

Analysis of the Psychological Impact of Adenomyosis and Endometriosis Complex

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ABSTRACT

Background: Adenomyosis and endometriosis are chronic gynecological conditions commonly associated with pelvic pain, menstrual disturbances, and infertility. This study aimed to assess the prevalence of anxiety and depression among women with adenomyosis and endometriosis complex and to compare their psychosomatic profile with that of healthy controls.

Methods: An analytical cross-sectional study was conducted in the Department of Obstetrics and Gynaecology at a tertiary care hospital in Chennai. A total of 100 women were included, comprising 50 cases diagnosed with adenomyosis or endometriosis and 50 healthy controls. Sociodemographic and clinical data were collected using a pre-structured questionnaire. Anxiety and depression were assessed using the Hospital Anxiety and Depression Scale (HADS). Socioeconomic status was classified using the Modified B.G. Prasad Scale (2024).

Results: Anxiety was present in 8 women (16.0%) in the study group compared with 1 woman (2.0%) in the control group, while depression was observed in 10 women (20.0%) versus 1 woman (2.0%) in controls. Both anxiety and depression were significantly associated with the presence of adenomyosis or endometriosis. Lower educational status and lower socioeconomic class were significantly associated with higher rates of anxiety and depression ($p < 0.05$). Other variables such as age, parity, BMI, and history of pelvic surgery did not show significant associations.

Conclusion: Women with adenomyosis and endometriosis have a markedly higher prevalence of anxiety and depression compared to healthy individuals. Incorporating routine mental health screening and adopting a multidisciplinary management approach may improve quality of life and overall outcomes in this population.

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Introduction

Endometriosis is one of the most common gynecological conditions that profoundly compromises women's physical, social, and psychological well-being, resulting in a marked reduction in health-related quality of life. It is a chronic inflammatory disorder characterized by the presence of endometrium-like tissue outside the uterine cavity, leading to a sustained inflammatory response and progressive symptom burden [1,2]. Epidemiological

studies estimate that endometriosis affects approximately 6-10% of women of reproductive age, making it a significant public health concern [3]. Clinically, the condition is associated with a wide spectrum of symptoms, including dysmenorrhea, chronic pelvic pain, ovulation-related pain, deep dyspareunia, infertility, and persistent fatigue, all of which substantially impair daily functioning and overall well-being. Population-based studies indicate that nearly 15-20% of women of

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reproductive age experience chronic pelvic pain, with endometriosis being one of the leading underlying causes [4].

Adenomyosis is a closely related gynecological condition that frequently coexists with endometriosis and shares overlapping clinical, pathological, and therapeutic challenges [5]. It is defined by the invasion of endometrial glands and stroma into the myometrium, resulting in uterine enlargement and altered uterine function [6]. Women with adenomyosis commonly present with menorrhagia, dysmenorrhea, and chronic pelvic pain, symptoms that may also contribute to infertility and adverse pregnancy outcomes [7]. The frequent coexistence of adenomyosis and endometriosis further complicates diagnosis and management, as their symptoms often overlap and can vary in severity, duration, and impact on quality of life.

Despite being described several decades ago, adenomyosis remains substantially underdiagnosed and understudied. The absence of standardized diagnostic criteria, heterogeneous clinical presentations, and limitations in noninvasive diagnostic modalities contribute to significant diagnostic delays [8]. As a result, women with adenomyosis often experience a prolonged interval between symptom onset and definitive diagnosis, a delay that may be even longer than that observed in endometriosis. Both conditions are associated with chronic pain, fatigue, and emotional distress, which collectively exert a detrimental effect on physical, psychological, and social functioning [9]. Comparable to chronic conditions such as diabetes mellitus and rheumatoid arthritis, endometriosis has been shown to impose considerable economic burden due to healthcare costs, loss of productivity, and work absenteeism [8]. Given that the majority of affected women are of working age, these economic and social consequences are particularly significant.

The impact of adenomyosis and endometriosis extends beyond physical symptoms, influencing interpersonal relationships, sexual health, fertility decisions, and psychological well-being. Reduced quality of life among women of reproductive age can adversely affect family planning, social participation, self-esteem, and both personal and professional relationships. However, while the quality-of-life implications of endometriosis have been relatively well explored, there remains a paucity of literature examining the specific impact of adenomyosis on psychosocial health and overall quality of life in women of reproductive age [10]. This knowledge gap is

particularly concerning given the chronic and recurrent nature of adenomyosis-related symptoms. Consequently, women undergoing conservative management frequently experience persistent or recurrent symptoms such as menorrhagia and dysmenorrhea, which progressively undermine both physical and mental health. Notably, women with adenomyosis have been reported to have a significantly higher prevalence of depression, with rates reaching up to 57.1%, and are more likely to require antidepressant therapy compared to women with uterine fibroids [11].

The relationship between chronic pain and psychological distress is well established. Individuals experiencing cancer-related pain, neuropathic pain, or visceral pain in the presence of anxiety or depression often report lower treatment satisfaction, diminished pain tolerance, poorer responses to analgesic therapy, and more severe and prolonged pain symptoms compared to those without psychological comorbidities [12]. In the context of adenomyosis, available medical and surgical treatments primarily target symptom control rather than the underlying disease mechanism, offering limited long-term relief. As such, expanding psychological assessment and addressing mental health comorbidities may be essential for improving overall treatment outcomes.

In recent years, researchers have begun to explore the psychological dimensions of adenomyosis, including its effects on anxiety, depression, and overall psychosomatic health, as well as the impact of various treatments on these parameters [13]. Against this background, the present study aims to evaluate the psychosomatic impact of adenomyosis among women of reproductive age, with particular emphasis on anxiety and depression, in order to better inform holistic and patient-centered management strategies.

Materials & Methods

Study design and setting

This analytical cross-sectional study was conducted in the Department of Obstetrics and Gynaecology at Sree Balaji Medical College and Hospital, Chennai over 3 month period (January to March 2025). The study was designed to evaluate the psychosomatic impact of adenomyosis and endometriosis among women of reproductive age, with a particular focus on anxiety and depression. Data collection was carried out after obtaining institutional approvals and was undertaken in a tertiary care teaching hospital that caters to a diverse urban and semi-urban population, ensuring access to both

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clinically diagnosed cases and healthy comparison participants.

Study population and eligibility criteria

The study population comprised women aged 18 years and above who attended the outpatient or inpatient services of the Department of Obstetrics and Gynaecology. Women diagnosed with adenomyosis or endometriosis based on clinical evaluation and relevant imaging or surgical findings were included as cases. Healthy women without a known diagnosis of adenomyosis, endometriosis, or other chronic gynecological conditions served as controls. All participants were required to provide informed written consent prior to enrollment. Women with other significant chronic medical illnesses, psychiatric disorders diagnosed prior to the study, or conditions that could independently influence anxiety or depression were excluded. Participants who were unable to comprehend or complete the study questionnaires due to cognitive, language, or physical limitations were also excluded to ensure data reliability.

Sample size and sampling

A total of 100 participants were included in the study, comprising 50 women diagnosed with adenomyosis or endometriosis (cases) and 50 healthy women (controls). Cases and controls were selected using a convenient sampling approach during the study period. Efforts were made to recruit controls from the same hospital setting to ensure comparability with respect to sociodemographic background and healthcare-seeking behavior.

Ethical considerations

The study protocol was reviewed and approved by the Institutional Human Ethics Committee of Sree Balaji Medical College and Hospital (Approval No. 002/SBMCH/IHEC/2024/2300). The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. Written informed consent was obtained from all participants prior to data collection. Confidentiality of participant information was strictly maintained, and data were anonymized prior to analysis.

Data collection procedure

After obtaining informed consent, all participants underwent a detailed clinical interview, which included collection of sociodemographic information, menstrual and obstetric history, and relevant clinical details. A general physical examination and gynecological examination were performed for cases as part of routine clinical care. Both cases and controls were then

administered a pre-structured questionnaire designed to capture demographic variables, clinical characteristics, and psychosocial factors. The questionnaire was administered in a face-to-face manner by trained investigators to minimize missing data and to ensure uniformity in data collection.

Assessment of anxiety and depression

Anxiety and depression were assessed using the Hospital Anxiety and Depression Scale (HADS), a validated screening instrument widely used in both clinical and research settings [14]. The HADS consists of 14 items divided equally into two subscales: the anxiety subscale (HADS-A) and the depression subscale (HADS-D). Each item is scored on a four-point Likert scale, resulting in a maximum possible score of 21 for each subscale. Higher scores indicate greater severity of anxiety or depressive symptoms. For the anxiety subscale, scores of 0-7 were considered normal, 8-10 indicated mild anxiety, 11-15 indicated moderate anxiety, and scores of 16 or above were classified as severe anxiety. A similar grading pattern was applied for the depression subscale, with higher scores reflecting increasing severity of depressive symptoms [14]. The HADS was chosen for its brevity, ease of administration, and ability to differentiate psychological symptoms from somatic complaints, which is particularly relevant in patients with chronic gynecological conditions.

Assessment of socioeconomic status

Socioeconomic status of all participants was assessed using the Modified B.G. Prasad Socioeconomic Scale (2025) [15], which categorizes individuals based on per capita monthly income adjusted for the current consumer price index. This scale is widely used in Indian epidemiological studies and allowed for standardized classification of participants into socioeconomic strata. Socioeconomic status was included in the analysis to explore its potential influence on psychological outcomes.

Data management and statistical analysis

Data collected from the questionnaires were entered into a secure database and checked for completeness and accuracy prior to analysis. Statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) version 21. Descriptive statistics were used to summarize the data. Continuous variables were expressed as mean and standard deviation, while categorical variables were presented as frequencies and proportions. Comparisons between cases and controls were conducted using appropriate inferential statistical

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tests. The Chi-square or Fisher's exact test was applied for comparison of categorical variables, depending on cell frequencies. A p value of less than 0.05 was considered statistically significant. The results were interpreted in the context of the study objectives, with emphasis on differences in anxiety and depression levels between women with adenomyosis or endometriosis and healthy controls.

Results

The study and control groups were comparable in age distribution, educational status, employment, socioeconomic class, parity, and history of pelvic surgery ($p > 0.05$). A higher proportion of women in the study group were overweight or obese (23/50, 46.0%) compared with controls (12/50, 24.0%). Anxiety was observed in 8 women (16.0%) in the study group versus 1 woman (2.0%) in the control group, while depression was present in 10 women (20.0%) among cases compared to 1 woman (2.0%) among controls. A previous history of psychiatric illness was reported by 6 cases (12.0%) and 1 control (2.0%). (Table 1)

Figure 1 shows the distribution of anxiety and depression among the study group. Among the study participants, anxiety was present in 8 individuals (16.0%, 95% CI: 5.8%-26.2%) and absent in 42 individuals (84.0%). Depression was identified in 10 individuals (20.0%, 95% CI: 8.9%-31.1%), while 40 individuals (80.0%) did not exhibit depressive symptoms.

Anxiety was significantly associated with educational status and coexisting depression. Women with schooling-level education had a higher prevalence of anxiety (6/14, 12.0%) compared with those holding diploma/undergraduate degrees (2/28, 4.0%) and postgraduate degrees (0/8, 0%), with a statistically significant association ($\chi^2 = 7.26$, $p = 0.027$). Anxiety was also significantly more common among participants with depression (4/10, 8.0%) compared to those without depression (4/40, 8.0%), showing a significant association ($\chi^2 = 5.36$, $p = 0.021$). No statistically significant associations were observed between anxiety and age group, employment status, socioeconomic class, BMI category, parity, or previous history of pelvic surgery ($p > 0.05$). (Table 2)

Depression was significantly associated with educational status and socioeconomic class. Women with schooling-level education had the highest prevalence of depression (7/14, 14.0%), compared with those with diploma or

undergraduate degrees (2/28, 4.0%) and postgraduate education (1/8, 2.0%) ($\chi^2 = 11.05$, $p = 0.004$). Depression was also more common among participants from lower socioeconomic classes (Class III-V: 8/26, 16.0%) compared with higher classes (Class I-II: 2/24, 4.0%) ($\chi^2 = 3.94$, $p = 0.048$). No statistically significant associations were observed between depression and age, employment status, BMI, parity, or history of pelvic surgery, although parity showed a borderline association ($p = 0.053$). (Table 3)

Discussion

In the present study, anxiety and depression were observed in 9% and 11% of participants, respectively. Notably, anxiety and depression were each identified in only 1% of individuals in the control group, compared with 8% and 10% of cases in the study group, respectively. These findings indicate a significantly higher psychological burden among women with adenomyosis and endometriosis complex when compared to healthy controls. Statistical analysis confirmed a significant association between the presence of adenomyosis/endometriosis and both anxiety and depression, underscoring the psychosomatic impact of these chronic gynecological conditions.

Our findings are consistent with earlier evidence highlighting the psychological sequelae associated with adenomyosis and endometriosis. Azizova ME et al. [16], evaluated the psychological condition of women of reproductive age with adenomyosis and demonstrated that the largest proportion of affected women belonged to the 36-40-year age group, accounting for 41.1% of cases in the study group and 44% in controls. In their cohort, 67.9% of women were of reproductive age, and nearly one-third were perimenopausal. Shalina MA et al. [17], further expanded this understanding by assessing psychosocial status and quality of life across different endometriosis phenotypes using validated pain, psychological, and quality-of-life assessment tools. The psychological burden of endometriosis has also been explored through qualitative and mixed-methods research. Dowding C et al. [18], reported that more than half of women with endometriosis had sought psychological support in the preceding year, primarily to cope with pain. Younger age, depressive symptoms, and part-time employment were associated with a higher likelihood of seeking psychological care.

The link between pain, mental health, and quality of life has been consistently demonstrated. Muharam R et

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al. [19] found that women with endometriosis who experienced mental health disorders and higher pain intensity, as measured by visual analogue scale scores, had significantly worse quality-of-life outcomes as assessed by the Endometriosis Health Profile-30. The strongest associations were observed in domains related to pain and feelings of control or powerlessness. Women with depression also reported higher pain scores, indicating a bidirectional relationship between pain severity and psychological distress. These results support the concept that mental health conditions substantially amplify the negative impact of endometriosis on quality of life.

Psychological constructs such as self-compassion have also been implicated in the psychosomatic experience of endometriosis. Niekerk LV et al. [20], demonstrated that anxiety and depression were strong negative predictors of self-compassion among women with endometriosis. Symptoms including fatigue, nausea, postcoital pain, lower back pain, dyspareunia, and dysmenorrhea significantly contributed to reduced self-compassion. These findings highlight the importance of individualized symptom-based assessment and interventions aimed not only at physical symptom control but also at enhancing psychological resilience.

Interventional studies further support the potential reversibility of psychological morbidity with effective treatment. Labor CBH et al. [21], assessed the impact of surgical treatment for deep endometriosis on metabolic parameters, quality of life, and psychological outcomes. Postoperatively, significant improvements were observed across multiple quality-of-life domains, including pain, emotional well-being, social functioning, work life, and sexual relationships. Anxiety and depression scores decreased significantly following surgery, accompanied by favorable changes in metabolic parameters. These findings suggest that effective treatment of disease burden can lead to meaningful improvements in both physical and mental health.

In the present study, women with adenomyosis and endometriosis complex were more likely to experience anxiety and depression, particularly those with lower educational attainment and lower socioeconomic status. This aligns with findings from a systematic review by Szyplowska M et al. [22], which reported a wide prevalence range of anxiety (11.5%-87.5%) and depression (9.8%-98.5%) among individuals with endometriosis. Across studies, health-related quality of life was consistently reduced, irrespective of assessment

tools used. The authors emphasized the multifactorial nature of psychological outcomes in endometriosis, influenced by pain severity, socioeconomic context, coping strategies, and access to care.

Specific evidence on adenomyosis further corroborates our findings. Alcalde AM et al. [13], compared women with adenomyosis to those without and demonstrated significantly higher anxiety and depression scores on the HADS scale among affected individuals. These women also reported markedly poorer scores across all dimensions of the SF-36 quality-of-life questionnaire, along with higher levels of presenteeism, absenteeism, and overall work productivity loss.

Eriksen HLF et al. [23], examined psychological profiles among women with and without pain complaints and found strong associations between pain intensity and perceived psychosocial impairment, as well as between coping mechanisms and anxiety or depression. However, they did not observe significant differences in anxiety or depression prevalence between groups, suggesting that coping strategies may play a moderating role in psychological outcomes rather than pain intensity alone.

Li N et al. [24], provided additional insight by demonstrating that adenomyosis was associated with significantly poorer physical and mental component scores of quality of life. Anxiety symptoms were present in 28.9% of patients, with moderate-to-severe symptoms in 10%, while depressive symptoms were observed in 14.4%. Employment status and perianal pain were identified as risk factors for anxiety, while perianal pain predicted depression. These findings reinforce the heterogeneity of psychological outcomes and the influence of both clinical and sociodemographic factors. Finally, Stein KV et al. [25], and Friedl F et al. [26], emphasized the broader psychosocial impact of endometriosis, reporting high prevalence of anxiety and depressive symptoms and markedly reduced quality of life compared to control populations. Friedl F et al. observed moderate-to-severe anxiety in 29% and depressive symptoms in 14.5% of patients, with both conditions coexisting in a substantial subset. Age was found to significantly influence mental health outcomes, particularly emotional role functioning.

This study has certain limitations. The cross-sectional design precludes causal inference between adenomyosis/endometriosis and psychological outcomes. The sample size was modest and drawn from a single tertiary care center, which may limit generalizability. Psychological assessment relied on self-

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reported screening tools rather than formal psychiatric diagnoses. Additionally, disease severity, pain intensity, and treatment history were not analyzed in detail, which could further elucidate psychosomatic relationships.

Despite these limitations, the study underscores the substantial psychological burden associated with adenomyosis and endometriosis. The findings support the integration of routine psychological screening, particularly for anxiety and depression, into gynecological care. Multidisciplinary management involving gynecologists, mental health professionals, and pain specialists is essential to improve overall outcomes. Addressing socioeconomic vulnerabilities, enhancing patient education, and incorporating psychosocial interventions alongside medical or surgical treatment may significantly improve quality of life for affected women.

Conclusions

This study demonstrates that women with adenomyosis and endometriosis complex experience a significantly higher burden of anxiety and depression compared with healthy controls, highlighting the substantial psychosomatic impact of these chronic gynecological conditions. Psychological morbidity was more pronounced among women with lower educational attainment and lower socioeconomic status, suggesting that social determinants play an important role in mental health outcomes. The findings reinforce that adenomyosis and endometriosis are not solely gynecological disorders but conditions with wide-ranging effects on emotional well-being and quality of life. Routine psychological screening and a multidisciplinary approach that integrates mental health support with gynecological care are essential to improve holistic outcomes for affected women.

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Table 1: Comparison of Sociodemographic, Clinical, and Psychological Variables between Study and Control Groups (n = 100)

Variable	Study Group (n=50) n (%)	Control Group (n=50) n (%)	Total n (%)	χ^2 value	p-value
Age group					
≤ 25 years	13 (26.0)	14 (28.0)	27 (27.0)	0.17	0.918
26–35 years	20 (40.0)	18 (36.0)	38 (38.0)		
36–45 years	17 (34.0)	18 (36.0)	35 (35.0)		
Educational status					
Schooling	14 (28.0)	15 (30.0)	29 (29.0)	0.82	0.665
Diploma/UG degree	28 (56.0)	24 (48.0)	52 (52.0)		
PG degree	8 (16.0)	11 (22.0)	19 (19.0)		
Employment status					
Student/Employed	16 (32.0)	10 (20.0)	26 (26.0)	1.88	0.171
Homemaker	34 (68.0)	40 (80.0)	74 (74.0)		
Socioeconomic status (BG Prasad)					
Class I	10 (20.0)	12 (24.0)	22 (22.0)	0.60	0.962
Class II	14 (28.0)	14 (28.0)	28 (28.0)		
Class III	13 (26.0)	14 (28.0)	27 (27.0)		
Class IV	9 (18.0)	7 (14.0)	16 (16.0)		
Class V	4 (8.0)	3 (6.0)	7 (7.0)		
BMI category					
Normal	27 (54.0)	38 (76.0)	65 (65.0)	6.36	0.041*
Overweight	13 (26.0)	9 (18.0)	22 (22.0)		
Obese	10 (20.0)	3 (6.0)	13 (13.0)		
Parity					
Nulliparous	12 (24.0)	11 (22.0)	23 (23.0)	0.18	0.912
Primiparous	16 (32.0)	18 (36.0)	34 (34.0)		
Multiparous	22 (44.0)	21 (42.0)	43 (43.0)		
Previous pelvic surgery					
Present	7 (14.0)	10 (20.0)	17 (17.0)	0.64	0.424
Absent	43 (86.0)	40 (80.0)	83 (83.0)		
Previous psychiatric illness					
Present	6 (12.0)	1 (2.0)	7 (7.0)	3.84	0.050
Absent	44 (88.0)	49 (98.0)	93 (93.0)		
Anxiety (HADS-A)					
Present	8 (16.0)	1 (2.0)	9 (9.0)	6.04	0.014*
Absent	42 (84.0)	48 (96.0)	90 (90.0)		
Depression (HADS-D)					
Present	10 (20.0)	1 (2.0)	11 (11.0)	8.33	0.004*
Absent	40 (80.0)	49 (98.0)	89 (89.0)		

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Table 2: Association between Sociodemographic, Clinical Variables and Anxiety among Study Participants (n = 50)

Variable	Anxiety Present n (%)	Anxiety Absent n (%)	Total n (%)	χ^2 value	p-value
Age group					
≤ 25 years	3 (6.0)	10 (20.0)	13 (26.0)	0.72	0.696
26–35 years	3 (6.0)	17 (34.0)	20 (40.0)		
36–45 years	2 (4.0)	15 (30.0)	17 (34.0)		
Educational status					
Schooling	6 (12.0)	8 (16.0)	14 (28.0)	7.26	0.027*
Diploma/UG degree	2 (4.0)	26 (52.0)	28 (56.0)		
PG degree	0 (0.0)	8 (16.0)	8 (16.0)		
Employment status					
Student/Employed	1 (2.0)	15 (30.0)	16 (32.0)	1.66	0.197
Homemaker	7 (14.0)	27 (54.0)	34 (68.0)		
Socioeconomic status					
Class I–II	2 (4.0)	22 (44.0)	24 (48.0)	2.02	0.155
Class III–V	6 (12.0)	20 (40.0)	26 (52.0)		
BMI category					
Normal	4 (8.0)	23 (46.0)	27 (54.0)	0.78	0.677
Overweight	3 (6.0)	10 (20.0)	13 (26.0)		
Obese	1 (2.0)	9 (18.0)	10 (20.0)		
Parity					
Nulliparous	3 (6.0)	9 (18.0)	12 (24.0)	3.84	0.147
Primiparous	4 (8.0)	12 (24.0)	16 (32.0)		
Multiparous	1 (2.0)	21 (42.0)	22 (44.0)		
Previous pelvic surgery					
Present	2 (4.0)	5 (10.0)	7 (14.0)	0.96	0.328
Absent	6 (12.0)	37 (74.0)	43 (86.0)		
Depression (HADS-D)					
Present	4 (8.0)	6 (12.0)	10 (20.0)	5.36	0.021*
Absent	4 (8.0)	36 (72.0)	40 (80.0)		

Table 3: Association between Sociodemographic, Clinical Variables and Depression among Study Participants (n = 50)

Variable	Depression Present n (%)	Depression Absent n (%)	Total n (%)	χ^2 value	p-value
Age group					
≤ 25 years	4 (8.0)	9 (18.0)	13 (26.0)	1.66	0.435
26–35 years	4 (8.0)	16 (32.0)	20 (40.0)		
36–45 years	2 (4.0)	15 (30.0)	17 (34.0)		
Educational status					
Schooling	7 (14.0)	7 (14.0)	14 (28.0)	11.05	0.004*
Diploma/UG degree	2 (4.0)	26 (52.0)	28 (56.0)		

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PG degree	1 (2.0)	7 (14.0)	8 (16.0)		
Employment status					
Student/Employed	1 (2.0)	15 (30.0)	16 (32.0)	2.78	0.095
Homemaker	9 (18.0)	25 (50.0)	34 (68.0)		
Socioeconomic status					
Class I–II	2 (4.0)	22 (44.0)	24 (48.0)	3.94	0.048*
Class III–V	8 (16.0)	18 (36.0)	26 (52.0)		
BMI category					
Normal	5 (10.0)	22 (44.0)	27 (54.0)	1.61	0.448
Overweight	4 (8.0)	9 (18.0)	13 (26.0)		
Obese	1 (2.0)	9 (18.0)	10 (20.0)		
Parity					
Nulliparous	4 (8.0)	8 (16.0)	12 (24.0)	5.88	0.053
Primiparous	5 (10.0)	11 (22.0)	16 (32.0)		
Multiparous	1 (2.0)	21 (42.0)	22 (44.0)		
Previous pelvic surgery					
Present	2 (4.0)	5 (10.0)	7 (14.0)	0.38	0.541
Absent	8 (16.0)	35 (70.0)	43 (86.0)		

* Statistically significant at $p < 0.05$

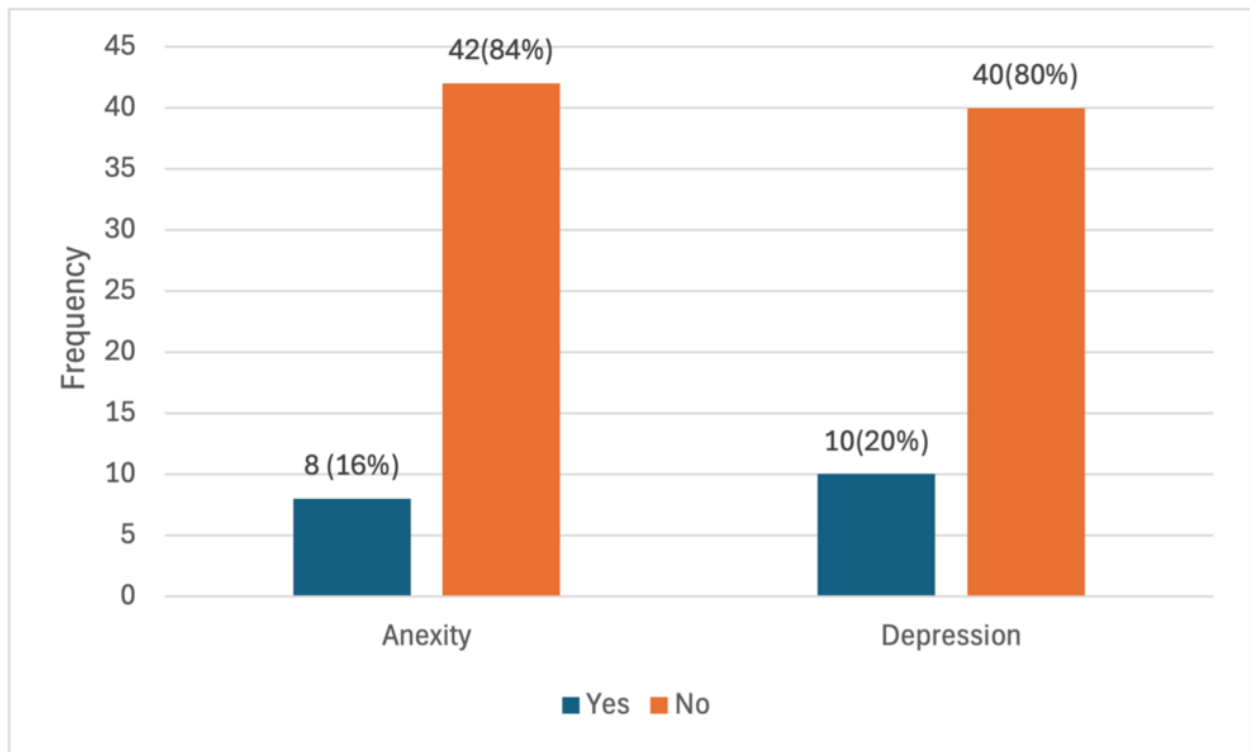


Figure 1: Distribution of Anxiety and depression among the study group (n=50)