THE EFFECTS OF COUNSELLING AND ENLIGHTENMENT ON THE PSYCHO
SOCIAL WELLNESS OF WOMEN IN MENOPAUSE IN EDO STATE: COUNSELLING
IMPLICATIONS

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Abstract
This paper attempts to examine the effects of Counselling and Enlightenment on the psychosocial
wellness of women in menopause in Edo state. The wellbeing of women in menopause cannot be over
emphasized if the wellbeing of the family, the society, and the world at large is to be achieved, since
the woman is a key factor and determinant of this. This study is a quasi experimental pre test and post
test with the use of randomly selected secondary school female teachers from two different schools in
Edo state. Three questionnaires were adapted and used- Menopause Rating Scale (MRS), Self
esteem Scale (SS) and General Health Questionnaire (GHQ) with Cronbach's alpha reliability
coefficients of 0.952, 0.968, and 0.973. The questionnaires were administered to 30 randomly
selected female teachers within the age of 39-60 years. Data collected were analyzed with the use of
Analysis of Covariance (ANCOVA). Result obtained indicated a significant effect of counseling and
enlightenment on the post-test wellness scores compared to the pre- test scores. Counseling
implications were discussed which highlighted the psychosocial effects of lack of counseling and
enlightenment on the wellness and productivity of women in menopause. Recommendations were
made based on the findings.

Keywords: Menopause, Rating Scale, General Health, Self esteem Scale, Midlife.

Introduction
Aging is a universal phenomenon that is obvious as well as inevitable. Preparation for old
age by women cannot be over emphasized. Ageing for the woman in menopause can be observed as
a consistent pattern of change that she undergoes starting at a very slow rate at around age 39, and
progressing at a more rapid rate beyond age 60 (Olowookere, 2003). Women have a greater
population and their average age and life expectancy is more than men, but their imperfection and
challenges is higher and they face special issues resulting from their natural and physiological
conditions; one of these issues is the menopausal transition period or final years of pregnancy Khalil,
Motahhareh, Mohammad, & Mohammad (2008). Menopausal transition, or perimenopause, is the period between the onset of irregular menstrual cycles and the last menstrual period. This period is marked by fluctuations in reproductive hormones (Soares & Taylor, 2007), and is characterized by the following: Menstrual irregularities, Prolonged and heavy menstruation intermixed with episodes of amenorrhea, decreased fertility, vasomotor symptoms, insomnia and other symptoms.

Menopause typically occurs about the age of 39 and 55 years depending on the woman. It may also be defined by a decrease in hormone production by the ovaries. The climacteric is used to refer to the wide variety of changes occurring in years immediately surrounding menopause (Barret-Connor, 1998).

Though signs and effects of menopause transition can begin as early as age 39, or even before, most women become aware of the transition in their mid to late 40s, which is often many years after the actual beginning of the perimenopausal window. The duration of perimenopause with noticeable bodily effects can last five to ten or more years.

The quality of life of women in menopause is strongly influenced by socio-cultural and economical settings in which they live. They face various challenges from coping with hot flashes, night sweats, mood swings, false pregnancy, low energy, low self-esteem to dealing with the discomfort and frustrations of vaginal dryness (Porter, Penney, Russell & Templeton, 1996).

According to Wiklund, (1998) Some category of women suffer more severe symptoms, have the lowest self-perception, the highest level of loss experience and loss of attractiveness due to their life experiences. This group most frequently includes women with a low level of education, women who are divorced and live alone, and women who could not have children. Every woman's experience of menopause is unique; she may experience all of the symptoms or none of them. Some women find the transition barely noticeable, while others find it life altering (Southin, 2010). Menopause was not considered a problem in Africa many years ago. This could be attributed to the life style which mothers of those days lived as well as the low level of education, whereby women were only meant to play the roles of child bearing and housekeeping.

Southin, (2010) pointed out that despite the nurturing roles of women as mothers and wives many women now still face a lot of hardships in their struggles to cater for their families, which explain why the average age of menopause has risen in recent times. This has become a cause for concern due to the sophisticated life styles of the modern day African and indeed Nigerian women who value aesthetics, self-esteem, and appearance more now, than before. Some women perceive the experience of menopause as 'the end of the road' due to their inability to remain attractive to their spouse. Looking at this, the women in menopause will be more stable if they are identified with positively, enlightened and counseled on how to cope better with the challenges. This paper is born
out of this concern. It is against this background that this study will examine the effects of Counselling and enlightenment on the psychosocial wellbeing of women in menopause.

Statement of the Problem

The transition to menopause and the associated challenges have been traumatic for most women and need urgent attention. Most women spend one-third to half of their lifespan in this phase into the post menopause, and this involves biological and psychosocial changes which may significantly impair their quality of life. Women are considered as the base of family's health, which, in addition to health management of family members, are original patterns of training and propagating a healthy lifestyle to the next generation. Improving the status of reproductive health for women is particularly necessary due to the high levels of maternal mortality and morbidity, especially in developing countries. The concern about women's health should not begin and end with the period that women are in the age range that they can get pregnant and give birth to children. The concern should continue even in menopause. As the number of older women is increasing in the labour market, organizations should be aware of their changing health conditions. Women also have the right to good health after they have completed their reproductive role.

There is no gainsaying the fact that this period can be uncomfortable for most women. According to Olawoye, Olarinde & Aderibigbe (1998), this turbulence is only slightly less than that which occurred at puberty. As a result of the turbulence associated with this period, the woman does not only feel the discomfort, but everyone around her gets a dose of the discomfort. This may be in form of show of hostility, rejecting others, being easily irritated, unexplained anger, unfriendliness, unproductive behaviours and others. This experience corrodes her confidence, self-esteem, ability to think straight and make decisions and the attitude of spouses and others could make the symptoms worse for the women or otherwise. These challenges make demands on her health, relationship with others and her wellbeing.

A woman may tolerate the challenges; it is how she adapts to the transition that makes a difference in how she feels about herself (Sherman, 1993). Being aware of a challenge is not enough, appropriate enlightenment and counselling is a crucial strategy that enables individuals to understand what is required to cope well in any given situation. Various attempts made to stop the challenges of menopause have not yielded the required result. Efforts such as Hormonal Replacement Therapy (HRT) and the use of various medications have not brought complete relief to the women in menopause. The big question is, should the woman be left uncared for despite her strategic role in national development? Should aging be the end of life and comfort for a woman? Should menopause be seen and treated as a taboo, and the woman uncared for? Hence the presentation of the counseling
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implications of the effects of counseling and enlightenment on the psychosocial wellbeing of women in menopause in this paper.

Purpose of the Study

The major aim of this study is to examine the effects of counseling and enlightenment on psychosocial wellbeing among selected women in menopause and the counseling implications.

Significance of the Study

This study is significant because it will be of benefit to women in menopause, the family, organizations, guidance counsellors, social workers, business environments and the society at large. It will also highlight the need for enlightenment, counseling and family help services for women in general.

Research Hypotheses

1. There will be no significant difference between the post-test mean scores of participants exposed to Counselling/enlightenment programme and the control group.
2. There will be no significant effect of treatment on the menopause rating scale on the post-test mean scores of participants.
3. There will be no significant effect of treatment on the self esteem post test scores of participants.
4. There will be no significant effect of treatment on the general health post test scores of participants.

METHODOLOGY

Research Design

This study adopted quasi-experimental design (Pre-test, post-test control group). The quasi-experimental design was appropriate for this study because it involves human behaviour and may not permit complete randomization of subject and control of all variables. There were two groups (one treatment group and one control group).

Population of the Study

It consisted of all female secondary school teachers. One public and private school in Edo state, whom are within the age of peri menopause and menopause (40-60 years old), and had some or all the menopause symptoms used for screening.
Sampling Procedure

A questionnaire containing information about age, last menstrual period combined with the ‘Menopause Rating Scale’ (MRS) was used to select about 30 female teachers who qualified for the study because they showed evidence of menopausal symptoms and will benefit from the intervention. The schools were randomly assigned to treatment and control groups.

Instrumentation

Three major instruments were selected and adapted psychometrically for use by the researcher to obtain data for this study.

1. Menopause Rating Scale (MRS)
2. Self-Esteem scale (SS)
3. General Health Questionnaire (GHQ)

MRS is an 11 item instrument measuring the severity of menopause symptoms. The items are on a 5 point scale and scored: 1- None; 2- Mild; 3- Moderate; 4- Severe; 5- Very severe. SS is a 10 item scale developed to measure self-worth by measuring both positive and negative feelings about self. All items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree. GHQ is a 12 item questionnaire to assess people’s overall psychological well-being. All items are answered using a 4-point Likert-type scale ranging from always to never. The instruments were given face and content validity. The Cronbach’s Alpha of the instruments are: 0.952, 0.968 and 0.973 respectively.

Data Collection Procedure

Participants were randomly assigned to treatment and control groups. All experimental participants were exposed to 6 treatment sessions with an average of 1 hour per session. The post test was done thereafter.

Treatment Programme

The researcher made use of resource persons like gynecologist, nutritionist and a dentist who have experienced menopause to facilitate the enlightenment. The researcher administered the menopause Rating scale (MRS) to the participants to find out the presence and severity of menopausal symptoms in the women identified for the baseline study. Women whose rating showed evidence of the symptoms were selected as those who need intervention and used for the study.
**Counselling/Enlightenment talks on achieving wellness in menopause**

The rationale for the treatment is to help participants get adequate knowledge about what causes menopause in women, the likely things to expect during this period and the various ways to manage it. The main focus was in the area of gynaecological make up, diet selection, exercises, dental care, food supplements and cosmetic improvement. The treatment was done in the school halls as assigned by individual schools.

This session was devoted to enlightenment talks, counselling, questions, answers and group discussion. The difficulties participants encounter in the course of the enlightenment activities and assignments were brought forward and discussed. Successes achieved thus far were also discussed. The researcher urged the participants to continue to practice the skills learnt during the training. The control group only participated in the pre-test and post-test assessment sessions; they were not exposed to any treatment.

**TESTING OF HYPOTHESES**

1. There will be no significant difference between the menopausal post-test mean scores of participants exposed to treatment and the control group.

**Table 1A: Descriptive statistics of respondents on pre and post test MRS**

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>PRE MRS MEAN</th>
<th>SD</th>
<th>POST MRS MEAN</th>
<th>SD</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOLUTION-BASED</td>
<td>15</td>
<td>25.0667</td>
<td>6.85010</td>
<td>18.0667</td>
<td>3.65409</td>
<td>-7</td>
</tr>
<tr>
<td>CONTROL</td>
<td>15</td>
<td>44.8667</td>
<td>3.11372</td>
<td>41.0000</td>
<td>2.23607</td>
<td>-3.8667</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>34.9667</td>
<td>11.34562</td>
<td>29.5333</td>
<td>12.03653</td>
<td>-5.4334</td>
</tr>
</tbody>
</table>

**Table 1B: Tests of Between-Subjects Effects**

**Dependent Variable:** POSTMRS

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>4020.837</td>
<td>2</td>
<td>2010.418</td>
<td>300.511</td>
<td>.000</td>
<td>.957</td>
</tr>
<tr>
<td>Intercept</td>
<td>221.545</td>
<td>1</td>
<td>221.545</td>
<td>33.116</td>
<td>.000</td>
<td>.551</td>
</tr>
<tr>
<td>PREMRS</td>
<td>76.303</td>
<td>1</td>
<td>76.303</td>
<td>11.406</td>
<td>.002</td>
<td>.297</td>
</tr>
<tr>
<td>TREATMENT</td>
<td>448.960</td>
<td>1</td>
<td>448.960</td>
<td>67.109</td>
<td>.000</td>
<td>.713</td>
</tr>
<tr>
<td>Error</td>
<td>180.630</td>
<td>27</td>
<td>6.690</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30368.000</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Corrected Total</td>
<td>4201.467</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1C: Pair wise Comparisons  
Dependent Variable: POSTMRS

<table>
<thead>
<tr>
<th>(I) TREATMENT</th>
<th>(J) TREATMENT</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 COUNSELLING/ENLIGHTENMENT</td>
<td>2.00 CONTOL</td>
<td>-16.790*</td>
<td>2.050</td>
<td>.000</td>
</tr>
<tr>
<td>2.00 CONTOL</td>
<td>1.00 COUNSELLING/ENLIGHTENMENT</td>
<td>16.790*</td>
<td>2.050</td>
<td>.000</td>
</tr>
</tbody>
</table>

Based on estimated marginal means
* The mean difference is significant at the .05 level.
a. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

**Interpretation:** Table 1A shows that treatment group has less post-test menopausal difficulties (18.0667) than the control group (41.0000). Though the table shows that the pre-menopausal score for control group (44.8667) was more than the pre-menopausal score for the group that later received treatment (25.0667) but the table equally shows that the treatment group showed more improvement in menopausal stress with a mean difference of -7 than the control group with a mean difference of 3.8667. This indicates that there is a difference between the two groups with respect to menopausal stress. To show whether this difference is significant, ANCOVA was carried out. Table 1B shows that treatment significantly predicts post-test scores in MR. Calculated F from Table 1B (67.109) is greater than F critical (2.88703) at df1,29 at 0.05 level of significance (F_{1,29}=2.88703 at 0.05 level of significance F_{1,29}=67.109 from the table > F_{1,29}). Therefore, the hypothesis that there will be no significant difference between the menopausal post-test mean scores of participants exposed to treatment and the control group is rejected.

To determine the difference in menopausal stress, between the two groups having adjusted for pretest MR scores, a Least Significance Difference (LSD) multiple comparison was employed. TABLE 1C shows the adjusted means for the treatment and control groups. However, From the table, the LSD post hoc test found the difference in menopausal stress between the control and treatment group to be significant, control group having higher post MRS (Mean difference = 16.790 p<0.05).

1. There will be no significant difference between the Self esteem (SS) post-test mean scores of participants exposed to treatment and the control group.
The Effects Of Counselling And Enlightenment On The Psycho Social Wellness Of Women In Menopause

Table 2A: Descriptive statistics of respondents on pre and post test SS

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>PRE. SS   MEAN</th>
<th>SD</th>
<th>POST. SS   MEAN</th>
<th>SD</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>COUNSELLING/ ENLIGHTENMENT</td>
<td>15</td>
<td>29.0000</td>
<td>4.69042</td>
<td>35.6667</td>
<td>1.44749</td>
<td>6.6667</td>
</tr>
<tr>
<td>CONTROL</td>
<td>15</td>
<td>14.0000</td>
<td>4.47214</td>
<td>14.6667</td>
<td>9.7590</td>
<td>0.6667</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>21.5000</td>
<td>8.85808</td>
<td>25.1667</td>
<td>10.74816</td>
<td>3.6667</td>
</tr>
</tbody>
</table>

Table 2B: Tests of Between-Subjects Effects

Dependent Variable: POSTSS

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>3337.133</td>
<td>2</td>
<td>1668.566</td>
<td>3456.440</td>
<td>.000</td>
<td>.996</td>
</tr>
<tr>
<td>Intercept</td>
<td>504.863</td>
<td>1</td>
<td>504.863</td>
<td>1045.824</td>
<td>.000</td>
<td>.975</td>
</tr>
<tr>
<td>PRESS</td>
<td>29.633</td>
<td>1</td>
<td>29.633</td>
<td>61.384</td>
<td>.000</td>
<td>.695</td>
</tr>
<tr>
<td>TREATMENT</td>
<td>602.556</td>
<td>1</td>
<td>602.556</td>
<td>1248.196</td>
<td>.000</td>
<td>.979</td>
</tr>
<tr>
<td>Error</td>
<td>13.034</td>
<td>27</td>
<td>.483</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22351.000</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>3350.167</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. R Squared = .996 (Adjusted R Squared = .996)

Table 2C: Pairwise Comparisons

Dependent Variable: POST SS

<table>
<thead>
<tr>
<th>(I) TREATMENT</th>
<th>(J) TREATMENT</th>
<th>Mean Difference (I- J)</th>
<th>Std. Error</th>
<th>Sig.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 COUNSELLING/ ENLIGHTENMENT GROUP</td>
<td>2.00 CONTOL</td>
<td>17.633*</td>
<td>.499</td>
<td>.000</td>
</tr>
<tr>
<td>2.00 CONTOL</td>
<td>1.00 COUNSELLING/ ENLIGHTENMENT</td>
<td>17.633*</td>
<td>.499</td>
<td>.000</td>
</tr>
</tbody>
</table>

Based on estimated marginal means

Interpretation: Table 2A1 shows that treatment group has higher Self esteem post-test mean (35.6667) than the control group (14.6667). Though the table shows that the pretest SS score for control group (14.0000) was less than the pretest SS score for the group that later received treatment (29.0000) but the table equally shows that the treatment group showed more positive improvement in Self esteem with a mean difference of 6.6667 than the control group with a mean difference of 0.6667. This indicates that there is a difference between the two groups with respect to Self esteem.

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To show whether this difference is significant, ANCOVA was carried out. Table 2B shows that treatment significantly predicts post-test scores in Self esteem. F calculated from Table 2B (1248.196) is greater than F critical (2.88703) at df, at 0.05 level of significance (F, 12, 24 = 2.88703 at 0.05 level of significance F at 0.05 level of significance F = 1248.196 from the table > F critical). Therefore, the hypothesis that 'There will be no significant difference between the Self esteem post-test mean scores of participants exposed to treatment and the control group is therefore rejected. This agrees with Saucier (2004), that problems related to a woman's realization that she no longer conforms to society's standards of youth and beauty include low self-esteem, depression and anxiety, therefore, counseling will help her.

To determine the difference in Self esteem between the two groups having adjusted for pretest Self esteem scores, a Least Significance Difference (LSD) multiple comparison was employed. The results are presented in Table 2C. TABLE 2C shows the adjusted means for the treatment and control groups. From the table, the LSD post hoc test found the difference in SS between the control and treatment group to be significant, treatment group having higher post Self esteem scores (Mean difference = 17.633 p < 0.05).

1. There will be no significant difference between the General Health (GH) post-test mean scores of participants exposed to treatment and the control group.

### Table 3A: Descriptive statistics of respondents on pre and post test General Health

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>PRE. GHQ</th>
<th>Post. GHQ</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MEAN</td>
<td>SD</td>
<td>MEAN</td>
</tr>
<tr>
<td>Counselling/Enlightenment</td>
<td>15</td>
<td>34.400</td>
<td>4.03201</td>
<td>43.4667</td>
</tr>
<tr>
<td>Control</td>
<td>15</td>
<td>15.6667</td>
<td>3.81101</td>
<td>18.6667</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>25.0333</td>
<td>10.27714</td>
<td>31.0667</td>
</tr>
</tbody>
</table>

### Table 3B: Tests of Between-Subjects Effects

**Dependent Variable: POSTGHQ**

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>4636.723*</td>
<td>2</td>
<td>2318.361</td>
<td>811.413</td>
<td>.000</td>
<td>.984</td>
</tr>
<tr>
<td>Intercept</td>
<td>425.838</td>
<td>1</td>
<td>425.838</td>
<td>149.041</td>
<td>.000</td>
<td>.847</td>
</tr>
<tr>
<td>PREGHQ</td>
<td>23.923</td>
<td>1</td>
<td>23.923</td>
<td>8.373</td>
<td>.007</td>
<td>.237</td>
</tr>
<tr>
<td>TREATMENT</td>
<td>438.532</td>
<td>1</td>
<td>438.532</td>
<td>153.484</td>
<td>.000</td>
<td>.850</td>
</tr>
<tr>
<td>Error</td>
<td>77.144</td>
<td>27</td>
<td>2.857</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>33668.000</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>4713.867</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Squared = .984 (Adjusted R Squared = .982)
Table 3C: Pairwise Comparisons  
Dependent Variable: POSTGHQ

<table>
<thead>
<tr>
<th>(I) TREATMENT</th>
<th>(J) TREATMENT</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 COUNSELLING</td>
<td>2.00 CONTOL ENLIGHTENMENT</td>
<td>20.386*</td>
<td>1.646</td>
<td>.000</td>
</tr>
<tr>
<td>2.00 CONTOL</td>
<td>1.00 COUNSELLING ENLIGHTENMENT</td>
<td>-20.386*</td>
<td>1.646</td>
<td>.000</td>
</tr>
</tbody>
</table>

Based on estimated marginal means

* The mean difference is significant at the .05 level.

a. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Interpretation:

Table 3A1 shows that treatment group has higher GH post-test mean (43.4667) than the control group (18.6667). Though the table shows that the pretest SS score for control group (15.6667) was less than the pretest GH score for the group that later received the treatment (34.4000) but the table equally shows that the treatment group showed more positive improvement with a mean difference of 9.0667 than the control group with a mean difference of 3.0. This indicates that there is a difference between the two groups with respect to general health. To show whether this difference is significant, ANCOVA was carried out. Table 3B shows that treatment significantly predicts post-test scores in GH. F Calculated from Table 3B (153.484) is greater than F critical (2.88703) at df, 25 at 0.05 level of significance. Therefore, the hypothesis that 'There will be no significant difference between the GH post-test mean scores of participants exposed to treatment and the control group is therefore rejected. This implies that counseling and enlightenment will significantly improve the General health of the women in menopause. This agrees with Howell (2001) that with value clarification and enlightenment for the woman to make their values congruent with their behaviours and circumstances, they feel happy, satisfied and comfortable; whereas incongruence in these areas will result in feelings of guilt, sadness, anger, anxiety, fear and loneliness.

To determine the difference in GH between the two groups having adjusted for pretest scores, a Least Significance Difference (LSD) multiple comparison was employed. The results as presented in TABLE 3C shows the adjusted means for the treatment and control groups. From the table, the LSD post hoc test found the difference in GH between the control and treatment group to be
significant, treatment group having higher post GH (Mean difference = 20.386 p<0.05).

The results obtained have all concluded that counseling and Enlightenment have a significant impact on the menopausal symptoms severity, self esteem and general health of women in menopause. This confirms that women in menopause will be better and healthier when counselled and enlightened on related matters.

**Counselling Implications**

Counseling is applied psychology, a process of helping individuals to cope with various life situations and make useful decisions. Hence the relevance of counseling and related enlightenment for women in the age ranges of transition into menopause. This is to assist in helping them to acquire all the needed information about the transition and learn the coping strategies. There is need for family counselling. It is obvious that coping with menopause challenges will be much easier if the spouse is knowledgeable about the situation, and understands how to help the partner cope with the situation.

There is need for political counseling especially in policy issues. Policy makers should be counseled to formulate and affect policies that would favor the female workers, especially those who are over forty years of age.

Woman generally need to be exposed to counseling as preventive measure to imbibe the value of self enlightenment through research on health issues as it concerns body make up and continuous health checks. Lifestyle has also contributed to the severity of menopausal crisis. This is also a counselling need for women.

Counselling is needed for health workers who receive the constant complaints of women in menopause. Ignorance of menopause transition, challenges, lifestyle modification interventions and menopause challenges have resulted in wrong, irrelevant diagnosis for women who just needed only counseling. Counselling centers should be established in hospitals and work places and manned by professional counselors vast in related issues.

Counselling and Enlightenment on menopause is an attempt to meet the vital psychological, social and health needs of the woman in menopause. Hence the need for help services to provide relevant and adequate information to all women to help her transit through this period gracefully, and remain alive to share her experiences to help other women in similar situation.

**Recommendations**

Based on the result of the findings and all that has been discussed in this study, it was recommended that enlightenment programme for women (especially those with lesser educational attainment) on
issues of menopause should be given optimum priority. Since menopause is a stage of life for every woman who live long enough to witness it, government, Counsellors and other stakeholders need to lay more emphasis on the enlightenment programme for uneducated women on issues related to reproductive health and menopause.

It is recommended also that members of the society should also be enlightened about menopause so that they can be more aware of menopause and its related problems so as to be empathic towards these women in their menopausal stage such as their wives, mothers, sisters, aunts, friends and co-workers as they go through this life changes. In so doing menopausal women will enjoy greater social support.

Marriage Counsellors really need to be equipped with information relating to menopause. More attention should be focused on multicultural counselling practices such that, Counsellors will be familiar with different cultural values and beliefs (especially as it relate to menopause) and thus become well informed about different taboos and cultural beliefs about menopause.

Conclusion

On the basis of these findings, the following conclusions were drawn: Counselling makes for significant difference in the menopause-related symptoms of women in menopause in Edo State. Enlightenment makes for significant difference in the Self esteem of women in menopause in Edo State. Counseling and Enlightenment makes for significant difference in the General health of women in menopause in Edo State.
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