



EXPLORING THE LINK BETWEEN MENSTRUAL DISTRESS AND SEXUAL BEHAVIOUR AMONG WOMEN OF DIFFERENT PARITY: A HEALTH PERSPECTIVE UNDER SDG 3

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Abstract

The present study examined differences in menstrual distress and sexual behaviour among nulliparous, primiparous, and multiparous women, and explored the relationship between menstrual distress and sexual behaviour across these groups. A purposive sample of 115 women (54 nulliparous, 31 primiparous, and 30 multiparous), aged 22–35 years, was assessed using Moos' Menstrual Distress Questionnaire (1985), the Sexual Behaviour Scale, and an interview schedule. An ExpostFacto and cross-sectional design was employed, with data analysed using one-way ANOVA, independent-sample t-tests, and product moment correlations. Findings revealed that multiparous women reported significantly higher fear of sex compared to the other groups, while nulliparous and primiparous women did not differ significantly on any variables. Among nulliparous women, menstrual distress was positively associated with sexual anxiety and fear of sex, and negatively associated with sexual esteem and sexual satisfaction. For primiparous women, menstrual distress correlated positively with sexual consciousness, while among multiparous women it correlated positively with sexual anxiety. The study concludes that fertility status is closely linked with variations in sexual behaviour, with fear of sex being particularly salient among multiparous women.

Keywords: *Menstrual Distress, Sexual Behaviour, Nulliparous, Primiparous, Multiparous Women.*

Introduction

Menstrual distress, encompassing conditions such as dysmenorrhea (painful menstruation), premenstrual syndrome (PMS), and related physical and psychological symptoms, represents a significant yet often under-addressed aspect of women's reproductive health. It manifests through symptoms like abdominal pain, headaches, backache, breast tenderness, irritability, depression, anxiety, fatigue, and behavioral changes that can disrupt daily functioning, interpersonal relationships, and overall quality of life. These experiences vary in intensity and are influenced by physiological, hormonal, and psychosocial factors, including the hypothalamic-pituitary-ovarian axis, stress, and emotional states.

Menstrual distress is not merely a biological phenomenon but intersects with broader dimensions of sexuality and gender roles. Sexual behavior—ranging from solitary activities like masturbation to socio sexual interactions—along with attitudes toward sexuality (e.g., sexual esteem, anxiety, assertiveness, satisfaction, and preoccupation) and sex roles (masculine, feminine, androgynous, or undifferentiated traits) psychological dimensions, including stress, depressive symptoms, and difficulties in sexual functioning, significantly influence women's experiences of reproductive processes. These factors may both intensify menstrual-related problems and emerge as consequences of menstrual disturbances.

A key dimension explored is parity—the number of times a woman has given birth—categorized as nulliparous (no births, primary infertility context), primiparous (one birth, often linked to secondary infertility), and multiparous (multiple births). Variations in menstrual experiences across these groups



may arise from post-childbirth physiological changes, hormonal adjustments, and evolving patterns of sexual behaviour and attitudes. For instance, nulliparous women may report higher severity of primary dysmenorrhea, while parity-related factors like breastfeeding, postpartum changes, or accumulated reproductive stress could influence distress patterns in primiparous and multiparous women.

This area of inquiry has gained heightened relevance within the global health agenda, particularly under Sustainable Development Goal 3 (SDG 3): Good Health and Well-Being, which aims to promote healthy lives and well-being across all stages of life. A key focus of SDG 3 is Target 3.7, which underscores universal access to comprehensive sexual and reproductive health-care services, including family planning, education, and the integration of reproductive health into national health policies. Menstrual health constitutes a vital component of reproductive well-being, as inadequate management of menstrual distress is associated with physical discomfort, psychological strain, reproductive health complications, and obstacles to achieving optimal sexual health. Addressing links between menstrual distress and sexual behavior/attitudes across parity groups aligns with promoting holistic women's health, reducing preventable suffering, and advancing gender-sensitive care—key to achieving SDG 3's vision of equitable health outcomes.

By investigating variations across nulliparous, primiparous, and multiparous women, this perspective aims to inform targeted interventions that enhance menstrual well-being, foster positive sexual attitudes and behaviors, and contribute to broader goals of universal reproductive health access and reduced health inequities.

Need For the Study

Although menstruation is a universal experience among women of reproductive age, menstrual distress remains under-recognized and under-treated. Many women silently endure pain, discomfort, and emotional distress due to a lack of awareness, social stigma, and inadequate healthcare support. This results in emotional distress and relationship problems. Antenatal anxiety and depression can occur due to physical discomfort, fear of childbirth, and role changes. The impact of these menstrual difficulties on sexual behaviour is rarely addressed in clinical or community health settings.

Existing studies have focused either on menstrual problems or on sexual behaviour, but very few have examined the relationship between the two, particularly with reference to parity differences. Cultural taboos surrounding menstruation and sexuality further limit open discussion and research in this area, especially in developing societies.

There is a pressing need to generate empirical evidence that highlights how menstrual distress affects sexual behaviour and how reproductive history moderates this relationship. Such knowledge can inform health education programmes, counselling services, and policy initiatives aimed at improving women's reproductive and sexual health. This study attempts to bridge this research gap and contribute to SDG-3 by promoting holistic well-being among women.

Literature Review

The reviewed studies consistently highlight that dysmenorrhea and menstrual distress have a substantial negative impact on women's quality of life and sexual behaviour across different stages of the reproductive lifespan. Research by Harel (2006) and Reina et al. (2024) and Reina et al. (2024) demonstrated that moderate to severe menstrual pain is associated not only with physical discomfort but also with emotional disturbances, impaired daily functioning, and reduced sexual desire, arousal, comfort, and intimacy. These findings suggest that menstrual distress contributes to sexual dysfunction



and avoidance of sexual activity. Studies examining parity and sexual behaviour further reveal that reproductive status plays an important role in shaping sexual functioning. Banaei et al. (2020) reported variations in sexual satisfaction, frequency, and comfort between nulliparous, primiparous, and multiparous women, indicating that childbirth-related physical changes, psychological adaptation, and increased responsibilities influence sexual behaviour. Lund et al. (2021) showed that parity does not protect women from the adverse effects of menstrual pain, as menstrual distress was significantly associated with reduced sexual desire and increased sexual problems even among parous women. Qualitative evidence by Demirtaş and Oskay (2024) complemented these quantitative findings by emphasizing the role of emotional sensitivity, pain, and socio-cultural beliefs in shaping sexual behaviour during menstruation. Overall, the literature underscores that menstrual distress, in interaction with parity-related biological, psychological, and socio-cultural factors, significantly affects women's sexual functioning and behaviour.

Theoretical Approaches

The present study is grounded in an integrated biopsychosocial model to explain the relationship between menstrual distress and sexual behaviour among nulliparous, primiparous, and multiparous women. The Biopsychosocial Model (Engel, 1977), menstrual distress is conceptualized as the result of interacting biological factors (hormonal fluctuations, reproductive history, parity), psychological factors (sexual anxiety, fear of sex, sexual esteem, sexual consciousness), and social influences (marital expectations, cultural norms, caregiving roles).

The Health Belief Model (HBM) was originally developed by Godfrey, Kegels & Irwin (1950) the model explains how perceptions of susceptibility to illness, the severity of health conditions, the benefits of preventive care, and barriers to healthcare influence behavior. Hence the Women's perception of menstrual pain and distress could influence Sexual avoidance; Sexual engagement; Health-seeking behaviour. Moreover, the Parity could also influence Perceived vulnerability: Pain tolerance and Coping ability.

Research Methodology

Research Problem

The main research problem of the study was to investigate the difference among nulliparous, primiparous, and multiparous women on menstrual distress, sexual behavior, as well as the relationship of menstrual distress with sexual behavior of these three groups of women.

Objectives

1. To ascertain whether a significant difference would exist on menstrual distress among nulliparous, primiparous and multiparous women.
2. To ascertain whether significant difference would exist on each dimension of sexual behavior among nulliparous, primiparous and multiparous women.
3. To investigate whether menstrual distress would be significantly related to each of the dimensions of sexual behavior of nulliparous women.
4. To investigate whether menstrual distress would be significantly related to each of the dimensions of sexual behavior of primiparous women.
5. To investigate whether menstrual distress would be significantly related to each of the dimensions of sexual behavior of multiparous women.



Hypotheses

1. Nulliparous, primiparous and multiparous women would differ significantly on menstrual Distress (Dennerstein et al. (2005).
2. Nulliparous, primiparous and multiparous women would differ significantly on each dimension of sexual behavior(Shifren et al., 2008).
3. Menstrual distress would not be significantly related to each of the dimensions of sexual behavior of nulliparous women.
4. Menstrual distress would not be significantly related to each of the dimensions of sexual behavior of primiparous women.
5. Menstrual distress would not be significantly related to each of the dimensions of sexual behavior of multiparous women.

Research Design: The study adopted an Expost Facto and cross-sectional design research to examine the relationship between menstrual distress and sexual behaviour among women of different parity.

Sample

The sample comprised 115 married women, including 54 nulliparous, 31 primiparous, and 30 multiparous women in their early adulthood. Majority of the participants were homemakers and graduates residing in Chennai city.

Tools Used

1. Menstrual Distress Questionnaire (MDQ) – used to assess physical, emotional, and behavioural symptoms related to menstruation.
2. Sexual Behaviour Scale – used to measure sexual attitudes, interest, and behavioral patterns.

Both tools were standardized and demonstrated satisfactory reliability and validity.

Tool Description

Moos Menstrual Distress Questionnaire (MDQ; Moos, 1968)

It included eight categories with a series of statements pertaining to the symptoms. A 6-point scale was used. The responses included ‘ No experience of symptom’, ‘Barely notice’, ‘Present Mild’, ‘Present moderate’, ‘ Pre strong and pre strong disabling Each symptom carried a weightage ranging from 2 – 7.

Multidimensional Sexuality Questionnaire (MSQ)

Multidimensional Sexuality Questionnaire (MSQ) by Snell., Fisher., and Walters, (1993) is an objective, self-report instrument designed to measure of 12 aspects of human sexuality: (1) Sexual esteem, (2) Sexual Preoccupation, (3) Internal Sexual control, (4) Sexual – Consciousness, (5) Sexual Motivation, (6) Sexual Anxiety, (7) Sexual Assertiveness, (8) Sexual Depression, (9) External Sexual Control, (10) Sexual Monitoring, (11) Fear of Sex, (12) Sexual Satisfaction. The Multidimensional Sexuality Questionnaire consists of 60 items arranged in a format where respondents indicate how characteristic of them each statement is: a 5-point Likert scale is used to collect data on people's responses, with each item being scored from 0 to 4.

Procedure

After obtaining informed consent, data were collected individually while ensuring confidentiality and ethical standards. Participants were informed about the purpose of the study and encouraged to respond honestly. These scales were administered along with the interview schedule as per the



standardized instructions and the responses were scored according to the instructions given in the manual concerned. Data was collected and analyzed statistically.

Statistical Analysis

The data were analyzed using descriptive statistics (mean and standard deviation) and inferential statistics such as ANOVA and correlation tests to examine differences and relationships among variables.

Results and Discussion

Table 1 Mean and Standard Deviation of Menstrual Distress, and Dimensions of Sexual Behaviour among Nulliparous, Primiparous and Multiparous Women.

Variables	Parity of Women (N=115)					
	Nulliparous (N=54)		Primiparous (N=31)		Multiparous(N=30)	
	Mean	SD	Mean	SD	Mean	SD
Menstrual Distress	96.31	33.62	99.06	32.28	102.03	27.74
Sexual Esteem	10.04	3.82	9.39	3.82	8.7	3.79
Sexual Preoccupation	7.83	3.62	7.84	3.62	8.43	5.03
InternalSexual Control	9.5	4.11	11.74	4.26	10.57	5.39
Sexual Consciousness	10.29	4.78	11.16	4.67	10.73	3.99
Sexual Motivation	10.17	4.62	9.64	3.32	8.97	4.24
Sexual Anxiety	6.25	4.68	5.64	3.82	5.67	3.89
Sexual Assertiveness	11.39	3.94	11.03	5.43	10.07	3.25
Sexual Depression	3.94	4.49	4.87	5.64	5.7	5.15
ExternalSexual Control	5.79	4.27	6.42	5.01	7.43	4.18
Sexual Monitoring	6.09	4.77	6.42	5.25	7.23	5.69
Fear of Sex	6.07	4.94	6.58	5.25	11.37	5.97
Sexual Satisfaction	13.42	5.32	13.45	4.43	13	4.70

Mean scores indicated a gradual increase in menstrual distress with parity, from nulliparous (M = 96.31, SD = 33.62) to primiparous (M = 99.06, SD = 32.28) and multiparous women (M = 102.03, SD = 27.74). Sexual esteem, motivation, and assertiveness showed a declining trend with increasing parity, while sexual depression, external sexual control, and sexual monitoring increased. Sexual preoccupation remained largely comparable across groups, with a slight elevation among multiparous women. Internal sexual control and sexual consciousness peaked among primiparous women. Sexual anxiety was marginally higher among nulliparous women. A pronounced parity-related difference was observed for fear of sex, which was substantially higher among multiparous women compared to nulliparous and primiparous women. In contrast, sexual satisfaction remained relatively stable across all three groups, indicating minimal variation in overall sexual satisfaction irrespective of parity. The observed trends may be attributed to cumulative biological strain, hormonal changes, and physical discomfort associated with repeated pregnancies and childbirth, which can heighten menstrual distress. Increased role demands, caregiving responsibilities, and fatigue with higher parity may reduce sexual motivation and assertiveness while increasing anxiety and fear related to sexual activity. Nevertheless,



emotional bonding, marital adjustment, and relational stability may help maintain overall sexual satisfaction despite these challenges.

Table 2 Differences in Menstrual Distress among Nulliparous, Primiparous and Multiparous Women

Variable		Sum of Squares	df	Mean Square	F	p
Menstrual Distress	Between Groups	642.001	2	321.001	0.317	0.729 (NS)
	Within Groups	113496.486	112	1013.361		

A one-way analysis of variance

(ANOVA) was conducted to examine whether there are significant differences in menstrual distress scores among nulliparous, primiparous, and multiparous women. The results revealed an F-statistic of 0.317 and a corresponding p-value of 0.729. Since the p-value is substantially greater than the conventional significance level of 0.05, the difference in mean menstrual distress scores across the three parity groups was not statistically significant ($F(2, 112) = 0.317, p = 0.729$). Hence the stated hypothesis 1 is rejected. Though the mean value suggests greater menstrual discomfort with increasing parity, the difference is not statistically significant. This indicates that, based on the present data, parity (i.e., whether a woman has had zero, one, or multiple previous births) does not appear to have a meaningful impact on the level of menstrual distress experienced. In other words, nulliparous, primiparous, and multiparous women reported similar average levels of menstrual distress, and any observed differences are most likely attributable to random variation rather than to differences in parity. Findings of the present study also supported by Pinzauti et al. (2013) & Ju et al. (2014). Menstrual distress is a multidimensional experience that is influenced not only by parity but also by hormonal management, stress levels, lifestyle, pain tolerance, psychological coping, and social support. This could account for the lack of a statistically significant difference. Even while there are physiological changes associated with parity, individual differences and adaptation measures may mitigate their effects, leading to similar levels of suffering across groups.

Table 3 Differences in Sexual Behaviour across Parity

Dimensions of sexual behavior	Mean Sum of Squares		F	P
	Among Groups	Within Group		
Sexual Esteem	17.57	14.53	1.209	NS
Sexual Preoccupation	3.97	16.13	0.246	NS
Internal Sexual Control	50.18	20.33	2.469	NS
Sexual Consciousness	7.53	19.78	0.381	NS
Sexual Motivation	13.98	20.57	0.680	NS
Sexual Anxiety	5.22	17.25	0.303	NS
Sexual Assertiveness	17.01	13.99	1.215	NS
Sexual Depression	30.73	24.33	1.263	NS
External Sexual Control	25.86	21.71	1.191	NS
Sexual Monitoring	12.62	25.92	0.487	NS
Fear of Sex	291.79	28.16	10.36	< .001**
Sexual Satisfaction	2.11	24.36	0.086	NS

* Fear of Sex is the only significant dimension related to parity The one-way ANOVA results indicate that there are no statistically significant differences among nulliparous, primiparous, and multiparous



women on most dimensions of sexual behaviour. Specifically, sexual esteem ($F = 1.209$, NS), sexual preoccupation ($F = 0.246$, NS), internal sexual control ($F = 2.469$, NS), sexual consciousness ($F = 0.381$, NS), sexual motivation ($F = 0.680$, NS), sexual anxiety ($F = 0.303$, NS), sexual assertiveness ($F = 1.215$, NS), sexual depression ($F = 1.263$, NS), external sexual control ($F = 1.191$, NS), sexual monitoring ($F = 0.487$, NS), and sexual satisfaction ($F = 0.086$, NS) do not show significant variation across parity groups, as the mean sum of squares among groups is not sufficiently larger than the within-group variance. However, a highly significant difference is observed for the dimension fear of sex, where the mean sum of squares among groups (291.79) is substantially higher than the within-group mean sum of squares (28.16), yielding an F value of 10.36, which is significant at the 0.001 level ($p < .001$). Hence hypothesis 2 stated above is partially supported as significant differences were found in one dimension (fear of sex), while the remaining dimensions did not show significance. Hence the finding indicates that fear of sex differs markedly among nulliparous, primiparous, and multiparous women, while all other dimensions of sexual behaviour remain statistically comparable across the three groups. In supporting the findings of the present study Laumann et al. (1999) observed that while most sexual behaviour dimensions show minimal demographic variation, fear and anxiety related to sex are particularly influenced by major life transitions such as childbirth. The stabilizing effects of marital adjustment, emotional intimacy, and shared relationship norms—all of which tend to be constant throughout parity groups—may be responsible for the lack of significant disparities across the majority of sexual behavior aspects. Similar results are obtained across populations because sexual attitudes, motivation, pleasure, and self-perceptions are frequently influenced more by psychological well-being, relationship quality, and cultural expectations than by reproductive history alone. On the other hand, parity-related physiological and psychological experiences, especially among multiparous women, can account for the large variation in fear of sex. Experiences like uncomfortable childbirth, changes in the body after giving birth, dread of discomfort, decreased libido from exhaustion, and worries about one's health or another pregnancy can all increase anxiety about having sex.

Table 4. Differences in Fear of Sex among Nulliparous, Primiparous and Multiparous women.

Groups of women	Mean	Comparisons	Standard Error	't' value	'p' value
Nulliparous (NP)	6.07	NP (Vs) PP	1.16	0.44	NS
Primiparous (PP)	6.58	PP (Vs) MP	1.44	3.32	<.01
Multiparous (MP)	11.36	NP (Vs) MP	1.30	4.10	<.01

The results presented in the table indicate clear differences in fear of sex among women of different parity. The mean fear of sex scores show a progressive increase from nulliparous ($M = 6.07$) to primiparous women ($M = 6.58$), with the highest level observed among multiparous women ($M = 11.36$). The comparison between nulliparous and primiparous women is not statistically significant ($t = 0.44$, NS), suggesting that the transition to first childbirth does not substantially alter fear of sex. However, highly significant differences are observed between primiparous and multiparous women ($t = 3.32$, $p < .01$) and between nulliparous and multiparous women ($t = 4.10$, $p < .01$). These findings indicate that fear of sex increases significantly with higher parity, particularly among multiparous women, possibly due to cumulative physical strain, childbirth-related trauma, concerns about bodily changes, fatigue, and negative prior sexual or obstetric experiences. Thus, parity appears to exert a selective influence on fear-based sexual responses rather than uniformly affecting all dimensions of sexual behaviour. Khajehei et al. (2015) similarly found that multiparous women reported



significantly higher levels of fear of intercourse and sexual pain compared to nulliparous and primiparous women, even when overall sexual satisfaction did not differ.

Additionally, Leeman and Rogers (2012) observed that repeated vaginal deliveries were associated with increased sexual anxiety and fear due to concerns about pelvic floor changes and discomfort during intercourse. These studies substantiate the present result that fear of sex rises significantly with increasing parity, particularly distinguishing multiparous women from nulliparous and primiparous groups.

Table 5 Relationship Between Menstrual Distress With Sexual Behavior of Nulliparous Women.

Variables	'r' value	'p'
Sexual Esteem	-0.27	< .05
Sexual Preoccupation	0.06	NS
Internal Sexual Control	-0.08	NS
Sexual Consciousness	-0.08	NS
Sexual Motivation	0.00	NS
Sexual Anxiety	0.46	< .01
Sexual Assertiveness	-0.06	NS
Sexual Depression	0.21	NS
External Sexual Control	0.17	NS
Sexual Monitoring	0.11	NS
Fear of Sex	0.27	< .05
Sexual Satisfaction	-0.34	< .05

From the table it is evident that Sexual esteem, sexual anxiety, fear of sex and sexual satisfaction were the four variables which had significant relationship ($p < 0.05$) with menstrual distress of nulliparous women. Hence hypothesis 3 was partially rejected as significant relationships were observed in four dimensions (Sexual esteem, sexual anxiety, fear of sex and sexual satisfaction), while the remaining eight dimensions did not show significant relationships. Those who had low sexual esteem had higher menstrual distress than those who had high sexual esteem. Thus there was a significant inverse relationship between sexual esteem and menstrual distress among nulliparous women. Sexual anxiety on the other hand had a significant positive relationship with menstrual distress. Anxiety and menstrual distress were always found to be significantly related to each other. Sexual anxiety was not an exception. So those who had high menstrual distress among nulliparous women definitely required psychological counseling not only to get relief from menstrual distress but also from sexual anxiety as well. Similarly fear of sex also was found to have significant positive relationship with menstrual distress among nulliparous women. Sexual satisfaction had a significant negative relationship with menstrual distress. That is, those who had high sexual satisfaction had less menstrual distress than those who had low sexual satisfaction. The present study clearly thus brought out the importance of sex related psychological counseling for nulliparous women to overcome menstrual distress. This could be attributed to the fact that low sexual self-esteem and negative attitudes toward sexuality were associated with increased dysmenorrhea and premenstrual symptoms (Harlow & Stewart, 2003 & Chen et al., 2010). Moreover, Laumann et al. (1999) noted that fear-based sexual responses and avoidance were associated with poorer reproductive health outcomes and higher symptom reporting.



Table 6 Relationship between Menstrual Distress and Sexual Behavior of Primiparous Women.

Variables	r	p
Sexual Esteem	0.10	NS
Sexual Preoccupation	-0.22	NS
Internal Sexual Control	0.20	NS
Sexual Consciousness	0.40	< .05
Sexual Motivation	0.22	NS
Sexual Anxiety	0.30	NS
Sexual Assertiveness	-0.09	NS
Sexual Depression	-0.29	NS
External Sexual Control	-0.26	NS
Sexual Monitoring	-0.01	NS
Fear of Sex	-0.09	NS
Sexual Satisfaction	0.08	NS

Table 6 shows that except sexual consciousness ($r=0.40$), all dimensions of sexual behavior did not reveal any significant relationship with menstrual distress of primiparous women. Hence the Null hypothesis 4 corresponding to sexual consciousness were rejected, whereas the null hypotheses for the remaining dimensions were retained (accepted). It could be attributed to the link among sexual consciousness, menstrual distress and decision to have another child (McQuillan et al. (2012); gynecological and menstrual discomfort (Dennerstein, Leher, and Burger (2005) & cognitive preoccupation (Harlow and Stewart, 2003).

Table 7 Relationship between Menstrual Distress and Sexual Behavior of Multiparous Women.

Variables	r	p
Sexual Esteem	-0.10	NS
Sexual Preoccupation	-0.12	NS
Internal Sexual Control	-0.16	NS
Sexual Consciousness	0.06	NS
Sexual Motivation	-0.01	NS
Sexual Anxiety	0.69	< .01
Sexual Assertiveness	-0.02	NS
Sexual Depression	-0.14	NS
External Sexual Control	0.23	NS
Sexual Monitoring	0.07	NS
Fear of Sex	-0.00	NS
Sexual Satisfaction	0.02	NS

From table 7, shows that almost all the dimensions of sexual behavior of multiparous women also did not reveal a significant relationship with menstrual distress, sexual anxiety alone was found to have a significant positive relationship with menstrual distress among multiparous women. Hence the Null



hypothesis 5 corresponding to sexual anxiety were rejected, whereas the null hypotheses for the remaining dimensions were retained (accepted). Those multiparous women, who had high sexual anxiety, reported more menstrual distress than those who had low sexual anxiety. Though they could prove their fertility by begetting more than one child, some of those who had sexual anxiety did suffer from high menstrual distress. This could be attributed to cumulative childbirth-related changes, fatigue, and concerns about pelvic health (Leeman and Rogers, 2012) among multiparous women. However, Harlow and Stewart (2003) noted that women with higher anxiety levels reported greater severity of dysmenorrhea and menstrual symptoms regardless of parity. This finding once more emphasized the importance of sex related psychological counseling to multiparous women also for managing sexual anxiety besides menstrual distress.

Discussion

The present study did not show any significant difference among nulliparous, primiparous and multiparous women on menstrual distress but fear of sex emerged as a lone factor differentiating the three groups of women based on parity. Hence the profile of each of these three groups of women had to be separately investigated with a focus on menstrual distress without which womanhood could not be established. Though by anatomy and naturally morphology as well women would not differ much from each other, functionally there could be differences particularly on a psychological plane.

Statistical analysis pointed out the relationship of fear of sex, sexual anxiety, sexual consciousness and sexual esteem with menstrual distress of women depending upon their parity status. The following were the marked signs of fear of sex found among nulliparous women. Being somewhat afraid of becoming sexually involved with another person; feeling jittery while thinking about sexual aspects of life and being fearful at the time of sexual activity.

If these features of fear of sex had positive relationship with menstrual distress, certain manifestations of sexual esteem such as thoughts of being a pretty good sexual partner, being better at sex than most other people etc. and sexual satisfaction like expression of satisfaction over their sexual acts had inverse relationship with menstrual distress. So by taking clues from these responses, one could proceed to psychological interventions to manage menstrual distress by addressing sexual aspects of nulliparous women.

Similarly, the following were the signs of sexual consciousness found among the primiparous women contributing to menstrual distress: Thinking about sex all the time; Thinking about sex more than anything else and Being aware of sexual feelings.

Though pleasure arising out of sexual thoughts would always keep parasympathetic nervous systems active over sympathetic nervous systems, failure to do important activities expected of married women that too after begetting a child could arouse feelings of guilt as well. Perhaps the feeling of guilt could be held responsible for the experience of menstrual distress during which time energy level would be fairly low. Feeling of guilt could lower the energy level all the more especially at the time of menstruation. In contrast to nulliparous women and primiparous women, the following features emerged from multiparous women: feeling anxious while thinking about the sexual aspects of life ; general fear of sexual relationships because of exploitation of fertility; and being concerned with how the sexual aspect of life would appear to others.



The above-mentioned features mainly found among nulliparous, primiparous and multiparous women with significant link with menstrual distress need to be addressed in any psychological intervention.

Conclusions

From the results of the present study the following conclusions were drawn

1. Menstrual distress of women does not differ significantly based on Parity (nulliparous, primiparous, and multiparous women).
2. Most dimensions of sexual behaviour are similar across parity groups, except fear of sex, which is higher among multiparous women.
3. In nulliparous women, higher menstrual distress is associated with lower sexual esteem; satisfaction; higher sexual anxiety and fear of sex.
4. Among primiparous women, menstrual distress is significantly related only to sexual consciousness.
5. In multiparous women, sexual anxiety emerges as the primary correlate of menstrual distress.

Limitations of the Study

1. The study being ex-post-facto in nature, cause and effect relationship could not be established with regard to the variables selected for the investigation.
2. Had the sample size been larger, multivariate statistics like multiple regression analysis, discriminant function analysis, cluster analysis could have been carried out. Multivariate statistics would have exercised better statistical control over extraneous variables than univariate statistics like one way ANOVA, student 't' test and product moment correlation.

Suggestions for Future Study

1. Efficacy of psychological interventions could be studied not only for the benefit of target sample but also from the point of methodology because such a study would definitely be either experimental or quasi experimental in nature.
2. Some more variables such as the ones relating to spouses could be included to pave the way for family oriented psychological interventions.

Significance of the Study

The significance of the present study lies in identifying factors related to menstrual distress among nulliparous, primiparous and multiparous women with reference to their sexual behavior. Sex being one of the main functions of marital life could very well be influenced by the cycle of menstruation. Sex is always projected as a healthy means to reduce emotional tension. Hence sex oriented psychological counseling and sex education would be of immense value in alleviation of menstrual distress. Overall, the study emphasizes that addressing sexual behavior through appropriate counseling and education is essential for the effective management and alleviation of menstrual distress.

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