmenopausal women reported a large number of mental health concerns (Heidari et al., 2017).

Peri-menopausal women frequently experience various depressive symptoms (e.g., poor mood, lack of motivation, loss of pleasure sense, and disrupted sleep), which can seriously impair their quality of life (de Kruif et al., 2016; Soares, 2020). Furthermore, the current findings demonstrated that depressive mode was widespread among postmenopausal women. The interpretation could be linked to unfavorable attitudes concerning menopause, as well as women's beliefs about the physiological and role changes that come with aging.

Concerning urogenital symptoms, the current study found out that most menopausal women experienced sexual issues (86.4%). A possible factor contributing to this result may be related to vaginal dryness as mentioned by majority of the participant women. These findings are in line with the study conducted in Sharoud Health Center in Iran (Modoodi et al., 2020b). Many women develop sexual dysfunction at menopause (Basson et al., 2002), even though the actual incidence and etiology are not reported. Also, Basson et al., 2002 indicated that one of the highlighted concerns after menopause is sexual dysfunction with varying causes and to reduce painful intercourse and improve sexual arousal and response, estrogen therapy and vaginal lubricants were used.

Problems in sexual functioning include lack of desire or interest in initiating sexual activities, lack of arousal, or inability to attain orgasm during sexual intercourse. Sexual dysfunction is generally caused by a combination of factors that may vary from psychological issues 'such as depression or anxiety disorders, conflict within the relationship, medication use, or physical problems that make sexual activity uncomfortable, such as endometriosis or

atrophic vaginitis' (Plácido Llaneza et al., 2012). One of the highlighted concerns after menopause is sexual dysfunction with varying causes (Basson et al., 2002). It is noted that treatment, is the use of antidepressant counseling, helps to enhance sexual functioning. To reduce painful intercourse and improve sexual arousal and response, estrogen therapy and vaginal lubricants were used.

It is notable that roughly 40 percent of the participants had a poor level of psychological capital. Hence, a strong negative connection between all menopausal symptoms and psychological capital categories was noted at a p-value of 0.01. These findings are consistent with a prior study of Spanish postmenopausal women using the **Wagnild and Young Resilience Scale**, which found that lower resilience was associated with more menopausal symptoms and depressive mood (P. J. Coronado et al., 2015). The study findings underscore the importance of nurses' involvement in assisting clients in adapting to present or anticipated health problems, and how they can further social commitment by including resilience principles into all client interactions (Lehman, 2006).

Interestingly, a previous study has found a link between resilience and menopause, which revealed that having a high level of resilience lessens the severity of menopausal symptoms (Beutel et al., 2009; Geukes et al., 2012). Women with a high level of physical and/or sexual activity have significantly greater health-related quality of life (HRQOL) and resilience. Antidepressant users, on the other hand, had reduced HRQoL and resilience (Pluvio J. Coronado et al., 2021). Emotional exhaustion has been proven to be substantially associated to menopausal symptoms. A possible explanation for this result may be the Emotional exhaustion has been proven to be substantially associated to menopausal symptoms. In this context (Converso et al., 2019) study revealed that the Emotional tiredness was found to be positively and strongly linked with menopausal symptoms. The influence of menopausal symptoms on emotional tiredness was mitigated by self-efficacy (Converso et al., 2019).

Furthermore, additional studies found that high levels of resilience and optimism may also assist to counteract specific menopausal symptoms, such as mood irritation or worry (Avey et al., 2011). Symptoms reported in peri- and postmenopausal women have also been associated with optimism, feelings of coherence, and health-related resilience, independent of emotional stability (Kuh et al., 2002). It was observed that women who manifested anxiety on an extreme levels or those who are less optimistic are more likely to experience unfavorable 'psychological or vasomotor symptoms.' These findings have significance for the development of successful therapies for women in their forties and fifties (Elavsky & McAuley, 2009).

In this context, the study results could be a basis for revisiting the existing health program among Egyptian menopausal women. Correspondingly, devising a comprehensive health education program that will focus on holistic management of menopausal symptoms could be a significant milestone among nurses working in the field of women's health.

The development of English to Arabic instruments that will determine the Psychological Capital of menopausal women could contribute to maternal and Gynecological fields of nursing practice. The constructs in this instrument gauge positive human behavior in terms of hope, self-efficacy, resilience, and optimism, which are important to assess women who experience the prevailing symptoms of menopause.

Menopause could significantly influences the woman's lives because of the complexity of menopausal symptoms and their side effects, which are commonly occurring at any stage. It brings a variety of physiological changes that alter a woman's life forever. There have been numerous theories regarding the symptoms that arise prior to, during, and after menopause. These symptoms make up the postmenopausal syndrome; they have a significant impact on women, and the therapy of these symptoms has recently become a focus of research (Dalal & Agarwal, 2015).

Implication to Nursing Practice

Understanding the prevailing menopausal symptoms in every stage is significant for nurses to develop a comprehensive plan of care among middle-aged women. Assessment of psychological capital could be a milestone in understanding the perplexity of menopausal stages in women's life. The English-Arabic translated instrument for MRS and PsyCap is a significant contribution in advancing nursing education pertaining to women's health in Arab countries.

Conclusion

Menopausal middle-aged women persistently experienced joint and muscular discomfort throughout menopausal stages. Correspondingly, anxiety and sexual problems affect women during pre-and perimenopause, while during the postmenopausal period, they are irritable and commonly endure bladder problems. Middle-aged women have low psychological capital concerning hope, optimism, and resilience. The psychological capital turns out to be lower as the menopausal symptoms persisted across menopausal stages.

Recommendation

With the variety of symptoms experienced during the menopausal period that ranges from physical to psychological, nurses may consider interventions that not only focus on physical concerns but psychological as well. When creating an educational program for menopausal middle-aged women, a holistic approach which encompasses all dimensions of care must be considered. Complementary and alternative ways of health management could be considered vis-a-vis eclectic therapy to enhance psychological capital, thus optimizing menopausal women's quality of life.

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