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THE ROLE OF SPOUSAL SUPPORT IN MITIGATION OF MENOPAUSAL SYMPTOMATOLOGY AND FOSTERING PSYCHOSOCIAL WELL-BEING AMONG MIDDLE-AGED WOMEN

Original Research

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ABSTRACT

Background: Menopause is a major biopsychosocial milestone in a woman's life, marked by physiological, emotional, and social changes that can impair quality of life. In patriarchal and culturally conservative societies such as Pakistan, menopause remains a stigmatized and often neglected topic, resulting in inadequate awareness and limited social support. The absence of empathetic spousal involvement may aggravate depressive symptoms and psychological distress, underscoring the critical need to understand the role of spousal support in promoting psychosocial well-being during this transition.

Objective: The study aimed to examine the association between menopausal symptomatology, spousal support, and psychosocial well-being among middle-aged women, emphasizing how spousal support mitigates menopausal distress and enhances mental health outcomes.

Methods: A quantitative, cross-sectional research design was adopted, involving 250 married women aged 45–60 years ($M = 51.70$, $SD = 4.54$) recruited from public and private healthcare institutions and gynecology clinics in Islamabad and Rawalpindi through non-probability purposive sampling. Data were collected using standardized tools: the Menopause Rating Scale (MRS) (1), the Menopausal Spousal Support Questionnaire (MSSQ) (2), and the Mental Health Continuum–Short Form (MHC-SF) (3). Descriptive and inferential analyses, including Pearson correlations and multiple regression, were performed using SPSS version 16.

Results: Findings revealed that 63.6% of participants were postmenopausal, while 36.4% were perimenopausal. A significant positive relationship was observed between spousal support and psychosocial well-being ($r = .74$, $p < .001$), whereas menopausal symptomatology showed a negative correlation ($r = –.25$, $p < .001$). Regression analysis indicated that spousal support strongly predicted psychosocial well-being ($\beta = .61$, $p < .001$) and menopausal symptoms were significant negative predictors ($\beta = –.28$, $p < .001$), accounting for 35.7% of variance in well-being ($R^2 = .357$). Women with higher education reported better adaptation and emotional balance, while those with more children experienced lower psychological well-being.

Conclusion: The study highlights that empathetic spousal support substantially improves psychosocial well-being and mitigates the adverse effects of menopausal symptoms. These findings emphasize the necessity for culturally sensitive, family-centered interventions integrating spousal education to enhance women's midlife mental health and quality of life in Pakistani settings.

Keywords: Aging, Menopause, Mental Health, Psychosocial Well-Being, Spousal Support, Women's Health, Women's Rights.

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INTRODUCTION

Menopause marks a significant biological milestone in a woman's life and represents the natural cessation of ovarian function leading to the permanent end of menstruation. According to the World Health Organization, natural menopause occurs after one full year of amenorrhea without any other pathological or physiological cause, resulting from the failure of the ovaries (1). This transition reflects not only a reproductive endpoint but also a complex biopsychosocial transformation that affects physical, emotional, and social well-being. Globally, the postmenopausal population is rising rapidly, with an estimated 373 million women in Asia expected to be postmenopausal by 2025, a number projected to exceed 1.2 billion by 2030 (2,3). In Pakistan, where the average female life expectancy is 68.62 years (4), women are anticipated to spend nearly one-third of their lives in the postmenopausal state. Menopause is not a sudden event but rather a gradual transition encompassing three stages: perimenopause, menopause, and postmenopause (5). Perimenopause is characterized by hormonal fluctuations, irregular menstrual cycles, and the onset of distressing vasomotor symptoms such as hot flashes and night sweats, which are among the earliest clinical manifestations (6-8). In the early postmenopausal stage, estrogen deficiency gives rise to neuropsychological and somatic changes, contributing to mood disturbances and cognitive decline (9). Moreover, urogenital symptoms, though often underreported, are common and include vaginal dryness, itching, dyspareunia, dysuria, and recurrent urinary tract infections (10). Despite their prevalence, these symptoms are frequently underdiagnosed and inadequately managed, as highlighted in European data on vulvovaginal atrophy (11). The hormonal decline also leads to a decrease in sexual desire, negatively affecting interpersonal relationships and overall psychological well-being (12).

Beyond the physiological consequences, menopause has profound psychosocial implications. Pakistani women, in particular, face challenges stemming from cultural taboos, limited awareness, and minimal healthcare access. Studies have shown that menopausal symptoms can severely impair a woman's quality of life, encompassing her psychological health, physical comfort, and social functioning (13,14). Anxiety, embarrassment about urogenital issues, and physical discomfort often lead to social withdrawal and emotional distress. Within this context, spousal support becomes a critical determinant of coping and adaptation. Spousal support encompasses the husband's understanding, empathy, and practical involvement in mitigating menopausal distress (15). Evidence suggests that women with supportive husbands experience fewer depressive symptoms and a higher sense of well-being, whereas lack of partner support may intensify depression, marital dissatisfaction, or even suicidal ideation (14,16). Supportive relationships foster positive health behaviors, encourage adherence to therapeutic interventions, and enhance overall psychosocial adjustment (17). Conversely, unsupportive attitudes or marital discord can exacerbate the emotional burden and strain sexual intimacy (18).

Psychosocial well-being, a multidimensional construct encompassing emotional, social, and spiritual domains, represents a woman's ability to cope with stressors and maintain functional stability within her family and society (12,18). According to the biopsychosocial framework, menopausal experiences result from the interplay of biological, psychological, and social factors (17). Declining estrogen levels alter neurotransmitter systems such as serotonin and dopamine, increasing vulnerability to mood disorders (16). Social stressors, including economic insecurity, family responsibilities, and lack of partner understanding, further compound psychological distress. These intersecting influences highlight menopause as both a physiological transition and a psychosocial challenge. In patriarchal societies such as Pakistan, menopause remains a stigmatized topic, often discussed in silence. Limited health literacy, coupled with dependence on husbands for emotional and financial support, magnifies women's vulnerability (18,19). Despite extensive research on physiological aspects of menopause, the psychosocial dimensions, especially within the Pakistani cultural setting, remain inadequately explored. Addressing this research gap is essential to understanding how menopausal symptoms, spousal support, and psychosocial well-being interact within this sociocultural framework. Therefore, the present study aims to examine the relationship between menopausal symptomatology, spousal support, and psychosocial well-being among middle-aged women in Pakistan. The study hypothesizes a negative association between menopausal symptoms and psychosocial well-being, and a positive association between spousal support and psychosocial well-being, while exploring the influence of key demographic variables on these relationships.

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METHODS

The present study adopted a quantitative, correlational, cross-sectional design to investigate the relationship between menopausal symptomatology, spousal support, and psychosocial well-being among middle-aged women. A non-probability purposive sampling technique was employed to recruit participants from public and private healthcare facilities and gynecology clinics situated in Islamabad and Rawalpindi. The sample size was determined using G*Power statistical software, yielding a final cohort of 250 participants. Eligible participants were currently married women aged between 45 and 60 years (M = 51.70, SD = 4.54), cohabiting with their spouses, and undergoing a natural menopausal transition (perimenopausal or menopausal). Inclusion criteria required at least one biological childbirth. Women were excluded if they were receiving menopausal hormone therapy, had a history of remarriage or divorce, were pregnant or lactating, or were suffering from chronic medical illnesses such as diabetes mellitus, cardiovascular disease, or malignancies. Additional exclusion criteria included those with severe psychiatric or hormonal disorders and individuals who had undergone surgical interventions leading to induced menopause, such as hysterectomy or oophorectomy. These selection parameters were applied to ensure homogeneity of physiological transition and psychological context among respondents. Data were collected through standardized, validated self-administered instruments alongside a demographic information sheet. The demographic proforma gathered details on age, education, occupation, type of family, number of children, marital duration, husband's occupation and income, menstrual and pregnancy history, and other relevant characteristics. The Menopause Rating Scale (MRS) was used to assess the severity of menopausal symptoms (1,13). This scale consisted of 11 items categorized into three subscales: psychological, somatic-vegetative, and urogenital symptoms. It demonstrated strong internal consistency across countries, with an overall Cronbach's alpha of 0.904 and subscale alphas of 0.889, 0.846, and 0.776 respectively, while the test–retest stability coefficients ranged from 0.6 to 0.9 for total and subscale scores.

Perceived spousal support was evaluated using the Menopausal Spousal Support Questionnaire (MSSQ), a 17-item self-report tool designed to measure the level of perceived emotional, instrumental, appraisal, and sexual intimacy support received from husbands during the past month (2). Each item was scored on a 10-point Visual Numerical Scale (VNS), where higher scores indicated stronger perceived support. The internal reliability for the MSSQ ranged between 0.80 and 0.90, reflecting excellent psychometric strength. To assess psychological and social well-being, the Mental Health Continuum – Short Form (MHC-SF) was administered (3). This 14-item instrument measured emotional, psychological, and social dimensions of well-being using a 6-point Likert scale ranging from 0 ("never") to 5 ("every day"). Higher total scores indicated greater positive mental health. The MHC-SF exhibited strong internal consistency ($\alpha > 0.80$) and robust discriminant validity among adult populations. Prior to data collection, ethical approval was granted by the Institutional Review Board of Bahria University, School of Professional Psychology. Official permission letters were submitted to participating healthcare institutions in Islamabad and Rawalpindi. Following institutional approval, written informed consent was obtained from all participants after a detailed explanation of the study's purpose, procedures, confidentiality assurances, and voluntary participation rights. Participants were informed that they could withdraw at any stage without penalty. Those who declined participation were treated respectfully and without prejudice. Data confidentiality was maintained through anonymized coding, and responses were used exclusively for research purposes in accordance with ethical research principles under the Declaration of Helsinki. Statistical analyses were conducted using IBM SPSS Statistics version 16. Descriptive statistics, including means, standard deviations, and frequencies, were computed to summarize demographic characteristics and key variables. Inferential statistics, such as Pearson's product–moment correlation, were employed to examine associations among menopausal symptoms, spousal support, and psychosocial well-being. Additional analyses, such as multiple regression, were considered to assess predictive relationships between study variables. The level of statistical significance was set at $p < 0.05$ for all tests to ensure reliability of inference.

RESULTS

Descriptive analyses revealed that the participants' mean age was 51.70 years (SD = 4.54), and the average number of years of education was 12.56 (SD = 4.25). In relation to family characteristics, 12.8% of women had one child, 24.8% had two, 26.4% had three, 14.4% had four, 10.8% had five, 5.2% had six, 4.8% had seven, and 0.8% had eight children. Regarding the occupation of husbands, 4.0% were unemployed, 38.4% were employed, 27.6% owned businesses, 16.8% were in the forces or government jobs, and 13.2% were retired. In terms of menstrual status, 36.4% of participants had irregular or absent periods for less than 12 months, while 63.6% had no menstrual periods for more than 12 months, confirming postmenopausal status for the majority of respondents. In the first phase of the analysis, descriptive statistics were computed for all demographic characteristics, followed by Pearson product–moment correlation to explore associations between demographic variables and psychosocial well-being. A significant positive correlation was found between age and

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overall psychosocial well-being ($r = .14$, $p < .05$) as well as with its social well-being dimension ($r = .16$, $p < .05$), while correlations with emotional and psychological well-being subdomains were non-significant. Education exhibited a significant positive relationship with psychosocial well-being ($r = .23$, $p < .001$) and its components—emotional ($r = .13$, $p < .05$), psychological ($r = .20$, $p < .01$), and social well-being ($r = .25$, $p < .001$). Conversely, the number of children was significantly and negatively correlated with psychological well-being ($r = –.13$, $p < .05$), indicating that higher parity may contribute to reduced psychological well-being among women in the menopausal transition. Menstruation status did not demonstrate any significant correlation with psychosocial well-being or its subdimensions.

In the subsequent phase, relationships among menopausal symptomatology, spousal support, and psychosocial well-being were examined using Pearson correlation analysis. Menopausal symptomatology showed a significant negative correlation with spousal support ($r = –.18$, $p < .01$) and its subdomains of emotional ($r = –.18$, $p < .01$) and appraisal support ($r = –.20$, $p < .01$). Psychological menopausal symptoms were also significantly and negatively related to emotional ($r = –.18$, $p < .01$), appraisal ($r = –.15$, $p < .05$), and sexual intimacy support ($r = –.14$, $p < .05$). Similarly, urogenital symptoms were inversely correlated with emotional ($r = –.17$, $p < .01$) and appraisal support ($r = –.23$, $p < .001$). These findings indicate that women reporting stronger perceived spousal support exhibited fewer menopausal symptoms across somatic, psychological, and urogenital domains. Further analysis revealed that menopausal symptomatology was significantly and negatively associated with psychosocial well-being ($r = –.25$, $p < .001$), emotional well-being ($r = –.24$, $p < .001$), psychological well-being ($r = –.21$, $p < .001$), and social well-being ($r = –.24$, $p < .001$). Conversely, spousal support was strongly and positively correlated with psychosocial well-being ($r = .74$, $p < .001$) and its respective domains—emotional ($r = .72$, $p < .001$), psychological ($r = .68$, $p < .001$), and social well-being ($r = .65$, $p < .001$). These findings support the hypothesis that increased spousal support corresponds with enhanced psychosocial well-being and reduced menopausal symptom burden among middle-aged women.

To further determine the predictive strength of menopausal symptomatology and spousal support on psychosocial well-being among middle-aged women, a multiple linear regression analysis was conducted. Psychosocial well-being served as the dependent variable, while menopausal symptomatology and spousal support were entered as independent predictors. The model was statistically significant, $F(2, 247) = 68.42$, $p < .001$, explaining 35.7% of the variance in psychosocial well-being ($R^2 = .357$, Adjusted $R^2 = .352$). Results demonstrated that spousal support emerged as a strong positive predictor of psychosocial well-being ($\beta = .61$, $t = 11.47$, $p < .001$), indicating that women who perceived greater emotional, instrumental, and appraisal support from their husbands reported higher levels of psychosocial well-being. Conversely, menopausal symptomatology was a significant negative predictor ($\beta = –.28$, $t = –5.94$, $p < .001$), suggesting that women who experienced more severe menopausal symptoms reported lower psychosocial well-being. These findings provide empirical support for the hypothesized model that spousal support enhances, while menopausal symptom burden diminishes, overall well-being during the menopausal transition.

Table 1: Descriptive Statistics of the Demographic Characteristics of the Sample (N=250).

Variables	f (%)	M(SD)
Age		51.70(4.54)
Education (years)		12.56(4.25)
Number of Children		
1	32 (12.8%)	
2	62 (24.8%)	
3	66 (26.4%)	
4	36 (14.4%)	
5	27 (10.8%)	
6	13 (5.2%)	
7	12 (4.8%)	

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Variables	f (%)	M(SD)
8	2 (0.8%)	
Husbands Occupation		
Unemployed	10(4.0)	
Employed	96(38.4)	
Business Owner	69(27.6)	
Forces/Government	42(16.8)	
Retired	33(13.2)	
Menstruation Status		
Irregular or Absence of periods since last 3 months but less than 12 months	91(36.4)	
Absence of periods for more than 12 months	159(63.6)	

Note. M=mean, SD=standard deviation, f=frequency, %=percentage

Table 2: Bivariate correlation between demographic variables (Age, Years of Education, Duration of Marriage, Number of Children, Menstruation Status) and Psycho-Social Well-Being (Emotional Well-Being, Psychological Well-Being, Social Well-Being), (N=250).

Variables	1	2	3	4	5	6	7	8
1. Age	-	-.06	.23***	.60***	.14*	.08	.12	.16*
2. Education		-	-.33***	-.03	.23***	.13*	.20**	.25***
3. Number of Children			-	.20**	-.11	-.08	-.13*	-.08
4. Menstruation Statusa				-	.10	.12	.05	.12
5. Psycho-Social Well-being					-	.87***	.92***	.93***
6. Emotional Wellbeing						-	.74***	.72***
7. Psychological Wellbeing							-	.749***
8. Social Wellbeing								-

a 0 = Irregular or Absence of periods since last 3 months but less than 12 months, 1= Absence of periods for more than 12 months, *p<.05, **p<.01, *** p<.001

Table 3: Bivariate Correlation between Menopausal Symptomatology (Somatic-Vegetative, Psychological, Urogenital), Spousal Support (Emotional Support, Instrumental Support, Appraisal Spousal Support, Sexual Intimacy Spousal Support) and Psycho-Social Well-Being (Emotional Well-Being, Psychological Well-Being, and Social Well-Being) in Middle-Aged Women, (N=250)

Variables	1	2	3	4	5	6	7	8	9	10	11		
1. Menopausal Symptomatology	-	.85***	.84***	.77***	-.18**	-.18**	-.06	-.20**	-.10	-.25***	-.24***	-.21**	-.24***
2. Somatic Vegetative		-	.61***	.49***	-.10	-.09	-.01	-.12	-.06	-.17**	-.15*	-.16*	-.16*
3. Psychological			-	.42***	-.18**	-.16*	-.11	-.15*	-.14*	-.31***	-.27***	-.28**	-.29**

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Variables	1	2	3	4	5	6	7	8	9	10	11		
4. Urogenital				-	-.17**	-.18**	-.01	-.23**	-.05	-.13*	-.15	-.08	-.14*
5.Spousal Support					-	.82**	.75**	.92**	.72**	.74**	.72**	.68**	.65**
6. Emotional Support						-	.51**	.70**	.52**	.50**	.51**	.46**	.44**
7. Instrumental Support							-	.56**	.54**	.57**	.55**	.57**	.47**
8. Appraisal Support								-	.57**	.65**	.61**	.58**	.58**
9. Sexual Intimacy Support									-	.66**	.61**	.62**	.57**
10. Psycho-Social Wellbeing										-	.87**	.92**	.93**
11. Emotional Wellbeing											-	.74**	.72**
12. Psychological Wellbeing												-	.75**
13. Social Wellbeing													-

Note. *p<.05, **p<.01, *** p<.001

Table 4: Multiple Linear Regression Predicting Psychosocial Well-Being from Menopausal Symptomatology and Spousal Support (N = 250)

Predictor Variable	B (Unstandardized)	SE B	β (Standardized)	t-value	p-value
Constant	41.82	3.24	—	12.89	<.001
Menopausal Symptomatology	–0.37	0.06	–.28	–5.94	<.001
Spousal Support	0.58	0.05	.61	11.47	<.001
Model Summary: $R = .597$, $R^2 = .357$, Adjusted $R^2 = .352$, $F(2, 247) = 68.42$, $p < .001$					

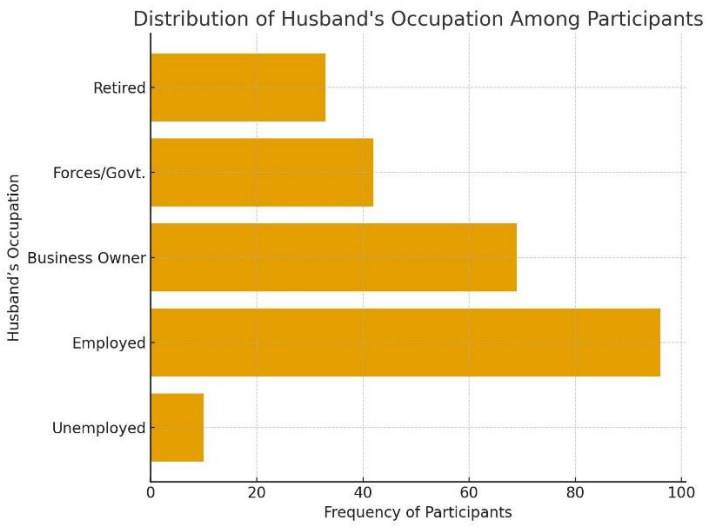

Figure 2 Distribution of Husbands Occupation Among Participants

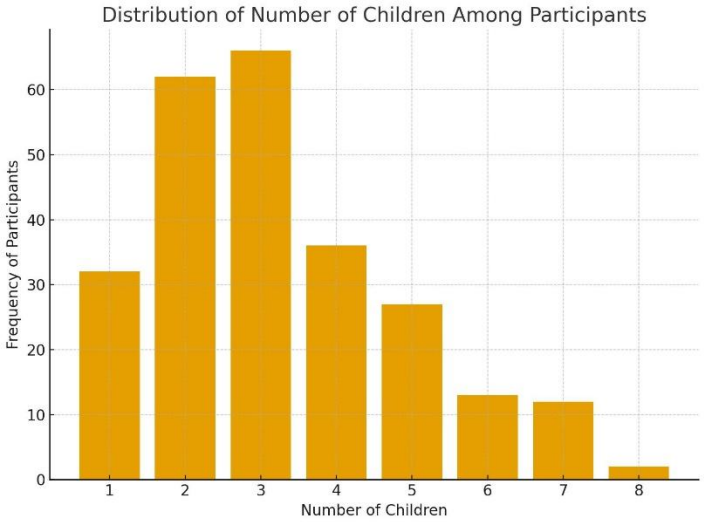

Figure 2 Distribution of Number of Children Among Participants

DISCUSSION

The present study explored the relationship between menopausal symptomatology, spousal support, and psychosocial well-being among middle-aged women, emphasizing the psychosocial complexities that accompany the menopausal transition. Findings revealed a multidimensional interplay between biological changes, social relationships, and individual psychological adaptation. The results demonstrated that women in the postmenopausal stage exhibited higher psychosocial well-being compared to those in the perimenopausal phase. This aligns with prior evidence indicating that menopausal symptoms tend to be more moderate or severe during the early menopausal period, gradually subsiding as adaptation progresses (10,11). The current study reaffirmed that age, although commonly perceived as a determinant of diminished well-being, was not significantly correlated with emotional or psychological well-being. This observation reinforces the notion that aging itself does not inherently diminish quality of life; rather, the cultural perception of aging and the presence of social support influence how women experience midlife transitions (12,13). In collectivist societies such as Pakistan, where interdependence and familial ties are deeply rooted, the cultural perception of aging may buffer against negative psychological outcomes associated with menopause (14). Education emerged as a significant positive predictor of psychosocial well-being, demonstrating that higher educational attainment was linked to improved emotional, psychological, and social adjustment during menopause. Prior research has similarly highlighted that educated women are better equipped to understand physiological changes, adopt healthier coping strategies, and maintain a more positive outlook toward menopause (15,16). The findings suggest that education enhances health literacy and fosters a sense of autonomy, which collectively strengthen adaptive capacities during menopausal transition. In contrast, the number of children was inversely associated with psychological well-being, implying that women with larger families may face greater stress due to caregiving responsibilities and emotional fatigue. This observation aligns with reports that women with multiple dependents often experience compounded psychosocial strain and diminished personal well-being (17,18).

A significant negative correlation was found between menopausal symptomatology and spousal support, particularly within the domains of emotional and appraisal support. These findings emphasize that the quality of marital relationships plays a pivotal role in shaping a woman's experience of menopause. Women who perceived greater empathy, understanding, and reassurance from their husbands reported lower symptom severity and better psychological health. This supports earlier evidence that positive spousal attitudes and emotional availability mitigate the intensity of vasomotor and psychosomatic symptoms (19,20). Emotional intimacy and mutual respect appear to serve as protective mechanisms that alleviate distress and enhance marital satisfaction during this phase of life. The analysis further indicated that urogenital symptoms were significantly alleviated among women who reported higher emotional and appraisal support from their spouses. The provision of reassurance, affection, and validation likely contributed to a reduction in distress associated with urogenital discomfort. Conversely, instrumental and sexual intimacy support were not significantly associated with these symptoms, possibly reflecting cultural constraints and limited communication about sexual health in South Asian societies. Cultural silence around

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menopausal sexuality and gender norms may prevent open discussions, exacerbating the psychosocial burden of these symptoms (21,22). The results reinforce that empathy and non-judgmental communication are critical for maintaining relational harmony and mitigating psychosexual dysfunction. Cross-cultural findings have consistently indicated that sexual dissatisfaction, low arousal, and reduced frequency of intercourse are common, yet culturally mediated experiences among menopausal women, with partner support emerging as a decisive factor in psychological adjustment (23,24). Psychological symptoms, including mood instability, anxiety, and irritability, were also negatively correlated with spousal support, underlining the interdependence between emotional partnership and mental health. The findings suggest that spousal empathy and shared coping foster psychological resilience and enhance a woman's perception of self-worth and relational security during menopause. These results highlight the biopsychosocial nature of menopausal adaptation, where physiological changes interact with psychological factors and social context to determine overall well-being.

The study contributes valuable insight into the psychosocial dynamics of menopause within a collectivist and patriarchal cultural framework. A notable strength of the research lies in its focus on naturally menopausal women in stable marital relationships, enabling an in-depth exploration of spousal influence on well-being. The inclusion of validated psychometric tools further strengthens the reliability of the findings. However, several limitations merit consideration. The sample was limited to women from Islamabad and Rawalpindi, restricting generalizability across Pakistan's diverse cultural and socioeconomic settings. The exclusion of divorced, widowed, surgically menopausal, and hormone therapy users narrows the scope of inference. Furthermore, the cross-sectional design precludes causal interpretation of observed associations. Future research should employ longitudinal or mixed-method designs to capture the evolving dynamics of psychosocial adjustment across different menopausal stages. Further investigation is warranted into the moderating and mediating roles of cultural beliefs, marital satisfaction, and socioeconomic status in shaping menopausal experiences. Including women from varied regions, educational backgrounds, and marital contexts would provide a more comprehensive understanding of how psychosocial well-being is influenced by cultural diversity. Future studies could also explore intervention-based approaches focusing on couple counseling and awareness programs aimed at enhancing men's understanding of menopause (25). In conclusion, the study underscores that menopause is not solely a biological event but a psychosocial transition influenced by relational, educational, and cultural dimensions. Spousal support emerged as a key determinant of psychological stability and social adjustment, while menopausal symptoms adversely affected overall well-being. Strengthening partner communication, promoting education, and fostering culturally sensitive health interventions may collectively improve the quality of life of menopausal women in Pakistan and beyond.

CONCLUSION

The present study concluded that menopausal symptomatology exerts a profound influence on women's psychosocial well-being, underscoring the emotional, physical, and relational challenges faced during this transitional stage of life. While aging and education emerged as factors contributing positively to overall wellness, a higher number of children appeared to compromise psychological well-being, likely due to increased caregiving demands and emotional strain. The findings revealed that menopausal symptoms—whether somatic, urogenital, or psychological—negatively affect well-being, whereas spousal support, particularly emotional, instrumental, and sexual intimacy support, plays a crucial protective role in mitigating these effects. By highlighting the significance of supportive marital relationships, this study broadens the theoretical understanding of gender roles and health transitions within the Pakistani cultural context. It emphasizes the need for healthcare practitioners and psychologists to integrate spousal involvement into therapeutic and educational interventions to enhance women's mental health and quality of life during menopause.

AUTHOR CONTRIBUTION

Author	Contribution
Jannat Salman*	Substantial Contribution to study design, analysis, acquisition of Data Manuscript Writing Has given Final Approval of the version to be published
Ayesha Rizwan	Substantial Contribution to study design, acquisition and interpretation of Data

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Author	Contribution
	Critical Review and Manuscript Writing Has given Final Approval of the version to be published
Afreen Komal	Substantial Contribution to acquisition and interpretation of Data Has given Final Approval of the version to be published

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