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Conformity to Female Gender Norms and Its Influence on Psychological Risk in Spanish Climacteric Women: A Descriptive Study

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Abstract: (1) Background: The climacteric phase is a crucial period in a woman's life, due to the changes that affect both her physical and psychological well-being. This study aims to explore the psychological risks associated with the climacteric period in Spanish women, evaluating the influence of conformity to female gender norms. (2) Methods: A descriptive correlational study was conducted with 429 women, using surveys to assess psychological risk (GHQ-12) and conformity to gender norms (CFNI-45). The sample was recruited from central Spain, covering women aged 45–64 years. (3) Results: 20% of the women showed signs or suspicion of psychological pathology, with a higher prevalence in younger women. Participants displayed greater conformity to gender norms related to domestic chores, but less conformity to norms of sexual fidelity and thinness. Health perception was identified as significantly influencing psychological risk and conformity to the norm of thinness, acting as a moderator in this relationship. (4) Conclusions: The study indicates that age and conformity to female gender norms influence psychological risk during the climacteric phase. Younger women and those with greater conformity to the norm of thinness exhibited higher psychological vulnerability. This highlights the need for interventions that address these factors in order to promote emotional well-being and a positive perception of health during this stage of life.

Keywords: climacteric; gender norms; mental health; women

Academic Editor: Ion G. Motofei

Received: 1 October 2024
Revised: 6 February 2025
Accepted: 14 February 2025
Published: 20 February 2025

Citation: Pérez, I.; Cárdaba-García, R.M.; Velasco-Gonzalez, V.; Cárdaba-García, I.; Durantez-Fernández, C.; Muñoz-del Caz, A.; Soto-Cámara, R.; Aparicio-García, M.E.; Madrigal, M.; Pérez-Pérez, L. Conformity to Female Gender Norms and Its Influence on Psychological Risk in Spanish Climacteric Women: A Descriptive Study. *Sexes* **2025**, *6*, 10. https://doi.org/10.3390/sexes6010010

1. Introduction

The climacteric phase, which precedes and follows menopause, is often seen as a critical period in women's lives, due to the changes that characterize it. In the initial phase, women experience a gradual decrease in sex hormones, particularly estrogens, resulting in a range of physical symptoms [1]. However, beyond the physical aspects, the climacteric phase is also associated with a few psychological challenges that can significantly affect women's quality of life [2].

Psychological risk during the climacteric period has gained increasing attention in the scientific literature, as hormonal fluctuations not only affect physical well-being, but also appear to influence emotional and mental states. Mood disorders, anxiety, irritability, and, in some cases, depression are common conditions reported during this period [3]. Furthermore, other social factors, such as the emergence of a new identity as a mature woman, can contribute to increased psychological vulnerability [4].

It is common to assess women aged 45 to 54 on the one hand, and women aged 55 to 64 on the other; women aged 40 to 45 rarely present symptoms of menopause, and at 65 years of age, are no longer considered menopausal, but are in an older stage. These age groups are appropriate to represent the climacteric transition, as younger women are usually in perimenopause or menopause, and older women in postmenopause.

In this context, conformity to female gender norms plays a crucial role in the psychological experience of women during the climacteric phase. Throughout their lives, many women internalize social and cultural expectations regarding how they should behave, look, and feel based on their gender. These norms, which often emphasize youth, physical beauty, and fertility, can intensify feelings of worthlessness and lower self-esteem as women enter the climacteric phase. The pressure to conform to these gender expectations in midlife may increase the risk of emotional disorders and contribute to deteriorating mental health during this life transition [5].

Several studies have highlighted the importance of considering psychological and social factors, alongside biological changes, when assessing women's well-being during the climacteric phase [6,7]. The interactions between environmental factors, previous experiences, and hormonal changes create a complex framework that may predispose certain women to experience more pronounced emotional difficulties. Understanding the mechanisms underlying psychosocial risk during the climacteric phase is crucial for developing interventions and support strategies that promote healthy aging and holistic well-being [8].

This article aims to explore the psychological risks associated with climacteric aging and conformity to female gender norms among Spanish climacteric women, examining these factors based on their age group (from 45 to 54 years old, or early menopausal transition, and from 55 to 64 years old, or late menopausal transition). Furthermore, the influence of gender norms on the climacteric experience is analyzed.

2. Materials and Methods

2.1. Study Design

A descriptive correlational study was designed using a questionnaire. The sample consisted of 429 women selected by non-probability sampling.

2.2. Study Setting and Recruitment

Women were recruited from central Spain, specifically from Madrid and Segovia. The recruitment process was facilitated by women's associations, including *Iniciativa Social de Mujeres Rurales*, *Asociación Mujeres Inquietas de Segovia*, *Asociación de Mujeres para la Igualdad en Segovia*, and *Federación de Asociaciones de Mujeres de la Comunidad de Madrid*. A link to an

online questionnaire, created using Google Forms®, was disseminated between 30 June 2018 and 1 February 2023. Data collection was paused during 2020 and 2021, due to the COVID-19 pandemic.

Inclusion criteria consisted of women aged between 45 and 64 years, residing in the central part of Spain, and voluntarily agreeing to participate in the study.

Exclusion criteria were women with hysterectomizing and/or bilateral adnexectomy, with polycystic ovary syndrome, with premature ovarian failure, with difficulty understanding the Spanish language, or without the ability to answer an online survey.

2.3. Ethical Aspects

The Ethics Committee of the Health Area of Segovia, Spain, approved the study (PI 34-2018), adhering to the principles of bioethics and the Declaration of Helsinki and its subsequent updates. The STROBE quality assessment guide for observational studies was also followed [9].

The women gave their consent to participate in the study after reviewing the information provided about their participation and the object of the study, as well as having been able to discuss, by email, any questions they had prior to completing the questionnaire.

2.4. Data Collection and Instrument

The variables collected included age group, place of residence, sexual orientation, marital status, educational level, employment status, number of household cohabitants, self-reported health status, psychological risk, and conformity to female gender norms.

Self-reported health status was assessed using an ad hoc 5-point Likert-type scale from 1 to 5. Lower scores were associated with worse perceived health status, and higher scores with better perceived health status.

Two primary instruments were used:

2.4.1. The General Health Questionnaire (GHQ-12)

Developed by Goldberg and Williams in 1998 [10] and adapted for Spanish populations by Sánchez-López and Dresch in 2008 [11], the GHQ-12 is a widely used screening tool for psychiatric pathologies. The questionnaire consists of 12 questions about the respondent's experiences over the past month. The intensity of the severity of symptoms is scored by women on a Likert scale from 0 to 3. A score of 0 corresponds to the worst outcome (higher chance of pathology), and 3 to the best outcome (lower chance of pathology). According to the creators of the survey, the analysis of the results is carried out by giving the values selected as 0 and 1 an arithmetic value of 0, and the values 2 and 3 an arithmetic score of 1. With these weightings of the responses, the questionnaire can have values between 0 and 12 points, with the lowest scores indicating less psychological alteration and the highest scores indicating alterations related to mental pathology. The interpretation of the questionnaire is categorized into the following ranges: 0 to 4 indicates an absence of psychopathology; 5 to 6 suggests a suspicion of subthreshold psychopathology; and 7 to 12 indicates signs of psychopathology. This scale includes two factors: depression and anxiety, and social dysfunction.

2.4.2. The Conformity to Female Gender Norms Inventory (CFNI-45)

The Conformity to Female Gender Norms Inventory (CFNI), in its reduced 45-item version [12], was adapted for Spanish women by Aparicio et al. in 2019 [13]. The scale measures conformity to female gender norms, ranging from complete acceptance of a social gender norm, to total opposition, based on levels of agreement or disagreement. The items are grouped into nine subscales: investment in appearance, childcare, domesticity, modesty, sweet and pleasant, relationships, romance, sexual fidelity, and thinness. The total score

ranges from 25 to 160, with each subscale scoring between 5 and 20. Higher scores indicate greater conformity to societal gender roles for women.

2.5. Data Analysis

Nominal categorical variables were described using frequencies and percentages, while quantitative variables were described using means and standard deviations. The Kolmogorov–Smirnov test was used to assess the goodness-of-fit to the normal distribution. Inferential analysis was conducted by age group (1: 45–54 years and 2: 55–64 years) using Student's *t*-test. A stepwise multiple linear regression analysis identified factors influencing mental impairment risk, with effect size assessed using the Durbin–Watson test.

A mediation analysis using the Hayes model was performed to assess the mediation role of self-reported health status in the relationship between conformity to all gender norms. Only thinness was found to be related to psychological risk. Statistical significance was set at $p < 0.05$. All analyses were performed using IBM SPSS (v26.0, SPSS Inc., Chicago, IL, USA).

3. Results

The study sample included 429 women, divided into two age groups. Women aged 45–54 years represented 65.3% (280 participants), and women aged 55–64 years represented 34.7% (149 participants).

The distribution of sociodemographic variables in the sample can be consulted in Table 1.

Table 1. Sociodemographic characteristics of sample (N = 429).

Variable	N	%		
Age group				
Between 45 and 54 years old	280	65.3		
Between 55 and 64 years old	149	34.7		
			Between 45 and 54 years old N(%)	**Between 55 and 64 years old N(%)**
Place of residence				
Urban	292	68.1	192 (68.6)	100 (67.1)
Semi-urban	95	22.1	62 (22.1)	33 (22.1)
Rural	42	9.8	26 (9.3)	16 (10.7)
Sexual orientation				
Heterosexual	408	95.1	270 (96.4)	138 (92.6)
Homosexual	7	1.6	4 (1.4)	3 (2.0)
Bisexual	9	2.1	5 (1.8)	4 (2.7)
Other	4	0.9	1 (0.4)	3 (2.0)
Marital status				
Single woman	67	15.6	47 (16.8)	20 (13.4)
Common-law couple	44	10.3	35 (12.5)	9 (6.0)
Married	218	50.8	131 (46.8)	87 (58.4)
Separated or divorced	89	20.7	60 (21.4)	29 (19.5)
Widow	11	2.6	7 (2.5)	4 (2.7)
Educational level				
Without studies	1	0.2	0 (0)	1 (0.7)
Primary studies	32	7.5	18 (5.4)	14 (9.4)
Secondary education or similar	144	33.6	93 (33.2)	51 (34.2)
University studies	252	58.7	169 (60.4)	83 (55.7)
Employment status				
Paid work and housework	293	68.3	203 (72.5)	90 (60.4)
Housework	43	10.0	23 (8.2)	20 (13.4)
Jobless	23	5.4	15 (5.4)	8 (5.4)
Retired and pensioner	26	6.1	7 (2.5)	19 (12.8)
Another situation	44	10.3	32 (11.4)	12 (8.1)

The average number of household members, including the participant, was 2.81 ± 1.25.

Regarding their general health, 58.3% of the participants rated their health as "average", with an overall mean score of 2.06 ± 0.689.

The reliability of the GHQ-12 scale was confirmed with a Cronbach's alpha of 0.88, indicating high internal consistency.

The mean total GHQ-12 score was 11.43 ± 5.6. For the depression and anxiety subscale, the mean score was 6.19 ± 3.62, while the social dysfunction subscale had a mean score of 5.05 ± 2.11. Differences in GHQ-12 scores across age groups are presented in Figure 1a–c.

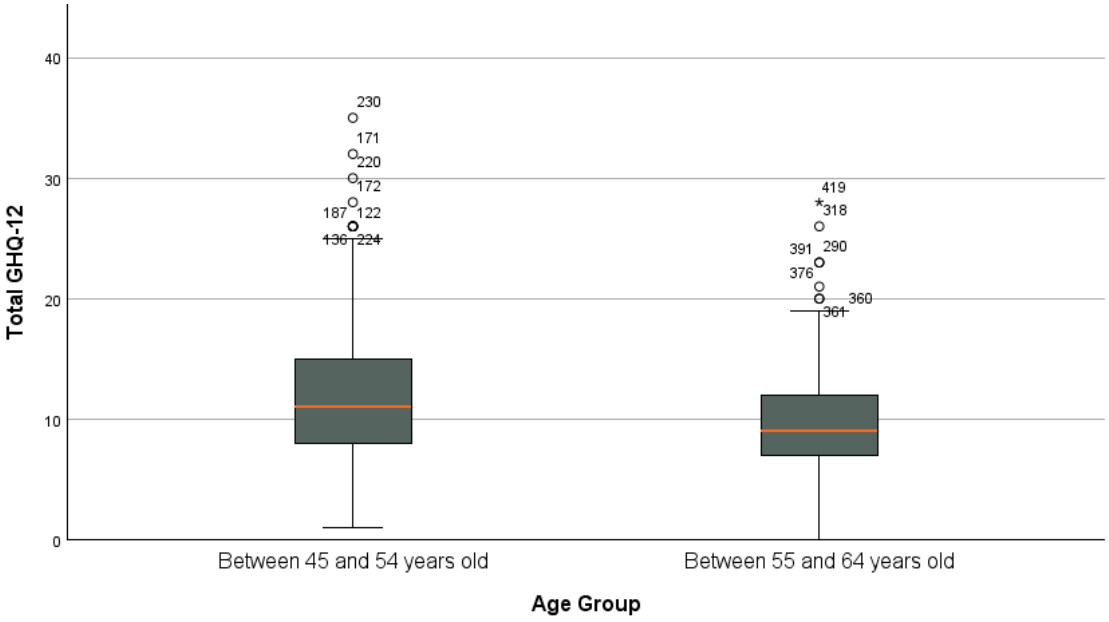
Of the 429 women in the sample, 80.7% were classified as having no psychological pathology according to the GHQ-12 scale, 6.9% were suspected of having subthreshold pathology, and 12.4% exhibited signs of psychological pathology.

The CFNI-45 scale, used to measure conformity to female gender norms, had lower reliability than the GHQ-12 scale, with a Cronbach's alpha of 0.694. While this value is not excellent, it is sufficient to consider the inventory as suitable for this population.

The mean total score on the CFNI-45 scale was 120.99 ± 11.68. The dimensions where women showed the lowest degree of conformity were sexual fidelity 11.62 ± 2.77, modesty 11.75 ± 2.40, and thinness 11.79 ± 2.86. In contrast, the highest degree of conformity was observed in the housework dimension, with a mean score of 16.59 ± 2.52.

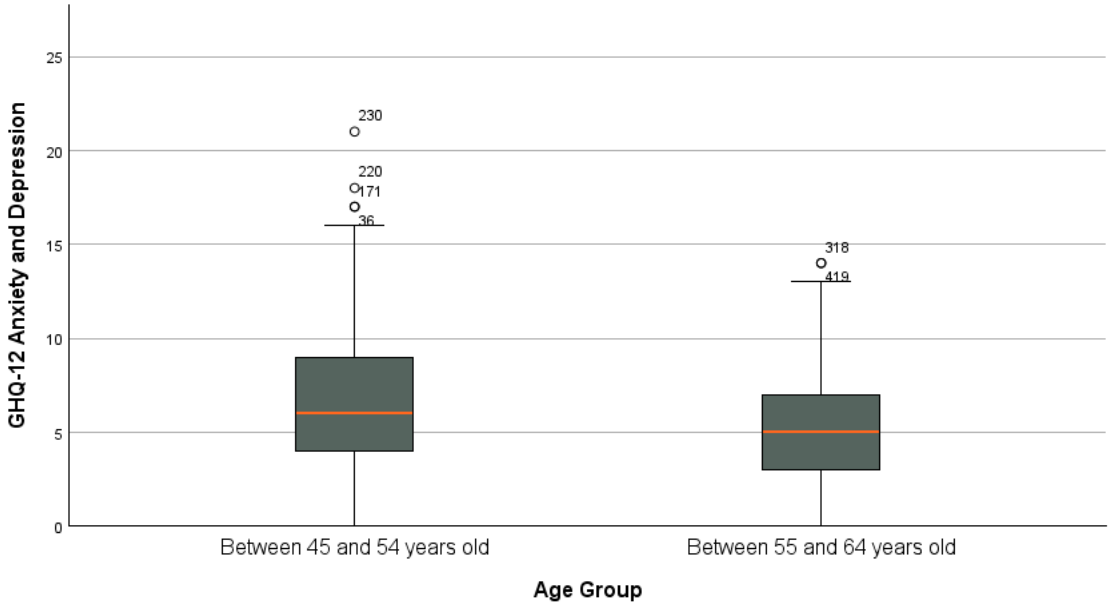
Regarding the age group differences, statistically significant differences between age groups were found only in the sexual fidelity dimension ($p = 0.012$), where older women exhibited greater conformity. No other subscales or the total score showed significant differences between the two age groups (45–54 and 55–64).

A multiple regression analysis was conducted to identify which dimensions of gender norm conformity influenced the GHQ-12 score. Among the gender norms measured, the thinness dimension emerged as a key predictor of psychological risk, together with other sociodemographic variables. This predictive model is shown in Table 2.

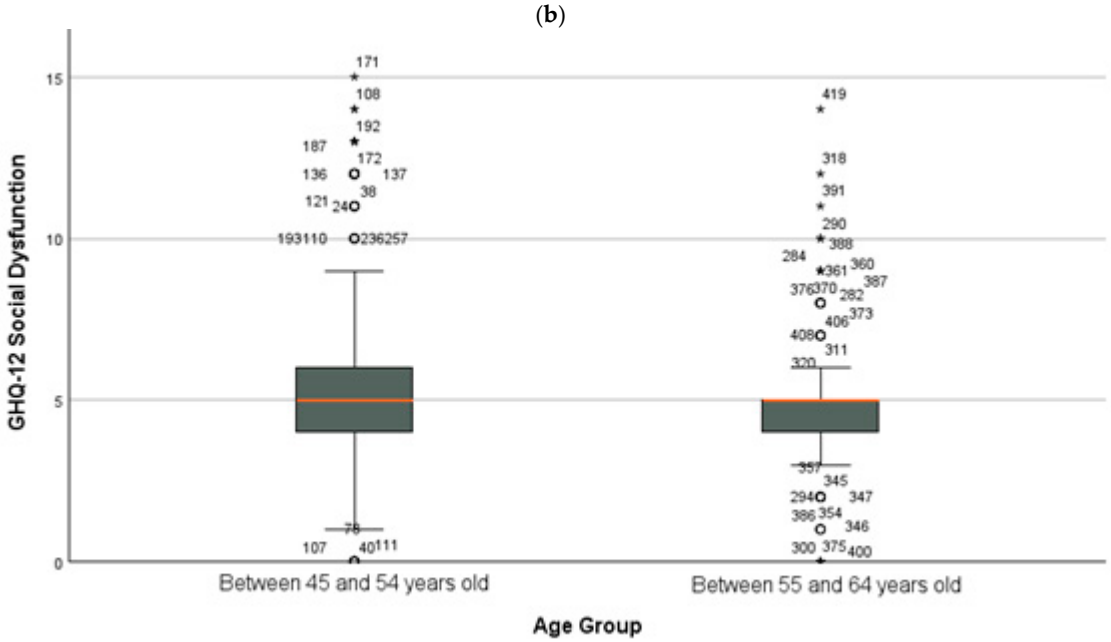


(**a**)

Figure 1. *Cont.*



(**b**)



(**c**)

Figure 1. (**a**). A box plot for the total score on the GHQ-12 scale, as a function of age group ($p < 0.001$). (**b**). A box plot for the score on the GHQ-12 scale for anxiety and depression, as a function of age group ($p < 0.001$). (**c**). A box plot for the score on the GHQ-12 scale for social dysfunction, as a function of age group ($p = 0.023$). * Extreme data, Red line: Median.

A mediation analysis was conducted using the Bootstrapping method to assess how declared health status (moderator variable W) influenced the relationship between the GHQ-12 score (predictor variable X) and the thinness dimension score from the CFNI-45 scale (outcome variable Y). It should be noted that only the thinness standard obtained statistical significance in this data analysis.

The variables reaching statistical significance were X (GHQ-12 score) and Y (thinness dimension score) ($p = 0.011$), suggesting a significant relationship between psychological risk and conformity to thinness norms; and X (GHQ-12 score) and W (declared health status) ($p < 0.001$), indicating a significant relationship between psychological risk and perceived health status. The mediation analysis showed that declared health status had

a moderating effect on the relationship between psychological risk and conformity to thinness norms, as illustrated in Figure 2.

Table 2. Multivariate linear regression: stepwise method. Effects of sociodemographic predictors and CFNI: thinness on total score on psychiatric risk scale (GHQ-12).

Factors Included in Model	β	CI 95% β	Error Deviation	t-Value	*p*-Value
Constant	7.655	4.395–10.915	1.658	4.616	<0.001
State of Health	2.401	1.674–3.128	0.370	6.490	<0.001
Age Group Reference: 55–64	−1.890	−2.960–−0.820	0.544	−3.473	<0.001
Thinness	0.222	0.048–0.396	0.089	2.503	0.013
Cohabitants	−0.449	−0.855–−0.043	0.207	−2.173	0.030

The regression model examining the predictors of psychological risk based on the GHQ-12 score produced the following key results: an R-value = 0.374, as well as an R^2 = 0.140, indicating a model prediction of 14%. The Durbin–Watson statistic was 1.939, which suggests that there is likely no autocorrelation in the residuals.

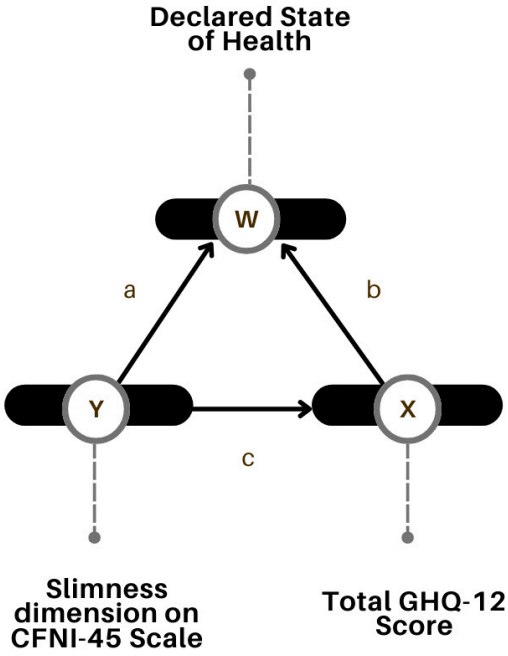


Figure 2. Mediation model for total GHQ-12 score and thinness on CFNI-45 scale, according to declared state of health.

In applying the PROCESS model (developed by Andrew Hayes) to explore the mediation effect of reported health status on the relationship between conformity to the female gender norm of thinness and psychological risk, the following results were obtained, as summarized in Table 3.

Table 3. Direct and indirect effects of thinness on total GHQ-12 score (moderating variable: declared health status).

Relation	β	SE	t	*p*-Value	95%CI
DE: thinness → total GHQ-12 score	0.1704	0.0580	2.9377	0.0035	0.0564–0.2843
DE: declared state of health → total GHQ-12 score	1.5561	0.2409	6.4602	<0.001	1.0827–2.0296
IE: thinness → declared state of health → total GHQ-12 score	−0.0794	0.0897	−0.8849	0.0376	−0.2557–0.0970

Note: Sample size bootstrap for indirect effects. Abbreviations: DE, direct effect; IE, indirect effect; SE, standard error; CI, confidence interval; β, non-standardized regression coefficient.

4. Discussion

In line with the objectives of the study, an initial analysis described the relationship between psychological risk and conformity to female gender norms.

One way to assess people's health is through self-reported health perception. The women in this sample rated their overall health as average—neither too bad nor too good. Considering that women in this period undergo various changes to which they must adapt, it is understandable that they perceive their health in this way. Additionally, the aging process begins, affecting self-image and self-esteem, contributing to a more negative view of health. Unfulfilled personal expectations or comparisons with other women who are in better health may further negatively impact women's well-being [14,15].

Regarding psychological risk, approximately 20% of the women in the study showed signs or suspicions of psychological pathology. Moreover, the women with the highest psychological risk scores (total score on GHQ-12) were the youngest climacteric women. Other authors have reported similar findings. Palacios et al. [16] attributed higher psychological risk in younger women to the emotional impact that the first climacteric changes can have, often accompanied by feelings of loss, anxiety, and even depression. The decline in estrogen is known to affect cognitive functioning, which may also explain the greater impact on younger women who experience the most abrupt hormonal declines [17]. Additionally, younger women may simultaneously face family, professional, and social responsibilities, increasing stress. Society also stigmatizes climacteric women as non-reproductive, non-beautiful, and with other negative associations [18]. For instance, some women may experience significant anxiety and sadness over the loss of fertility, which can diminish their self-esteem. Adjusting to this new reality can be challenging for younger women as they distance themselves from non-climacteric women, leading to emotional distress [19,20].

In terms of conformity to female gender norms, the women in the sample showed moderate acceptance, with lower acceptance of norms regarding sexual fidelity, modesty, and maintaining a slim figure. In contrast, the highest acceptance was for the norm of being domestic and performing household chores. Sexual fidelity is a gender norm that has rarely been imposed on men. Historically, it was seen as necessary to ensure legitimate offspring. Today, with various family models emerging and marriage no longer being a prerequisite for forming a family, the norm of sexual fidelity has become less significant [21]. Climacteric women may re-evaluate themselves and their relationships, reflecting on their needs and desires. After years of fulfilling family, parenting, and societal expectations, they may feel a greater need to focus on themselves and their well-being. This may lead some women to feel less compelled to adhere to the norm of female sexual fidelity if they no longer identify with it [22]. Furthermore, the decline in fertility eliminates the risk of pregnancy, which may lead to a more relaxed attitude toward sexual practices. Some women may seek new sexual experiences or relationships that fulfill them differently, which may not always align with sexual fidelity. It is also important to recognize that mature women often have the life experience to discern what is fair, such as the inequity of greater social permissiveness for male infidelity. Sometimes, a lack of sexual or emotional connection within a relationship may lead women to seek emotional or sexual satisfaction outside of it [23,24].

Climacteric women may distance themselves from modesty, due to the introspection that often occurs during this period. The climacteric phase can be seen as an opportunity for women to liberate themselves from societal expectations, including modesty, which has often been imposed throughout their lives. This sense of empowerment may lead to greater self-assertion and a desire to express themselves without the constraints they previously felt. Additionally, in cultures that prioritize youth, climacteric women may reject modesty in an effort to claim visibility and recognition, as modesty could be seen as a form of self-suppression that hinders their goal [25,26].

Regarding the ideal of thinness, the climacteric women in the study generally rejected this norm. Physical changes such as weight gain and fat redistribution, particularly around the abdomen, make the ideal of thinness unrealistic [27]. The pressure to maintain a slim body can lead to anxiety, stress, and low self-esteem among climacteric women. This demand can be particularly harmful, as many women at this stage struggle with body acceptance and adjusting to the aging process [28]. Climacteric women, with their accumulated life experiences and wisdom, may reject this demand as a form of resistance against the objectification and social control of their bodies. Kilpela et al. [29] advocate for a holistic approach to health that emphasizes good nutrition, adequate exercise, and emotional well-being, rather than focusing on a specific physical appearance.

Unlike the other gender norms, climacteric women seemed more comfortable with the norm of performing household chores. Women are often socialized from a young age to take on domestic roles, leading them to continue these responsibilities even in adulthood and during the climacteric years [30]. For some women, housework is not just an obligation, but a source of identity and fulfillment. Caring for the home and family may have been central to their lives for decades, and relinquishing these responsibilities could feel like a loss of their vital role. Other women may view these tasks as a way to maintain control and authority within the household. Taking a central role in household duties allows them to feel that they are maintaining order and harmony within the family. Despite progress toward gender equality, cultural shifts are often slow. The lack of support or recognition for changing these gender norms within the family or community may cause women to continue performing these tasks out of habit or a lack of viable alternatives [31,32].

To address the second objective of the study, regression and mediation analyses were conducted. These analyses revealed that psychological risk, as measured by the GHQ-12 questionnaire, was related to perceived health status, age group, acceptance of the thinness norm, and the number of cohabitants in the household. Chorot et al. [32] confirmed these findings, indicating that self-perceived health is a subjective indicator of general well-being. When a woman perceives her health negatively during this stage, she is more likely to experience psychological distress, which increases psychological risk. With age, women may feel increased social pressure due to the loss of youth, contributing to an elevated risk of psychological issues. They may also worry about the onset of chronic health problems and potential declines in quality of life as they age [33]. The social and family environment significantly influences the mental health of climacteric women. Pressure to conform to beauty ideals, such as thinness, often leads to body dissatisfaction, eating disorders, and increased vulnerability to mental health issues like anxiety and depression [34,35]. Women living alone may be at greater risk of social isolation, while those living with multiple people may experience stress due to increased family responsibilities or a lack of personal space, which can also negatively affect their psychological well-being [36–38]. A moderating effect of health perception was found in the relationship between psychological risk and acceptance of the thinness norm. As found in this study, psychological risk is associated with both self-perceived health [3] and agreement with the thinness ideal; however, the impact of thinness on women's psychological health during the climacteric period was previously unknown to be moderated by perceived health.

As with other studies, this research has limitations. The non-random sampling could lead to selection bias, limiting the generalizability of the findings. There is also a risk of response bias, as conformity to gender norms is a sensitive issue, and responses may have been influenced by social desirability, despite anonymity. Another limitation could be not having consulted women about their menopausal status, and using age as a classifier for groups, but more and more others are opting for this classification, which facilitates data comparability.

On the other hand, the study has strengths, such as its moderate cost, its versatility in gathering information through surveys, and its capacity to estimate population trends through statistical inference.

5. Conclusions

This study explored psychological risk and conformity to female gender norms in climacteric women, examining how certain study variables relate to psychological risk in this group. Nearly a quarter of the sample exhibited psychological risk, with the youngest women being the most affected. The climacteric women generally conformed to the gender norm that women should be responsible for household chores. However, they disagreed with the imposition of norms regarding female sexual fidelity, modesty, and maintaining a slim figure. Psychological risk was associated with self-perceived health, age group, conformity to the thinness ideal, and the number of cohabitants in the household. Additionally, a moderating effect of health perception was found in the relationship between psychological risk and acceptance of the thinness norm. Based on these findings, the inclusion of female gender norm exploration in programs aimed at health promotion and disease prevention for climacteric women is recommended, thus fostering a holistic approach to care.

Author Contributions: Conceptualization, R.M.C.-G. and V.V.-G.; methodology, R.M.C.-G. and V.V.-G.; software, R.M.C.-G.; validation, M.E.A.-G., R.S.-C. and I.C.-G.; formal analysis, R.M.C.-G. and V.V.-G.; investigation, R.M.C.-G., V.V.-G., L.P.-P., C.D.-F., A.M.-d.C., M.M. and I.P.; resources, L.P.-P.; data curation, L.P.-P.; writing—original draft preparation, R.M.C.-G., V.V.-G., L.P.-P., C.D.-F., A.M.-d.C., M.M. and I.P.; writing—review and editing, M.E.A.-G., R.S.-C. and I.C.-G.; visualization, M.E.A.-G., R.S.-C. and I.C.-G.; supervision, R.M.C.-G. and I.P.; project administration, R.M.C.-G. and I.P. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of the Health Area of Segovia (PI 34-2018).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data underlying this article will be shared by the corresponding author upon reasonable request.

Conflicts of Interest: The authors declare no conflicts of interest.

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