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UMI®
THE EXPERIENCE AND KNOWLEDGE OF MENOPAUSE AMONG
LOW-INCOME CLEVELAND WOMEN

by

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Submitted in partial fulfillment of the requirements
For the degree of Doctor of Philosophy

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The Experience and Knowledge of Menopause Among Low-Income Cleveland Women

Abstract

By

MARGARET CECILIA COONEY

This study examines the experience and knowledge of forty low-income women, aged 39 to 55, in Cleveland, Ohio. Through in-depth interviews, it focuses on their knowledge about menopause and from whom they seek information about menopause. It employs Kleinman’s Explanatory Models to elucidate women’s understanding of menopause and examine the level of medicalization of menopause in this population. The study examines women’s personal experiences with the changes associated with menopause, including the signs and symptoms they have and attribute to menopause. Finally, it explores women’s treatment choices regarding the use of hormone replacement therapy, alternative remedies, or managing their symptoms on their own.

The results show that the forty women in the study do not see menopause as a problematic life event. Most do not find their lives disturbed by the changes occurring at the end of menstruation. In fact, they mentioned having more non-menopause symptoms (e.g., aches and pains, shortness of breath) than signs of menopause (e.g., hot flashes, night sweats). The hallmark signs of menopause include hot flashes, sweats, problems sleeping, fatigue, vaginal dryness, feeling blue, and mood swings.

Women in the study do not conceive of menopause as a disease or medical condition. If a woman has difficulty with menopause, she should talk to her doctor.

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Because few define menopause as a medical event, these women generally do not seek medical interventions. Only a fraction of them take hormone replacement for symptom relief, and many were unfamiliar with use of hormones at menopause. Consequently, it does not appear that many women find their symptoms to be unbearable.

To learn about menopause, women largely consulted reading materials if they sought information about menopause or health topics. They were also likely to discuss menopause with health care providers or friends, but less often. The women appeared to mistrust medical advice when they received it. Most women thought that younger women would like information about menopause before it happens.

The women in the study do not experience menopause as a “medicalized” condition.
CHAPTER 1
INTRODUCTION

This study examines the experience and knowledge of forty low-income women, aged 39 to 55, in Cleveland, Ohio. It focuses specifically on their knowledge about menopause and from whom they seek additional information about menopause. The study also examines women's personal experiences with the changes associated with menopause, including the signs and symptoms they have and attribute to menopause. Finally, they study explores the women's treatment choices regarding the use of hormone replacement therapy, alternative remedies, or managing their symptoms on their own.

The research took place in Cleveland, Ohio, a large city in the north of the state. Among its nearly half a million residents, most are African American or "white." The city, formerly a northern industrial center, currently focuses on service, construction, and manufacturing industries. Participants in the study come from the west side of the city, recruited from a number of social service agencies. The study sample, consisting primarily of European American (47.5%), African American (35%), and Hispanic (15%) women, contains three of the city's largest ethnic groups.

One of the largest cohorts of U.S. women, members of the Baby Boom generation (born between 1946–1964), are at or nearing the menopause transition. These women are participants in numerous long-term and short-term studies of midlife and menopause, ranging from drug trials to studies of their perceptions about aging. The majority of women who are recruited for research studies have been predominantly European-American, educated, and middle-class (e.g., Clinkingbeard, Minton, Davis & McDermott...

A recent multi-site national survey—the Study of Women's Health Across the Nation (SWAN)—has helped address the issue of limited ethnic diversity by seeking African American, Hispanic, Japanese- and Chinese-American participants in addition to European-American women, though most participants have greater than a high school education (e.g., Harlow and Signorello 2000; Pope, Sowers, Welch & Albrecht 2001; Sowers, Pope, Welch, Sternfeld & Albrecht 2001). SWAN research focuses on various aspects of the menopause transition including menopause status designations, beliefs and attitudes about menopause, and ethnic comparisons of menopause experiences. The SWAN research project has the potential to greatly increase our understanding of menopause in a broader range of women, but still lower income and less well-educated women are not the subject of study.

A small but growing number of studies have examined menopause from the perspective of low-income women. These studies have examined attitudes toward menopause among young women (Standing and Glazer 1992), used focus groups to examine women’s understandings of hormone replacement (Padonu, Holmes-Rovner, Rothert, Schmitt, Kroll, Rovner, Talarczyk, Breer, Ransom & Gladney 1996), studied menopause coping styles in a rural population (Nixon, Mansfield, Kittell & Faulkner 2001), examined use of hormone replacement (Appling, Allen, Van Zandt, Olsen, Brager
& Hallerdin 2000), or surveyed women about their health expectations in relation to hormone use (Holmes-Rovner, Padonu, Kroll, Breer, Rovner, Talarczyk & Rothert 1996).

My research examined menopause among low-income women who remain underrepresented in menopause research. The research site is Cleveland, Ohio. It is important to learn about the experiences and perspectives of menopause of lower income women because they are likely to have less access to medical care due to their economic situation. This may affect the knowledge, experiences, and health of these women. Low-income women may also have less education resulting in less knowledge about their health and more difficulty seeking information about health and menopause. These characteristics are likely to affect their experience and knowledge of menopause.

The goal of the current project was to use in-depth interviews to document how a group consisting primarily of European American and African American, low-income, urban women experience and interpret menopause and to give voice to women who have been underrepresented in menopause research. I look at several aspects of the menopause experience: women's knowledge about menopause, the physical and psychological changes they attribute to menopause, their attitudes toward and expectations of menopause, and finally whether they choose hormone replacement therapy. I use Kleinman's (1980) Explanatory Model approach to facilitate understanding the women's perspectives on menopause.

Issues of Terminology

Before beginning, some cautionary remarks are in order. By referring to the cessation of menstruation among women in their forties and fifties as ‘menopause,’ I am following the construction of this aging process as based in the notions of western biomedicine. However, as some cross-cultural data demonstrate, not all cultures
conceptualize the specific idea of 'menopause' (Davis 1989; Kearns 1982; Lock 1993b). Certain assumptions which western biomedicine holds to be 'truths' or 'universals' must be questioned. In addition, biomedicine itself is a cultural construction, and as such articulates cultural values and biases rather than remaining neutral (Gaines and Hahn 1985; Hahn 1995; Hahn and Gaines 1982), hence may reinforce negative and biological deterministic notions of womanhood. Similarly, 'biomedicine' is not monolithic (Gaines and Hahn 1985; Lock 1985).

Biomedicine is socially and culturally informed and grounded in the tenets of naturalism as conceived in the Enlightenment (Gordon 1988). Following the natural science paradigm, scientific rationality and objectivity are the hallmarks of biomedical constructions of the human body and its processes. Consequently, the body is seen as

"an 'it,' a physical object (and as such passive), with a stable identity (anatomy and physiology were 'discovered' and are universal...); separate from the self...and bounded from others by skin." (Gordon 1988:30)

Specific areas of study, including the end of menstruation, must be seen as grounded in a notion of Local Biology (Gaines 1994). The concept of Local Biology encourages the recognition of the cultural constructedness of the body and the interplay between the local context and conceptions of human biology, and "contributes to the analysis of both popular and scientific notions of biology and human development" (Gaines 1994:2). Alternatives to the notions of biology, taken by biomedicine to be real and universal, include those of Kleinman (1980), Unschuld (1985), and Farquhar (1994) on Chinese traditional medicines, Jordan (1989) on Maya obstetrics, DelVecchio Good on Islamic physiology (1980), and Lock (1993a,b) and Lock and Kaufert (2001) on the Japanese ethnomedical view of konenki (change of life or menopause). We must
recognize that these ethnomedicines, as well as others like western biomedicine, present us with versions of reality as pertains to health, disease and the body, each meaningful and derived from a particular set of social, cultural, and historical circumstances (Gaines and Hahn 1985).

Therefore, the biomedical/clinical, historical, and various cross-cultural perspectives on the end of the female reproductive life cycle are equally valid constructions of reality. Thus, while most of the research cited throughout this paper is built around the biomedical notion of 'menopause,' we must bear in mind that this version is similarly a cultural construction, particular to a place and historical moment.

Use of the word "symptom" in relation to changes occurring at menopause is problematic. Biomedicine has co-opted the signs that indicate to women the physical and emotional changes associated with menopause and renamed them "symptoms," a practice perpetuated by popular media and even some women themselves (Buchanan, Villagran & Ragan 2001; Zita 1993). Unfortunately, the search for "symptoms" of menopause reinforces the notion of menopause as a deficiency disease and further labels a natural, normal part of women's midlife as a medical problem in need of intervention (Lock and Kaufert 2001; Rips 1993).

A disease orientation toward menopause results in women being viewed as at the mercy of their hormones and defined by their biology that is beyond culture (Rostosky and Travis 1996; Tavris 1992). For the purpose of the description and elaboration of the physical and psychological changes women in the study experienced, I will interchangeably use the terms "signs" and "symptoms" to refer to these changes. In addition, I rely on the women to specify which signs or symptoms they specifically
attribute to menopause rather than try (beyond providing a symptom checklist) to reinforce the disease and symptom stereotype.

Finally, in common parlance, most people refer to the transitional period from regular menstruation to the final menstrual period as “menopause.” As I will elaborate below, the clinical use of the term is different, and there is a specific term—climacteric—to describe the transitional time. However, speaking with women in the study about the end of menstruation, it is clear that they used the blanket term “menopause” or sometimes “the change” to refer to the entire process rather than solely to their final period (cf. Kaufert 1988). The different meanings for the word “menopause” held by different groups, in this case biomedicine versus lay, can and probably does lead to confusion and conflation—a problem of terminology and definition—that may influence the discourse on the midlife cessation of menstrual periods.

The current chapter presents definitions of terminology and concepts used throughout the document. It also contains a discussion of the theoretical approaches to menopause research. I will also briefly examine the literature on specific topics relevant to the conception of the study, with more extensive reviews of pertinent literature about these topics within the individual chapters.

Menopause—Clinical Definition, Medical Construction

Definition

The cessation of menses which most people in the West simply call ‘menopause’ is characterized clinically as two discrete elements, the climacteric and menopause. The officially recognized definition of the climacteric is “that phase in the aging process of women marking the transition from the reproductive stage of life to the nonreproductive stage,” such that menopause is a woman’s final menstrual period when followed typically
by twelve months amenorrhea not due to pregnancy or other known cause (Utian 1980:105). The median age at which menopause (as defined above) occurs among women in industrialized countries is 51 (North American Menopause Society 2000). Menopause may take place naturally, surgically through removal of the ovaries, or artificially, due to radiation or chemotherapy.

A variety of changes occur on a hormonal and physiological level associated with the aging process. In the stereotypical scenario, as a woman ages there are fewer follicles in her ovaries and her hormonal levels start to change. Postmenopausally the ovaries contain almost no follicles as a result of the aging of the ovaries. In addition, genetics, radiation, and exposure to toxic substances can hasten follicle death. However, inhibition of ovulation through frequent continuous pregnancies or use of contraceptives has not been shown to shorten the time of a woman’s fertility (Gosden 1987).

As the number of available ovarian follicles decreases, the ovarian-pituitary-hypothalamic communication loop which regulates the menstrual cycle is interrupted (Leidy 1999). The production rate of estrogen decreases and cyclical production of estrogen and progesterone ceases. Androgen levels increase relative to estrogen, and androstenedione becomes more important because it remains, in levels lower than before menopause, as the source for conversion to estrone (Utian 1980). Follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels, which stimulate maturation of the follicle and release of the egg respectively, increase immediately following menopause, and then gradually decrease over the next thirty years. Measurement of the levels of these two substances is used to ‘diagnose’ menopause (Utian 1980).
After the final menses, the body continues to produce some amount of most hormones. Endogenous estradiol (estrogen) comes from the peripheral conversion of estrone and testosterone. Estrone comes from the conversion of androstenedione and testosterone. The adrenal glands produce small amounts of progesterone. The adrenal glands contribute 80% of the androstenedione while the ovaries generate 20% (Greendale and Judd 1993:426-27). The amount of androstenedione the body produces is also related to obesity and liver disease (Varma 1992:176).

Within the clinical model of the climacteric and menopause, hormone replacement therapy (HRT) is used for relief of short term symptoms and prevention of long term conditions resulting from estrogen deficiency (Utian 1980). I discuss the specifics of HRT in Chapter 6.

The construction of menopause by western biomedicine is problematic in the sense that it assumes a homogeneous biological process across populations. Furthermore, much early research working to define symptoms of menopause relied on clinical populations of women who were actively seeking medical care rather than learning about the normal or typical presentation of menopause among women in the general population (Kaufert and Syrotuik 1981; Leidy, Canali & Callahan 2000). Thus, the pattern of hormones reported as 'normal' is specific to clinical samples. A construction based on a non-representative sample of women and generalized to all women disregards biocultural differences, particularly in diet and fertility experiences, both in western populations, on which the research is ostensibly based, and among non-western peoples to whom the findings are generalized (Lock and Kaufert 2001).
Clinical Symptoms

According to the clinical definition, symptoms of menopause are grouped into three categories: those related to decreased ovarian activity and hormonal deficiency, sociocultural factors of a woman's environment, and psychological factors which depend on a woman's character. In this way, the actual symptoms may include amenorrhea, hot flashes, atrophic vaginitis, incontinence, osteoporosis; psychologically manifested symptoms of palpitations, fatigue, vertigo, irritability, depression, frigidity, and insomnia (Utian 1980:107-113). These symptoms and a variety of other nonspecific symptoms typically constitute the 'climacteric syndrome.'

An extensive variety of symptoms has been attributed to menopause. This is in part related to the fact that not all clinicians, doctors, and lay people, even within one culture, share a common model through which to understand menopause (Lock 1985). Clinical definitions of menopausal symptomatology are typically classified in two categories— quantitative, physiological symptoms, and qualitative, psychological symptoms.

Following the biomedical models, most doctors, social scientists, and the general population accept such symptoms as hot flashes or flushes, night sweats, atrophic vaginitis, and other “objective” physiological symptoms. These hot flashes and sweats are directly related to changing hormone levels and the others to related physiological mechanisms (Avis, Kaufert, Lock, McKinlay, and Vass 1993). The physiological symptoms and their amelioration, traditionally achieved through drug treatment, are located within the individual's body rather than recognized as part of a natural transition to which various cultural implications are attributed. The more questionable psychosomatic symptoms include fatigue and loss of sleep, depression, irritability,
dizziness, and painful intercourse among others (Lock 1985:117; Utian 1980:105). In addition, there are likely to be concomitant changes in vaginal dryness, sexual interest and frequency (Dennerstein, Dudley & Burger 2001; McCoy 1998).

At menopause women have been thought to be at greater risk for psychiatric disorders. According to Freud, menopause brought a series of symbolic losses and a woman's “unduly increased libido” which could lead to states of high anxiety. Freud argued that if a woman was not so already, at menopause she would probably become neurotic (Lock 1993b). Furthermore, hysteria was conceived as a mental disorder, one that simply accompanied womanhood. The Freudian view of womanhood and that held by the young science of gynecology are highly concordant. Consequently, although Freud’s talking therapy was less invasive than the gynecological surgery used to treat women and their complaints grounded in reproductive disorders, the “Freudian theory of female nature was in direct continuity with the gynecological view which it replaced” (Ehrenreich and English 1973:44).

In the early twentieth century, German psychiatrists catalogued many diverse conditions which they believed were associated with menopause: sleep disturbance, forgetfulness, anxiety, scandal-mongering, untruthfulness, jealousy, explosive affect, hypochondria, fear of madness, pyromania, kleptomania, spitefulness, and maliciousness, among many others (Hällström 1973:7). However, there is no clear evidence demonstrating any link between menopause and an increase in psychiatric disorder in the psychiatric literature of Britain, Sweden, Netherlands, and the United States (Ballinger 1990; Lock 1993b).
Kaufert and colleagues argue that viewing menopause as a crisis for women “may be a medical phenomenon, following from the representation of menopause as a disease or deficiency condition” (Kaufert, Lock, McKinlay, Beyene, Coope, Davis, Eliasson, Gognalons-Nicolet, Goodman & Holte 1986:1288). Western biomedical constructions of menopause, which attribute all changes to a biological origin, can conflict with western as well as non-western cultures in which people hold different beliefs about health and illness. These differences in beliefs, and in the various symptoms women experience, make the acceptance of universal biologically-caused menopausal “symptoms” problematic.

**Sociocultural Perspectives**

At this point I address a significant theoretical issue that has been instrumental in shaping menopause research and the ongoing debate over the meaning of menopause and the role of hormone replacement therapy—the medicalization of menopause. Medicine is seen as acting as an agent of social control by controlling women’s bodies, sexuality, and reproduction (Ehrenreich and English 1973; Foucault 1990; Jacobus, Keller & Shuttleworth 1990; Martin 1992; Zola 1972). Examples in the U.S. include the biomedical management of childbirth (Davis-Floyd 1992), reproductive technology (Rapp 1993), abortion (Ginsburg 1989) and, currently, menopause. These are evidence of the ever-expanding role of medicine, or what Foucault calls ‘bio-power’ (1990). There is a long tradition of the practice of medicine as directed to the control of women’s lives, as Ehrenreich and English (1973) have documented for the late 19th and early 20th centuries, and Gaines (1992) has shown for the work of psychiatry, especially nosological work, in pathologizing women’s lives. The study of menopause provides a domain for discovering the potentially opposing social and cultural knowledge, beliefs, and practices.
The biomedical field influences the reification and cultural construction of menopause to different degrees. Some might argue that menopause has in fact been medicalized, though this is debatable (Bell 1990; Kaufert and Gilbert 1986). According to Zola (1972), medicine has become an institution of social control as evidenced by the fact that we are forced to rely on experts to tell us if we are healthy or ill. There are several levels on which to consider the medicalization of menopause. On the one hand, the ways menopause is described in medical texts is one indicator of medicalization. Thus, referring to menopause as a “metabolic and endocrine disorder” or as a “clinical disorder of the ovary” shows that in a clinical setting menopause is labeled a disease requiring treatment (Gannon and Ekstrom 1993:276). Additionally, analysis of the language and metaphors used to describe the workings of the female body at menopause reveal and perpetuate negative stereotypes of the aging female body (Martin 1992). I will elaborate on two indicators of the medicalization of menopause—the creation of menopause as a deficiency disease and a counter-argument which states that menopause is only partially medicalized—and conclude by discussing the successor to the deficiency disease model of menopause, that of menopause as a risk factor for debilitating diseases.

**Menopause as Deficiency Disease**

On the one hand, biomedicine is responsible for the definition and distortion of menopause by constructing it as a ‘deficiency disease.’ The deficiency disease model, prevalent starting in the 1960s, is based on the notion that the decreasing levels of estrogen in a woman’s body are the result of a malfunction rather than a normal change. The work of the field of sex endocrinology in the early 20th century developed laboratory
techniques for measuring and monitoring female hormone levels (Bell 1990). According to the misconception of menopause as a deficiency disease, a woman at menopause does not age but rather decays. Hence, discussions of the hormonal changes associated with menopause may refer to this area of study as the 'pathophysiology' of menopause (c.f. Kopera and van Keep 1991; Varma 1992).

As a disease, menopause could be 'treated' with the addition of hormones, in this case, estrogen. This treatment procedure likens menopause to other deficiency diseases, like hypothyroidism or diabetes, which are treated by replacing the missing substance, estrogen, thyroid, or insulin, respectively (Bell 1990). Estrogens were used as a 'cure' for which the 'disease' was constructed by the medical field. Thus, even if a menopausal woman has no symptoms, she still needs medical intervention. Prior to and again after the tremendous popularity of the deficiency disease model, the only true menopause symptoms were those clearly caused by hormone fluctuation, that is vasomotor symptoms such as hot flashes.

One of the main proponents of Estrogen Replacement Therapy (ERT), gynecologist Robert Wilson, posited, by contrast, that ERT could avert such physiological and psychological menopause symptoms as hot flashes, vaginal atrophy, and osteoporosis, as well as depression, alcoholism, frigidity, and absent-mindedness (McCrea 1983:113). Wilson believed that menopause and its hormonal cure should be seen in a broader context. Menopause has an effect not only on the woman’s body, but also on her husband, family, and the entire outside world who have to deal with the woman in her “diseased state.” It is a woman’s social and moral obligation to ‘cure’ her menopause. To him, estrogen was a youth pill to enable women to avoid the “death of
their womanhood” (Wilson 1966). Wilson’s biological determinist explanation of women’s experiences of aging reinforced the existing biological and philosophical beliefs about the inferiority of women.

Thus, by one standard, menopause is subject to medicalization because of its equation with disease and the corresponding need for treatment. The deficiency disease model of menopause rests on the philosophical belief that women are inferior to men. This view posits that they are ruled by their biology, and hence at menopause are naturally hormone dependent.

Is Menopause Medicalized?

On the other hand, Kaufert and Gilbert (1986) question whether menopause is completely medicalized, drawing on the comparison to pregnancy which they view as highly medicalized. Using data from their menopause study in Manitoba, they argue that only some women consulted a doctor at menopause, while others did not approach a doctor at all. Therefore the menopause experience is not highly medicalized at the present time, a view supported by others (Leidy et al. 2000; Oddens, Boulet, Lehert & Visser 1992).

Pregnancy, on the other hand, is medicalized to a greater degree than menopause because it is a highly visible process, which once apparent requires a woman to seek medical care. By contrast, menopause remains largely a concealed occurrence and medical intervention is not unequivocally required of “menopausal women [who] are at the end of their reproductive lives and society does not put pressure on menopausal women in the same way [as on pregnant women]” (Kaufert and Gilbert 1986:19). Simply because a biomedical model exists to characterize menopause is not sufficient to demonstrate the medicalization of menopause, since at this time women are still free to
choose whether to seek treatment or advice from a doctor and whether to take hormone supplements.

**Menopause as Disease Risk**

Finally, the deficiency disease model has recently been replaced with the idea that menopause is a risk factor for heart disease and osteoporosis. According to the risk model there are three key ‘facts’: a great number of women are entering midlife, menopause affects all women, and women are living longer. As they age, particularly in the years past menopause, women develop increasing rates of heart disease and they may experience a significant amount of bone loss. It is said that the costs for providing health care for decrepit, elderly women will pose a great burden to society. For example, the North American Menopause Society states in a menopause study guide for doctors that the health decisions made at menopause can make a “significant impact on public health” (NAMS 2000:18).

Kaufert and Lock (1992) document a health crisis orientation to menopause in Canada. A great influx of aging women are expected to create a burden on health systems; however estrogen can keep them stronger and healthier: “the economic appeal of estrogen therapy and lifestyle modification lies in the promise that money will be saved by delaying or preventing high-cost conditions, such as hip fractures, by exercise, diet, and hormone therapy” (1992:216). Rogers (1999) also points to the sky-rocketing costs to the Australian public of caring for all of the elderly women with osteoporotic fractures.

Mid-life women are thus prime candidates for hormone replacement therapy for its ability to control cholesterol levels in the fight against heart disease and to prevent unnecessary bone loss that could lead to osteoporotic fractures. Due to the primacy of the
risk factor model of menopause, osteoporosis has become a “household word,” according to Worcester and Whately (1992). Biomedicine and the pharmaceutical industry have combined forces to market preventive HRT to a large market share by playing on women’s fears of disability, life-threatening conditions, and, consequently, aging.

The recent reconception of HRT use as a public health issue has drawn sharp criticism from feminist opponents of HRT. They find fault with biomedicine’s use of cost-effectiveness analyses to advocate women’s long-term use of HRT to prevent heart disease and osteoporosis (Lyerly, Drapkin, Myers & Faden 2001). They argue that there is little evidence—scientific, moral, or economic—to demonstrate that all women should use HRT for osteoporosis (Rogers 1999). Only one-fourth of women will develop osteoporosis, and HRT use increases the risk of a number of cancers as well as other disorders, raising questions about whether it is safe and ethical to prescribe HRT to all (many healthy) women (MacPherson 1993).

Using HRT to prevent cardiovascular disease is similarly misguided. Feminists question the association of menopause with heart disease, again because biomedicine conflates age and menopause. While most women have reached menopause by age 55, only a fraction of women this age develop heart disease. Instead, women’s rates of heart disease do not increase until age 70 (MacPherson 1993). In fact, family history, smoking, hypertension, and high cholesterol are more important causal factors of heart disease than menopause.

Thus, feminists argue that using the public health/disease prevention model to recommend HRT use to all women is a harmful idea based on faulty logic. Some researchers view the recommendation of universal HRT as a form of “medical violence
against women” due to the medical and psychological hazards forced on women (Klein and Dumble 1994). Likewise, MacPherson concludes her analysis of the rationale behind using HRT to prevent heart disease and osteoporosis by arguing that “Potent hormones given to healthy women, not to treat any disease, but to decrease the potential of disease—specifically osteoporosis and CVD—from menopause until death seems like a reckless endeavor” (1993:155).

Cross-cultural perspectives in menopause research

Research by psychologists (Ballinger 1990; Neugarten, Wood, Kraines & Loomis. 1963), historians (Formanek 1990b; Smith-Rosenberg and Rosenberg 1973) and sociologists (Kaufert 1988; Kaufert and Gilbert 1986) shows that menopause is not simply a biological event; rather, it is largely culturally shaped. The work of anthropologists and other social scientists demonstrates that cross-cultural conceptions of menopause, women’s experiences of menopause, and sociocultural factors including morality, politics, religion, and gender, shape differing meanings of menopause cross-culturally (Komesaroff, Rothfield & Daly 1997).

Cultural representations of menopause vary greatly both historically and cross-culturally. An abundance of cross-cultural evidence serves to illustrate the variety of ways women experience menopause and the range of approaches used to study it. Researchers address menopause as an aspect of aging (Datan, Antonovsky & Maoz 1981; Du Toit 1990), from a biocultural perspective (Beyene 1989), and in terms of determining the unique meanings given to menopause by various cultures (Flint 1975; Kaufert 1988; Skultans 1988; Wright 1982).

Such studies demonstrate that the biologically inevitable end of menstruation is subject to many interpretations—a sense of loss or relief at the end of child bearing,
increased authority of middle-aged women, or changing restrictions or taboos surrounding women's reproduction. Medical constructions of disease and illness are a reflection of broader social themes (Kleinman 1980; Martin 1992; Russett 1989), as demonstrated in studies of women's reproduction and medicine in Victorian America (Smith-Rosenberg 1985) or comparisons of the language used in gynecology texts to women's experiences of menopause in contemporary America (Hahn 1987; Martin 1992).

Cross-culturally menopause research has taken place in a vast range of societies, including the United States (McKinlay, McKinlay & Brambilla 1987; Mingo, Herman & Jasperse 2000), Canada (Kaufert and Gilbert 1986), Japan (Lock 1993b), South Africa (duToit 1990), India (Flint 1975), Mexico (Bell 1995), Thailand (Punyahotra and Dennerstein 1997), Greece (Beyene 1989), Wales (Skultans 1988), Italy (Gifford 1994), Israel (Datan et al. 1981), and Newfoundland (Davis 1989) to name a few. This research has documented the terms (if any) which women use to distinguish the end of menstruation, learned about the physical and psychological changes women experience as their periods end, examined changes in women's culturally constructed social roles as they leave their reproductive stage of life, analyzed the linguistic elements that women use to discuss menopause, and discussed women's social interactions and expectations.

Such cross-cultural research also contributes to an understanding of the female life course to demonstrate the cultural variability of the lives of middle-aged women. As Kerns and Brown's collection (1992) illustrates, middle age can be a woman's prime of life due to changes in her freedom, authority, and increases in power and status as she moves beyond her reproductive years. The current study will contribute to these streams
of research by presenting a picture of the experience and construction of menopause among urban, low-income women in Cleveland, Ohio.

Knowledge about Menopause and Information Sources

It is important for women to understand the normal and natural changes of their bodies whether in reference to menarche, menopause, or their general health. Their knowledge will contribute to their expectations of menopause and possibly to their well-being during the menopause transition. They need to know what to expect and what is normal because they may need to decide the path of their health care at menopause or for health problems they may encounter at various times in their lives.

From the feminist perspective, women gain a sense of empowerment by understanding the workings of their own bodies (Tavris 1992). Research indicates that there are gaps in women’s knowledge about the age- and menopause-related health conditions for which they may be at risk (Padonu et al. 1996, Walsh et al. 1997, Wilcox and Stefanick 1999; Stadberg, Mattson & Milsom 1997 find similar gaps among Swedish women). For example, women tend to be more familiar with osteoporosis than heart disease as conditions they should be aware of as they get older (Appling et al. 2000; Clinkingbeard et al. 1999).

Most studies look at menopause knowledge in terms of the increased postmenopausal risk of other diseases, namely heart disease and osteoporosis, as well as making an informed decision about taking hormone replacement. I am interested in a more basic level of knowledge about menopause. I sought to learn women’s Explanatory Models (Kleinman 1980) of menopause—what makes it happen, when, and how women know they are going through menopause. Women may not know exactly at what age to expect menopause; they may not know they could have changes in their menstrual cycles.
without being pregnant; they may be curious about how long the menopause transition lasts. A study of college women found that women knew that menopause brought the end of their periods but were unable to provide clear details on issues of hormone change or the age when menopause normally occurs (Koff, Rierdan & Stubbs 1990).

Hand-in-hand with women's knowledge and understanding of the mechanisms of menopause are the sources from which they seek additional information. A number of studies show that women are more likely to turn to sources other than health care providers, including print media, friends, or family, for information about menopause and treatment options (Clinkingbeard et al. 1999; Hunskaar and Backe 1992; Mansfield and Voda 1993; Padonu et al. 1996; Pham, Freeman & Grisso 1997; Roberts 1991; Seidl 1998a; Walsh et al. 1997). Less initial reliance on health care providers for information may be related to the increase in reports of menopause research in both medical and popular literature (Kaufert et al. 1998) or to the fact that women do not consider menopause to be a medical problem.

Furthermore, some women experience communication difficulties in exchanges with their physicians (Clinkingbeard et al. 1999; Marmareo, Brown, Batty, Cummings & Powell 1998). Women may also find that their doctors prefer to treat symptoms rather than provide answers or explanations (Jones 1999). They may feel, as well, that their doctor is not knowledgeable or sympathetic to their problems, or some women refuse to believe that menopause is a medical problem in the way biomedicine constructs it (Marmareo et al. 1998).

The current research contributes to the understanding of women's information sources and demonstrate what a sample of low-income women in Cleveland know about
their bodies and the mechanisms of menopause. It also documents where they seek information to learn more about menopause and the physical and psychological changes they experience in midlife. The study offers an opportunity to learn what women, whose education profile contrasts with the higher education levels of many women who have taken part in previous menopause research, know about their bodies, menopause, and health.

**Making Treatment Decisions**

The importance of educating women about menopause is growing because of the emphasis on women taking an active role in making decisions about taking HRT rather than relying solely on their health care providers’ recommendation. Many researchers agree that HRT decision making should be a mutual one between a woman and her health care provider (Clinkingbeard 1999; Johnson and Ferguson 1993; Kaufert et al. 1998; Liao and Hunter 1998; Mansfield and Boyer 1991; Stadberg et al. 1997). Indeed, there are a number of risks inherent to taking HRT. When combined with a woman’s individual medical history and needs, decision making becomes a complex process. There are a number of forces pushing to educate women.

On the one hand, feminists believe that a woman’s participation in decisions about her health and care is a way to empower women and break down the paternalism of the patient-doctor relationship (Ladd 1993). Another reason to educate women about health and hormones is to enhance the chance that women will remain compliant (also described as continuance) with their hormone replacement regimen (Motheral and Fairman 1998; NAMS 1998). Along these same lines, it is important to learn from women themselves what they expect from HRT, what is their understanding of HRT, and who or what is their main source of menopause and health-related information.
Most women who start HRT discontinue using it within two years (NAMS 1998). For example, a Dutch study which examined how long women take HRT found that 60% discontinued HRT by the end of 2 years. The authors believe that most women chose hormone replacement for symptom relief rather than disease prevention (Groeneveld, Bareman, Barentsen, Dokter, Drogendijk & Hoes 1998). A number of other reasons women stop taking HRT include fear of cancer; negative side effects of the medication like breakthrough bleeding, breast tenderness, or weight gain; lack of knowledge and even misinformation about HRT; and even a failure of HRT to have the desired effects (e.g., relief of hot flashes) (NAMS 1998).

Sociocultural factors such as education and ethnicity affect duration of HRT use. Continuing use of HRT is often associated with increased education levels (NAMS 1998; Rabin, Cipparrone, Linn & Moen 1999). Different rates of HRT use also exist between white and African American women in the US, with the former more likely to use HRT at all as well as the number of years a women continues using it, as shown by data from a national health and nutrition survey (Brett and Madans 1997).

The current research will contribute to the discussion of HRT decision-making and use among women who may have inadequate access to health care and financial difficulties paying for medications. The examination of patterns of HRT use and information sources in the current sample of women will contribute to the debate over the medicalization of menopause.

Structure of the Dissertation

Chapter 2 is a discussion of the methods of the study, specifically the sample recruitment, data collection and analysis. I describe the women in the study by
examining demographic and health information and present an account of their menopause status.

The third chapter looks broadly at what women know about menopause. It specifically examines what women know about the age at which menopause occurs, why it happens, and what women consider to be the first indicators of menopause. Secondly it examines women’s information sources regarding menopause, whether mothers, friends, or health care providers. To the same end it inquires whether women felt like they were adequately prepared for menopause and what details they would tell other women to prepare them.

Chapter 4 is a discussion of the signs and symptoms women in the study have experienced recently. It consists of symptom frequencies and examines which symptoms women specifically attribute to menopause. The chapter also provides a report of these menopause symptoms as women themselves describe them.

Chapter 5 examines women’s attitudes toward menopause in relation to aging, physical changes, and the end of reproduction.

Chapter 6 provides a discussion of the uses for hormone replacement therapy. It also examines women’s choices of treatment options for short-term menopause symptoms and long-term disease prevention.

The final chapter summarizes the primary research findings and outlines study limitations and offers directions for future research. The results show that the forty women in the study do not see menopause as a problematic life event, as other authors have shown. Most of them do not find their lives disturbed by the changes occurring at the end of menstruation. In fact, they mentioned having more non-menopause symptoms
(e.g., aches and pains, shortness of breath, lack of energy) than signs of menopause (e.g., hot flashes, night sweats, vaginal dryness). To these women, the hallmark signs of menopause include hot flashes, sweats, problems sleeping, fatigue, vaginal dryness, feeling blue, and mood swings.

Contrary to biomedicine’s authoritative knowledge, menopause is not a disease or medical condition to the women in the study. However, if a woman has difficulty with menopause, some women suggest, she should talk to her doctor. Because few define menopause as a medical event, these women generally do not seek medical interventions. Thus, only a small fraction of them take hormone replacement therapy, and many were not familiar with use of hormones at menopause.

The majority of the women’s Explanatory Models have a precise explanation of why their periods would come to stop; they understand it as a matter of the life course of a female, that the eventual cessation of menses is part of being a woman. However, most knew that a woman’s periods will stop sometime between ages of 40 and 50.

Where did women get their information about menopause? Women largely consulted reading materials if they sought information about menopause or health topics. They were also likely to discuss menopause with health care providers or friends, but less often. There was clear evidence that the women mistrusted (male) medical advice when they received it. Most women thought that younger women would like information about menopause before it happens.

Few women in the study make use of any pharmaceutical or alternative remedies for symptom relief at menopause. It does not appear that many women find their symptoms to be unbearable.
This study shows that menopause for this group of low-income women is not medicalized, nor do they seek or accept biomedical knowledge or interventions. This study is in contrast to the middle-class women in other studies.
CHAPTER 2

METHODS & DESCRIPTION OF PARTICIPANTS

Study Design

An abundance of cross-cultural and social scientific research shows the diversity of menopause throughout the world. Much US research, whether small or large studies, has involved only a small segment of the US population—European American, educated, middle-class women. By contrast, the current study looks to the other end of the socioeconomic and ethnic spectrum by examining menopause among lower income women who often have less education and lower-paying jobs than previously studied women.

The interviews focus on women's personal experiences of menopause and their understanding of the changes that occur at menopause, as well as their self-perceptions of related issues such as body image, self identity, and gender roles. I examine women's perceptions of menopause based on their own experience as well as information they receive from friends, relatives, media, and health care providers. I ask about the types of symptoms women associate with menopause both generally and personally, and examine their knowledge about diseases and health care issues (e.g., heart disease, osteoporosis, cancers) which biomedicine attributes to menopause and aging. Research indicates that there are gaps in women's knowledge about the age- and menopause-related health conditions for which they may be at risk (Walsh et al. 1997; Padonu et al. 1996), potentially influencing their health care decisions in the years surrounding menopause.

In my research, I used a semi-structured interview with a variety of question types. I included open-ended questions about menstrual and menopausal experiences, symptom lists where women indicated whether they had experienced a given symptom in
the last two weeks, open-ended questions about their reproductive history and current health practices, and a 10-point Likert-type scale (1=“disagree,” 10= “agree”) where women indicated the degree to which they agreed or disagreed with a series of statements about menopause. I derived the symptom lists from those used by Leidy (1997) and Clinkingbeard, Minton, Davis & McDermott (1999); the scale statements, with responses ranging from agree to disagree, are from Woods and Mitchell (1999). (The study protocol was approved by the CWRU IRB.)

The questionnaire begins with demographic questions regarding age, ethnicity, marital status, education level, employment status, type of medical insurance, a brief reproductive history—age at menarche, number of pregnancies, births, contraceptive use, current menstrual status. Another set of questions addresses whether women think they are in menopause, what makes them think that, why menopause occurs and at what age, what women go through at menopause, if women knew anything about menopause before it happened and from whom they learned about it, and how they would describe menopause to a younger woman. Another series of questions inquired about symptoms women were having and to what they could be attributed, as well as asking them to identify which symptoms in a list they thought could be related to menopause. I also asked women whether they felt that menopause was a positive or negative experience, how they felt about getting older, what they thought about their family size and composition, and how they would describe what menopause is like for them.

Because I am interested in what women know about menopause and their health, I asked them about their health related information sources. I wanted to know if women turned primarily to their health care providers, to written sources, or to family and friends...
if they had questions about their health or, more specifically, about menopause. Finally, I asked them about their current health practices, namely smoking and dietary habits, how often they get physical or gynecological exams, what current health or medical problems they have, and their knowledge of their risks for cancers, heart disease, etc. that may be related to age or associated with diminishing estrogen levels.

Recruitment

Because I wanted to reach a low income, non-clinical population of women, I decided to contact them through social service agencies on the west side of Cleveland. I recruited women through three centers (all pseudonyms): the Forest City Family Center, West Side Community Center, and the Brighton Hunger Center. The former is run by the Cuyahoga County Commissioners’ office and the latter two operate under the auspices of a church-based social service agency. In addition, a woman I met at one of the food centers posted my informational flier in the building where she lived (a transitional housing unit), yielding three other women who contacted me to participate in the study.

To gain access to potential recruitment sites, I initially met with one of the intake assessors at the Forest City Center, and with an outreach worker at both West Side and Brighton centers. I described the research project to them and indicated that I was interested in contacting low income women who might participate in the research. I indicated that I had received approval from CWRU to conduct the research. I further explained that the research involved a one-hour interview and that I would compensate the women $10 for participating in the interview. One outreach worker was particularly interested in the potential for the research because she had noticed that women around 50 years of age tend to lack access to support opportunities because they are outside of the childbearing age but not yet elderly.
Once these contact people indicated support and approval of my recruiting study participants through their institutions, they introduced me to the directors of the centers as well as to other staff members. I again described the nature and procedure of the study to the directors and received their support to recruit participants from the centers. During the recruitment period at each center, I continued to maintain contact with and receive encouragement from the directors. I recruited women from the Forest City Family Center during July and August 2000, from the West Side Community Center from October 2000 through January 2001, and I recruited at the Brighton Hunger Center from January to June 2001.

To recruit women, I visited the centers during their food distributions. All three contact people indicated that my best opportunity to reach women was during these distributions. For several hours during 5 or fewer days each week, the centers distribute food provided by the USDA supplemented by donations to and purchases by their parent organizations. Food distribution at the centers is based on an individual’s or family’s self-declared need for food and that they be residents of the area served by the distribution center. While the centers do not distribute food based strictly on level of income, they do require documentation annually of proof of income, usually paperwork from Social Security, pay stubs, etc. This documentation process ensures that the large majority of people coming to receive food are from low-income households.

I typically went to the centers two days a week for two to four hours in the morning and early afternoon. I learned that the centers were busiest during the last week and a half to two weeks of each month as monthly incomes dwindled and people’s food supplies ran out. Therefore, I often did not go to the centers during the first week of the
month because very few people came for food. I sat in the area where people waited to
receive food. In one instance the distribution center was in the basement of a church, in
another center people waited in the center’s reception area, and in the third people came
to a multipurpose room at the center. People who came to receive food first signed in and
provided a photo ID card for identification and address information and then took a seat
and waited to be called to the depot where center volunteers packed bags of groceries.

While people waited in line for food, I approached women I thought looked like
they might be between 40 and 55 years old. I introduced myself and explained that I was
looking for women who were between 40 and 55 who would be interested in taking part
in an short interview about women’s health and menopause. I handed them a flier and
briefly told them about the study, that it involved questions about their periods and
menopause, health care they receive for women’s issues, who they ask if they have health
questions, and that it did not involve any medical exam or prescribing medications, just
talking. I informed women that participation was voluntary and that I would give them
$10 to reimburse them for their time.

Women’s reactions to my solicitation were varied. Some women cut me off and
told me they were not interested. Others listened politely and indicated if they were
interested in hearing more. Yet others refused to participate because they were not going
through menopause, had had a hysterectomy years ago (though this was not among any
exclusion criteria), that they were too young, or were otherwise not interested or too
busy. Some women teased me about why I had chosen them (did they really look “that
old”), started to tell me immediately about what they were going through, and even told
me about their mothers or friends. Others took the fliers and said they would think about
it. In a few instances, women who indicated that they were interested in participating actually turned out to be over 55 years old, including one who was in her 70s. When this happened, I reiterated that we were looking for women of a particular age and thanked them for their interest. Several times at one center, Hispanic women indicated to me that they did not speak English. The women either asked if the bilingual outreach worker was available to facilitate or they simply walked away or waved me off.

If women indicated that they were interested, I offered to meet them at a time and place convenient for them. Often they told me they were too busy at the present time, but could me meet later. Sometimes I interviewed the woman on the spot, especially if there were few people coming for food, though I preferred to arrange to meet other times to make the most of my recruitment schedule. The women and I negotiated a time and place to meet for the interview. In addition to noting their names and ages, I offered to call them on the phone the night before the interview to remind them. Most of the women accepted this offer, and in several cases the phone call served as a useful reminder of the appointment or enabled us to reschedule if the initial time was no longer convenient. If I was meeting the woman at her home, I also asked for directions to get there.

The criteria I used in generating the sample included age and interest in participation. Initially, I intended to interview women 45 to 55 years old, but after several weeks of recruiting, I met a number of women who were between 40 and 45 who thought they were experiencing menopause. Upon approval from the CWRU Institutional Review Board, I began recruiting women as young as age 40. Expanding the age range provided the opportunity to include women at a number of points in the
menopause transition—from women who were just beginning to experience symptoms and menstrual irregularity to those who had few symptoms and no longer menstruated, as well as to examine women's own definitions of what menopause is, the symptoms it includes, and when it begins and ends. As described above, I refused women only based on their age and not menopause status, including whether they had had a hysterectomy. A small number of women excused themselves from participating in the study about menopause because they had had hysterectomies, but this was based on their own assumption and not on my criteria.

Total number recruited and interviewed:

While recruiting, I handed out fliers and spoke to approximately 130 low-income women living on the West Side of Cleveland. Forty-five women agreed to be interviewed. Four women, however, never showed up for the interview or, after setting the appointment later indicated they were no longer interested. I was unable to attend one appointment and could not recontact the woman because she did not have a telephone and I never saw her again at the center. I successfully recruited a total of 40 women from the three centers and from the flier posted at the transitional housing unit. I completed interviews with all 40 women.

Description of Cleveland and recruitment areas:

The study took place in Cleveland, Ohio, which is located on the southern coast of Lake Erie at the mouth of the Cuyahoga river. Cleveland is situated in Cuyahoga County, the most heavily populated area in the state (Greater Cleveland Growth Association 2002). With a population of 478,403 (US Census 2000), Cleveland is the 30th largest city in the United States (Greater Cleveland Growth Association 2002). At the same time, however, there has been a trend of population decline within the city itself.
as people move to the surrounding suburbs (Bania, Coulton & Leete 2000). The city was historically a sizeable industrial center producing steel and automobiles. Following economic decline and stagnation in the 1970s and 1980s the city’s economy is now centered on service-producing industries (e.g., communication, transportation), service industries (particularly health care), construction, and manufacturing (Labor Market Review 2002). The two largest employers are the federal government and Ford Motor Company (Greater Cleveland Growth Association 2002). Most large employers are situated outside of the city of Cleveland in surrounding areas of Cuyahoga County (Bania et al. 2000).

Cleveland residents are predominantly African American (51%) and “white” (41.5%), with 7.3% of the population being Hispanic and smaller numbers of American Indian, Chinese, Filipino, Korean, Indian, Pacific Island, and Vietnamese. There is very little immigration into Cleveland of foreign-born individuals compared to other large metropolitan areas (Bania et al. 2000). Most of Cleveland’s population is over the age of 18, with a median age of 33 (US Census Bureau 2000; CANDO neighborhood profiles 2000).

Participants in the study are from three areas on the Near West and West side of Cleveland. The first area is Tremont, home to 8,239 people. It is an industrial and residential neighborhood which is home to a growing artistic community. Initially settled by Irish, German, Polish, Greek, and Ukrainian immigrants, it now contains over thirty ethnic groups (Van Tassel & Grabowski 1996). Currently the population in this part of the city is 65% “white,” 23% Hispanic (primarily Puerto Rican), and 20% African American (CANDO neighborhood profiles).
As of 1990 census figures, the median income of Tremont residents was $11,786 and 47% of the residents lived below the poverty line (CANDO neighborhood profiles). By contrast, the median income in the city of Cleveland in 1990 was $17,829 and 28.7% lived below the poverty level (CANDO neighborhood profiles).

The second area from which I recruited participants is Ohio City, one of the oldest neighborhoods in Cleveland (Van Tassel & Grabowski 1996). It is the site of considerable redevelopment and gentrification. The 9,276 residents of Ohio City are 58% "white," 27% African American, and 27% Hispanic. Over half of the residents (53%) were living below the poverty line in 1990 with a median income of $9,811 (CANDO neighborhood profiles).

Finally, the third area from which participants come is Old Brooklyn. This former commercial hub for farmers selling produce dates to the early 1800s and is a conglomeration of several smaller neighborhoods and townships (Van Tassel & Grabowski 1996). Old Brooklyn has the largest population of the areas in the study with 34,169 residents. It is also less ethnically heterogeneous with over 90% of its residents being "white," 6% Hispanic, and 3% African American (CANDO neighborhood profiles). The median income of Old Brooklyn residents in 1990 was $25,440 and just over 9% lived below the poverty line.

The three centers where I recruited are located in the Cleveland neighborhoods described above. The West Side Community Center is located in Ohio City. According to the center's outreach worker, the center's service area is largely African-American and Hispanic and a number of the clients of the center are "street people." The majority of the women I recruited at the center reflect the ethnic makeup of the area, with 60% of
women interviewed being African American (n=9), 33% European descent (n=5), and 7% Hispanic (n=1), for a total of 15 women.

Located in the Old Brooklyn area, the Brighton Hunger Center serves a clientele evenly divided among "whites," blacks, and Hispanics, with a large number of their clients being senior citizens, according to the outreach worker. Over half of the women I interviewed were of European descent (n=12, 57%), 23.8% were Hispanic (n=5), 14.3% African-American (n=3), and 1 was American Indian (4.8%), for a total of 21 women.

The Forest City center, serving Tremont and Ohio City, also serves a diverse population, composed primarily of people of European descent, with smaller and comparably sized African American and Hispanic populations (CANDO Neighborhood Profiles 2000). I recruited an equal number of women of African American and European American descent, with 2 women in each category.

Interview Procedure

I met women for the interviews at times and places that were convenient for them. The interviews usually occurred after 10:00 a.m. and before 6:00 p.m. The interviews lasted on average 1.25 hours, including additional time for description of the research prior to commencing the interview. At least one interview lasted nearly two hours because the woman was generally very talkative and spoke extensively about her experience with menopause and other health issues. By contrast a few interviews lasted about 45 minutes, generally with women who had not really started menopause or did not even know what it was.

I mainly conducted interviews at two locations—women's homes or the social service agency where I had met the women. In some cases, I met the woman at someone else's home—a friend's house, a mother's house. In many cases I conducted interviews
at the centers: three-fourths of the interviews at Forest City, two-thirds at Brighton, and fewer than one-third at the West Side Community Center.

I conducted three interviews at the Forest City center using empty staff offices where we could shut to door to obtain privacy and quiet. Occasionally someone came to the door looking for the staff member who owned the office and the phone sometimes rang.

When I conducted interviews at Brighton, I used either a staff member’s free office or met in a large classroom/meeting room. Occasional interruptions included the phone ringing (in staff offices) or center staff opening the door to the classroom to discover it occupied. In one instance, the room was being used for child immunizations and I used it during their lunch break. When the nurses returned early after lunch, we moved to a different room to finish the interview. The majority of the time during the interviews at the center, we had adequate privacy so that the women could speak freely. Some women would have been comfortable conducting the interview anywhere and simply spoke their minds; other women whispered certain “taboo” responses even though we were the only two in the room.

Among the women from the West Side Community Center, I conducted four of interviews at the Center itself. In one case, I used the outreach worker’s office while he was out, so we had privacy and no interruptions. In the other instances, I conducted the interview in the large church basement. Long tables and chairs fill the room which was used for the evening meals provided by the center, and we sat toward the opposite side of the room from where people were signing in for the food distributions.
The Interviews

At the beginning of an interview, I took a few minutes to chat with the woman. I explained a little more about the study while I took out my paperwork and got it in order. I typically explained that I was from the Anthropology department and was not a doctor offering health care. I usually explained what anthropology is, though some were familiar with it being like archaeology or studying dinosaurs. I described the kinds of questions I would ask them to prevent any surprises during the interview. I sought and obtained written informed consent from all participants: I explained the need for their consent before proceeding with the interview. I showed the letter to the women and read through it with them. I asked them to sign if they agreed with the information in the letter and understood the kind of questions I would ask. We both signed two copies of the letter, one for them to keep and one for my records.

I asked each woman if I could tape record the interview and showed her a small recorder with a little microphone on it. If the woman agreed to record the interview, I handed her the microphone to clip onto her shirt or collar. The microphone worked very well to pick up the woman's voice, particularly in the cases where there was some background noise. Some women laughed about being recorded, but most were not bothered by it. Three interviews were not tape recorded: one woman refused to be recorded, so I relied solely on my written notes to document the interview; in two cases I got distracted turned on the recorder but not the microphone. In addition to tape recording, I took notes throughout the interviews.

As part of my introduction to the interview, I explained to women that they could refuse to answer any questions, to terminate the interview at any time, and that they could ask me any questions that arose in relation to the what I asked them. No one refused to
answer my questions, and no one terminated the interview at any point. During some of the interviews, we paused momentarily for interruptions—phone calls, someone ringing a doorbell, bathroom breaks, etc. I asked the questions in the same sequence for each interview. Occasionally, however, a woman might provide information relevant to a question I had not yet asked. Nonetheless, I returned to the sequence of questions as appropriate.

After the interview, I asked women if there were topics I didn’t ask them about or if there was anything that I had left out. Most women felt that I had covered all the relevant issues, though a few added symptoms or bodily changes that I had not included—hair loss, tooth fragility. I also gave women the opportunity to ask me questions, particularly to clarify any curiosity that arose due to the interview questions. Generally women asked me for information about hormone replacement therapy or about natural treatments for menopause symptoms. Some women were curious about whether their symptoms seemed “normal” compared to other women’s. They also asked about the duration of symptoms—how much longer are the hot flashes going to last?—and how long menopause itself would last. I also heard stories of friend’s or other family member’s unusual menstrual or menopausal experiences.

When the interview and follow up questions were finished, I turned off the tape recorder and retrieved the microphone. I gave women $10 as compensation for participating in the interview, asking them to sign a receipt indicating that I had given them the money. Although I included information about compensation on the flier I handed women, and covered the issue in reviewing the consent letter, some women were surprised by the money. One woman wanted to refuse to take the money, saying that she
didn’t want it and hadn’t participated for the money. I suggested that she could give the money to someone else, such as a church or other charity if she did not want to keep it herself. She accepted the money but did not indicate what she would do with it. Two other women told me that they planned to give the money to their grandchildren—one for a birthday gift, another as a first communion gift. Others stated outright that they would spend it on lunch, beer, or cigarettes. For a number of the women it seemed clear the offer of $10 was a motivating factor in their participation.

Following the interviews, I either jotted down notes on paper or tape recorded them to be transcribed later. These notes included details about the location and time of the interview, any circumstances during the interview including interruptions or distractions, and general impressions about the woman I interviewed or perhaps something we had talked about once I turned off the tape recorder.

A Spanish-language translator facilitated interviews with three of the Hispanic women I interviewed. The translator is a 30-something Puerto Rican immigrant who currently works as an outreach worker at one of the centers. She has previously worked as a medical translator at a local hospital. In addition to translating during the interview, she helped explain the study during recruitment and arranged the interview appointments. During the interviews, I read the instructions and questions in English and the translator gave this information to the women in Spanish. Occasionally the translator had to explain terminology or describe a symptom, particularly when there wasn’t a clear, exact translation of a word. The women responded in a combination of English and Spanish. For example, they usually responded in English to questions requiring yes/no answers as well as to questions about their family makeup, reproductive history, and occupations. At
least two of these women were currently, or had in the recent past, taken lessons in learning English from the translator through the center. Because the women already knew the translator through her role as a Spanish-speaking outreach worker, they seemed very comfortable working with her during the interview and she had already developed a sense of rapport with the women.

Handling the interviews

I transcribed all of the interviews with the aid of a transcribing machine. From the beginning of the interview phase, I attempted to complete a transcription within a few days of the interview so that it would be fresh in my memory, particularly in the event that a tape recording was incomplete or corrupt. Despite trying to keep up with the accumulation of completed interviews, the number of untranscribed tapes grew, so I continued transcribing for one and a half months beyond the interview phase of the project. Interviews exist in transcribed electronic files as well as on cassette tapes.

While transcribing, I noted recurring themes and unusual or surprising comments from the interviews, writing them down accompanied by the ID number of the speaker. I also kept track of potential topics I could use in analysis and writing. These notations became the starting point for some of the codes I developed.

Data Analysis

The first step in analyzing the data involved separating the clearly narrative data from the more quantitative information. I entered the quantitative data into SPSS 8.0. Specifically, I created variables for age, ethnicity, marital status, job status, family income, education level, number of pregnancies, self-described menopause status, number of pregnancies/abortions, age at menarche, symptoms and their causes, information sources for health and menopause, beliefs about menopause, health
behaviors, menopause treatment, knowledge of health risks, and symptoms that may be related to menopause. I generated frequencies to assist in interpreting the data. In most cases, throughout the analyses the frequencies are calculated for the entire sample.

In the specific case of working with the list of symptoms women had experienced in the previous two weeks, I initially calculated the frequencies across the entire sample, then divided the sample into four broad ethnic categories I created—European American, African American, Hispanic, and American Indian—and again generated frequencies. Finally, I calculated symptom frequencies by menopause status—premenopause, perimenopause, and postmenopause.

I coded the narrative data using WinMax Pro. I began by identifying and coding passages related to the specific symptoms women experienced and what the symptoms were like. I also coded passages in the narratives related to women's views on menopause, familiarity with menopause among family or friends, menopause treatment options, aging, childbearing, advice to other women regarding menopause, and other thoughts on menopause. By using WinMax I was able to easily pull together all coded passages related to a specific subject, with each passage containing the speaker's participant ID number and the location of the particular passage within the entire interview.

I printed a list of coded passages to read through and look for common elements, themes, or unusual statements as I examined what women said about menopause.

Description of Participants

I interviewed a total of 40 women about their experiences with menopause. The women in the sample were between 39 and 55 years old, with a mean age of 47. The youngest woman, 39 years old, told me that she was 40 when I recruited her but stated
her age as 39 during the interview. I created four broad categories to distinguish the ethnic or descent backgrounds of the women in the sample. The largest proportion of women, 47.5% (n=19) were of European descent, which consists of women who described themselves as “American,” “white,” a “Heinz 57—a little bit of everything,” or “my family’s been here a long time.” The next most prevalent ethnic group representing 35% (n=14) of participants were African American, which included one woman who described herself as a “woman of color,” another as Caribbean, and others as Black or Black Baptists. 15% of the sample were Hispanic (n=6). One Hispanic woman was born in the United States of immigrant parents, but the others were immigrants, coming from Puerto Rico, Peru, and Guatemala. The immigrant women had lived in the United States ranging from the past 6 months to 40 years. There was also one American Indian woman among the participants.

Figure 2.1 Ethnicity of Study Participants

![Pie chart showing ethnicity distribution]

Overall, most women were single (n=23, 57.5%) either because they were never married or currently considered themselves single, divorced, or separated. The remaining women were either married or had a partner. Twenty percent of the woman I interviewed
were currently married \( (n=8) \) and living with their husbands. Nine women were living with a partner but were not married to him \( (22.5\%) \). Beyond whether women were currently married or had a partner, they lived in a wide variety of household arrangements. Fourteen women lived alone, without a partner, family members, or friends. Ten women lived only with their partner or husband. Five women lived with their husbands and children, and five women lived with just their children but no husband or partner. One woman lived with her adult child and grandchildren, one had custody of her grandchild, and another lived with her two adult children and her daughter’s two toddlers. Two women lived with another family member \( (e.g., \) a sister \) or with a person she simply called a friend.

**Table 2.1 Demographic Information**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Single ( n=23 ) (57.5%)</th>
<th>Partnered ( n=9 ) (22.5%)</th>
<th>Married ( n=8 ) (20%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Level</td>
<td>Less than high school ( n=13 ) (32.5%)</td>
<td>High school diploma ( n=10 ) (25%)</td>
<td>Some post high school ( n=14 ) (35%)</td>
</tr>
<tr>
<td>Employment Status</td>
<td>Employed ( n=22 ) (55%)</td>
<td>Unemployed ( n=18 ) (45%)</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>$0-7500 ( n=18 ) (45%)</td>
<td>$7501-15,000 ( n=12 ) (30%)</td>
<td>$15001-30,000 ( n=9 ) (22.5%)</td>
</tr>
</tbody>
</table>
I sought several kinds of information to illustrate the socioeconomic status of the women in the sample. Because I recruited women who had been screened to receive income-based social services, in principle they all had low incomes. I also looked at their educational backgrounds, current employment status, and whether they received disability. In fact, regardless of the household composition, women’s incomes ranged from less than $5000 per year to $30,000 per year. Only one woman’s annual income was greater than $30,000; combined with her husband’s salary, their income was approximately $60,000. However, she had only recently moved into that income level following years of raising 4 children with the assistance of Aid to Dependent Children (ADC).

The women in the sample have a wide range of educational backgrounds. One-third of the women (35%, n=14) had at least some post-secondary education, including a few years of college, work towards an associates degree, or were currently attending a local community college. Several of the women were currently attending college or were receiving job training and education through a social service program (e.g., as part of the “package” of living in transitional housing, two women were learning new trades at a local community college). Almost the same number of women had not completed high school (32.5%, n=13). One of the Hispanic immigrants had only a 5th grade education, but the majority of these non-graduates had completed school through the 11th grade. However, one woman in this group, who had completed the 9th grade, was unable to read. Two of them were currently studying to receive their GEDs (high school equivalency diplomas). Of the remaining women, 10 (25%) had received high school diplomas and 3 women had college degrees (7.5%).
By comparison, among adults in Ohio 13.8% have a bachelor’s degree, 19.2% have completed some college, 38.5% hold a high school diploma, 11.6% have completed some high school, and 4.0% have received less than an 8th grade education (Chronicle of Higher Education 2001). Almost three times more women in the study have not received a diploma than in the general population of the state. However, a greater percentage of women in the study have completed some college education than in the general statewide population. The women in the study were half as likely to hold a college degree than the general population of Ohio. Finally, women with high school diplomas appear with less frequency in my study sample than in the state of Ohio.

Women worked in a variety of low-paying jobs that often offered no health insurance benefits. Over half of the women (n=22, 55%) were either employed outside the home (n=16) or considered themselves housewives (n=6). They worked as domestics, nurse’s aides, provided care for their grandchildren, stocked shelves in stores, or worked various types of jobs through a temporary agency. The remaining 18 women (45%) in the sample were currently unemployed. Most of these women were unable to work due to chronic health problems (emphysema, stroke, breast cancer, fibromyalgia, arthritis, recovering alcoholic) or injuries (nerve damage, badly healed broken knee) that prevented them from being able to work physically demanding jobs of the types they used to hold. In addition, one woman witnessed a violent crime at work and one woman was diagnosed with multiple mental illnesses. It is unclear why a few women were no longer working.

One-third of all the women in the sample receive some kind of public assistance to support themselves (n=15, 38.5%, information missing for one case). This figure only
includes assistance for the women and does not include cases where a woman’s dependents receive assistance. Most of the women receiving assistance are unemployed. Of the 18 women who were unemployed, two-thirds (n=11, 61.1%) receive assistance. They receive SSI (Supplemental Security Income), a type of disability payment. By contrast, only 4 of 22 women who had jobs (18.2%) receive SSI. Women received SSI for reasons including mental illness, physical disability due to an injury, arthritis, job violence, emphysema, or other chronic health conditions that prevent them from working.

Because I am interested in learning about women’s experiences with medical care surrounding care at menopause, I asked women if they had any medical insurance and what aspects of medical care it covered (examinations, prescriptions, etc.). Nearly half (n=17, 43%) of the women had no medical coverage at all. However, five of these women had applied for welfare and were awaiting the start of coverage through Medicaid, though they remained uninsured at the time of the interview. The remaining 57% (n=23) had some level of medical insurance. The majority of them were covered by Medicaid (n=14), generally in conjunction with the SSI they received. Five more women had private insurance through their work or their husband’s. Two women cited that they made use of the city hospital’s sliding scale to pay for medical care in lieu of insurance (the amount they pay is based on what they can afford). Under the scale, they are required to pay only what they can afford based on their income. The two remaining women receive care at Veterans Administration hospitals as part of their status as military veterans.

Reproductive History

Examination of the women’s reproductive history reveals information about women’s age at menarche; number of pregnancies and births; and their current menstrual
or menopausal status. This information is all based on the women's recall of these aspects of their reproductive lives and may be subject to recall error. As noted, the forty women in the study range in age from 39 to 55 with a mean age of 47.4 years old. The average recalled age at menarche for this group of women is 12.10 years and the median is 12 years old. Ages ranged from the youngest experiencing her first menstrual period at age 9 to the oldest at 15. One woman could not recall or even guess how old she was at her first period. Some women specifically remarked that the women in their family “started early”, and others had very graphic recollections of their first periods, particularly if they hadn’t been prepared for it by their mothers, older sisters, or school nurse.

Half of the women (n=20) were still menstruating, though with varying degrees of frequency and “normality.” Among the menstruating women, their periods occur with what they consider to be a typical frequency and duration (n=6). Other women have periods two or more times a month (n=5). Some women’s periods skip a month or two but resume after this interruption (n=4). An irregular start date or unpredictable number of days menstruating can also be a problem for women (n=5). Of the women who are no longer menstruating, 6 have had a hysterectomy (30% of non-menstruating women, 15% of total sample).

Women’s self-assessment of their menopause status—whether premenopausal, perimenopausal, or postmenopausal—is known to be suspect because recall accuracy declines the farther from an event one gets (den Tonkelaar 1997) and due to rounding up or down in age for an event in which several months can make a difference in status, and because there can be an overlap in the menopause status categories (Holte 1998). Of the
total sample, 17 women considered themselves to be going through menopause, but seven others have yet to start. Five women were not sure or did not know if they were going through menopause. Six women indicated that their doctors told them they were in menopause, and one woman thought she was in menopause but blood tests performed by her doctor indicated otherwise. Three women specifically described themselves as being in "premenopause," and one woman indicated that she was completely done with menopause.

**Table 2.2 Menopause Status**

<table>
<thead>
<tr>
<th>Status Category</th>
<th>N (%)</th>
<th>Ave. Age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premenopausal</td>
<td>7 (17.5%)</td>
<td>44</td>
</tr>
<tr>
<td>Perimenopausal</td>
<td>14 (35.0%)</td>
<td>46</td>
</tr>
<tr>
<td>Postmenopausal</td>
<td>13 (32.5%)</td>
<td>49.5</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>6 (15.0%)</td>
<td>49.2</td>
</tr>
</tbody>
</table>

The standard categories of menopause status used in menopause research are premenopausal (any time in the reproductive cycle prior to menopause), perimenopausal (characterized by irregular menses, prior to menopause), and postmenopausal (designated by twelve months amenorrhea and marked by low estrogen levels) (World Health Organization 1981). I categorized women in the study into the three standard groups, based on an examination of what women said about whether they were still menstruating and how often. Thus seven women in the current sample (17.5%) are premenopausal, 14 (35.0%) are perimenopausal, and 13 (32.5%) are postmenopausal. The remaining six women (15%) had a hysterectomy and are postmenopausal as a result of the surgery. Premenopausal women, as would be expected, were the youngest among the women grouped by menopause status at an average age of 44 years old. The perimenopausal
women averaged 46 years old. Postmenopausal women were 49.5 years old and those who had a hysterectomy averaged 49.2 years old. For the purposes of subsequent analyses, I will use these categories. Women were assigned to the categories based on their explanations of current menstruation patterns, whether they had hysterectomies, or when their last menstrual period occurred.

Most of the women in the sample had given birth to at least one child (n=33, 82.5%). Seven women (17.5%) had no children, either as a result of an abortion, miscarriage, or having never been pregnant. Eighteen women had one or two children, 13 woman had between 3 and 5 children, and two women had 6-8 children. In addition, some women had larger family sizes because of adoptions, spouses joining families, and women taking over parenting of grandchildren.

Health Behaviors

As a gauge of the health of the women in the study, I asked them about several health-related behaviors in which they might engage. I asked about their exercise and eating habits, about taking vitamins and smoking and drinking alcohol. Many of the women (n=24, 60.0%) said that they exercise regularly. In most cases the exercise consists of walking which often doubles as the women’s mode of transportation. Many women walk to stores, to and from home and bus stops, one woman once walked from the west side of Cleveland to a suburban shopping mall, a trip of nearly 5 miles one-way. A small number of the exercisers walk specifically for exercise and some also ride exercise bikes or use a stair climber. The exercisers vary in how often they work out. For the women who consider their walking-transportation to be their exercise, they usually walk every day. Purposeful exercisers try to work out several times a week, by going for walks, working with exercise videos, yoga, bike riding, using a treadmill or...
rowing machine at a gym, or doing sit-ups and lifting weights. Sixteen women (40.0%) do not exercise regularly, and three of them stated that they knew they should exercise but still did not.

Smoking is a health behavior that may be related to menopause. Specifically, women who smoke may go through menopause at an earlier age than non-smokers (Cramer, Harlow, Xu, Fraer & Barbieri 1995; Harlow and Signorello 2000). In the current sample, 13 women (32.5%) currently smoke and 12 (30.0%) used to smoke but have quit. Fifteen women (37.5%) have never smoked. However, because the sample is so small, there is little difference in the relation between age, menopause status, and smoking behavior.

I asked women if they were conscious of maintaining a good diet. This included what they ate regularly, if they had any dietary restrictions that they monitored, and if they felt they ate a healthy diet. Over half of the women felt that their diets were healthy (n=22, 55.0%). They tried to stay away from ‘greasy’ food, switching instead to baked meat or fish. Eating fewer sweets and drinking fewer soft drinks were other tactics. Many mentioned avoiding red meats in favor of chicken or fish, and eating more vegetables and fruits. A number of them indicated that they were careful about avoiding too much salt or sugar as well. Four other women (10.0%) indicated that they “should” eat a better diet but didn’t because it was too expensive to eat a nutritional diet or that they just did not put forth the effort to eat better. Finally, 35.0% of the women (n=14) admitted that they basically ate what they wanted to regardless of its nutritional or healthful quality.
A number of women told me that they thought they might need to start taking vitamins, particularly when we talked about their health. Women who felt tired or had little energy often felt that taking vitamins would help this problem. Just over half the women (n=21, 52.5%) take vitamins daily. Daily multivitamins are the most common form of supplement, though a number of women take only specific vitamins: E, B6, B12, folic acid, potassium, calcium. Many of the women taking multivitamins received handfuls of samples or a full supply of the medicine from their doctors. The remaining women (n=19, 47.5%) do not take vitamins, mainly because they do not like to take pills or they do not feel like they need to take vitamins for any reason—they get enough vitamins in their food.

General Health Status

I wanted to gain some insight into the general health of the women in the study, for comparison to menopause complaints and to gain perspective on their general health. A recent survey shows that residents of large Ohio cities are likely to be at a disadvantage in terms of their health and health care access compared to suburbanites (Coulton, Colabianchi, Cook & Kim 2001). These inequalities are magnified for individuals living in severely disadvantaged neighborhoods in cities. City residents are more likely to lack health insurance which makes them less likely to have seen a health care provider. Throughout Ohio, 19% of people who live in central cities are currently uninsured. Lack of insurance is due largely to sociodemographic factors such as poverty and low educational attainment.

Inaccessible and unaffordable health care results in central city residents having worse health than suburbanites. For example, city dwellers rate their own health to be poorer than that of their suburban counterparts. In Cleveland 23% of people living in the
city reported poor/fair health while only 13% of suburbanites did. Based on scores on a 12-item health survey, 24% of city dwellers have poor health compared to 15% of suburb dwellers. African American and Hispanic individuals have more health problems than “white” residents. Adult women (age 18-64) who live in cities have more problems than their male counterparts (Coulton et al. 2001). Similarly, adult residents of cities have more chronic health problems than do people who live in suburbs.

To learn about the women’s health, I asked them to tell me about their current health problems, which included things that were either diagnosed, undiagnosed, or simply bothersome. The women presented a wide range of general and specific health problems. Most women listed 2 or 3 health problems. However, one woman documented as many as 14. By contrast, five women stated that they had no health problems which bothered them on a regular basis, and they considered themselves to be in very good health. However, half of the women, when asked to label their current health, considered themselves to be in fair or poor health.

The women in the study have at least 27 different types of health problems including arthritis, high blood pressure, pulmonary problems (asthma, emphysema, bronchitis), mental illness, being overweight, diabetes, elevated cholesterol, thyroid conditions, heartburn/acid reflux, menopause, podiatric problems (gout, bunions, spurs), sinus and allergy problems, bad knees, bronchitis, fibromyalgia, glaucoma, nerve damage, heart problems (arrhythmia, angina), and severe menstrual problems including fibroids. Of these problems, the most common is arthritis, something 12 women told me about. Ten women have pulmonary conditions, primarily asthma. Nine women have high blood pressure, the next most common condition. Six women considered
themselves (or were told by a doctor) overweight. It is interesting to note that only three
women considered menopause to be a health problem though many more than that
indicated that they thought they were going through menopause, as we will see in
subsequent chapters.

Six women had been diagnosed with a mental illness. Most of these six women
had been diagnosed as depressed, though two women produced laundry lists of diagnoses
that included bipolar, panic attacks, anxiety, Post-traumatic stress disorder (PTSD), and
eating disorders in one case and major depression, mood disorder, and personality
disorder.

Much less common health problems, but noted by at least one person, are
emphysema, hernia, HIV, incontinence, irritable bowel syndrome, temporomandibular
joint syndrome (TMJ), smoking, and aches and pains. Nine women live with a variety of
undiagnosed complaints, conditions like stomach pains, vertigo, dizziness, painful aching
in the legs and joints, headaches, and trouble breathing. Most of these are problems for
which the women have not sought medical care or which their providers have not been
able to diagnose, as in the case of the woman with severe headaches and the one with
painful, aching legs. Three women in the group have had cancer within the last five
years, including one with breast cancer resulting in a mastectomy, and two women who
had hysterectomies for uterine cancer.

I also asked women to indicate how regularly they received medical care in the
form of gynecological and physical examinations. This information could prove to be
relevant to a number of areas of the study including whether women consider menstrual
or menopause problems to need medical care, whether they depend on their health care
providers as information sources, and what part their providers play in providing
treatment options for menopause.

Fewer than half of the women (n=17, 42.5%) went to the doctor on a yearly basis
for a physical examination. On the other hand, 15% (n=6) of the women receive much
more regular care, with some having appointments as often as monthly. These women
generally get frequent care because they are being monitored for their chronic health
conditions. Specifically, several women have very regular visits for monitoring of
diabetes or asthma and management of their medications for the conditions. Other
women have to see their provider in order to refill prescriptions for their psychotropic
medications, or to have blood work and other examinations to look for a recurrence of
cancer. A small group of women (n=5, 12.5%) admit that they only go to the doctor
every few years because they get off the track of yearly exams. Three other women only
visit the doctor when they think they need to (7.5%) or on an emergency basis because
they do not have insurance to cover medical expenses (n=5, 12.5%).

Table 2.3: Health Practices—Regular Medical Care

<table>
<thead>
<tr>
<th>Frequency of Physical Exams</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly</td>
<td>17 (42.5%)</td>
</tr>
<tr>
<td>Frequent visits for monitoring chronic conditions*</td>
<td>6 (15.0%)</td>
</tr>
<tr>
<td>Infrequent, irregular schedule</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>No regular care, emergency care only</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>No response</td>
<td>4 (10.0%)</td>
</tr>
<tr>
<td>Only visit doctor as necessary</td>
<td>3 (7.5%)</td>
</tr>
</tbody>
</table>

* Chronic conditions include diabetes, asthma, mental illness, cancer monitoring

I asked women how often they received Pap tests as a way to gauge how regularly
women receive gynecological care. Responses appear in Table 2.4 below. Just over half
of the women get Pap tests every year (n=21, 52.5%). Fewer than a quarter of the women (n=8, 20%) get Pap tests on a more sporadic basis, generally every two or three years, but are not consistent about getting yearly care. Six women could not remember the last time they had a Pap test because they go to the doctor so infrequently, generally as a result of their inability to pay for medical care due to having no insurance. These women may not have insurance to cover regular preventive care, so they go when they have enough money to pay for an appointment. One woman had never had a Pap test to the best of her memory and another had only recently had her first Pap test and gynecological exam. Several women get Pap tests twice a year. For example, a woman who has a family history of cervical cancer gets Pap tests twice a year. Finally, a woman who had a hysterectomy indicated that she gets pelvic exams every year instead of Pap test.

The majority of the women in the study are of an age when they should have yearly mammograms. American Cancer Society guidelines call for women over 40 to get a mammogram yearly in addition to yearly clinical breast exam (2002). In fact, more than half of the women in the study (n=25, 62.5%) receive mammograms frequently. Most of them have yearly mammograms, but three of them are screened every 2 years and another woman has mammograms at least twice a year due to benign lumps in her breasts. The fifteen other women (37.5%) receive mammograms infrequently or never. Of them, several noted that the procedure was unpleasant because of the squeezing and pinching involved. Another woman insisted that breastfeeding her six children protected her from breast cancer. Another woman was avoided mammograms out of fear because her previous test detected several lumps. She had left the lumps untreated because she feared cancer due to her family history of breast cancer.
Table 2.4 Use of Women’s Health Screenings

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number (Percentage)</th>
<th>Frequency</th>
<th>Number (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly</td>
<td>21 (52.5%)</td>
<td>Yearly</td>
<td>20 (50.0%)</td>
</tr>
<tr>
<td>Never</td>
<td>8 (20.0%)</td>
<td>Never</td>
<td>8 (20.0%)</td>
</tr>
<tr>
<td>Rarely, infrequently</td>
<td>6 (15.0%)</td>
<td>Rarely, infrequently</td>
<td>7 (17.5%)</td>
</tr>
<tr>
<td>Twice a year</td>
<td>5 (12.5%)</td>
<td>Every 2 years</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Twice a year</td>
<td>2 (5.0%)</td>
</tr>
</tbody>
</table>

In all three angles of looking at women’s use of medical care—physical exams, Pap tests, and mammograms—it is clear that only half of them are receiving regular preventive care. This figure also concurs with the 23 women (57.5%) who have health insurance. The costs associated with exams and screenings often prohibit uninsured women from receiving adequate health care. Furthermore, the fact that approximately half of the women receive either physical exams or women’s health screenings makes it appear that only this portion of the women have a regular health care provider with whom they might discuss menopause and the changes that accompany it.

Many women in the current study personify the statistics Coulton et al. (2001) cite, particularly in terms of their lack of regular medical care and insurance. Half the women in the current study consider themselves to be in poor or fair health. Similarly, many of the women in the current study report having chronic health conditions. Thus, the fact that these women have low incomes and most have no more than a high school education and that they live in poor neighborhoods with many residents living below the poverty line sets them up for poorer health and less access to medical care, as demonstrated throughout the state of Ohio as well.

In the following chapter, I will examine what women know about menopause in terms of when and why it occurs and if there are specific signs indicative of menopause.
I will also consider the sources of information on which women rely to learn about menopause.
CHAPTER 3

MENOPAUSE KNOWLEDGE AND INFORMATION SOURCES

In order to more fully understand women's experiences of menopause, I sought to learn what they know about menopause and where they get this information. For example, do women know at what age to expect menopause, why it happens, and what are the common first signs they attribute to menopause? Further, how, when, and from whom do women learn about menopause? Women's knowledge about menopause, or lack thereof, may influence their experience and expectations of menopause.

I chose to incorporate Kleinman's conception of Explanatory Models (EMs) to facilitate learning what women know about menopause. EMs are "the notion about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (1980:105). Patients and providers all hold their own EMs about a given condition or sickness and the interaction of their EMs gives insight into how people understand a condition and treat it. Kleinman identifies five major questions about an illness episode which EMs can help to explain: the etiology, time/mode of symptom onset, pathophysiology, course, and treatment. While menopause in the current study is not conceived as a sickness or illness per se, use of Kleinman's concept of Explanatory Models enables me to learn about how women understand menopause from a number of viewpoints.

In order to learn what women know about menopause, particularly to understand whether women think of menopause as a medical problem, I devised questions about menopause based on Kleinman's five EM questions to direct the portion of the interview dealing with women's knowledge and understanding of menopause. For example, a
question about etiology is “What do you think makes your periods stop at menopause?” while one that examines the time and mode of onset is “How did you first know that you were at menopause? When was that?”

Age Menopause Occurs

To learn more about women’s knowledge about menopause, I asked them if they knew when menopause generally occurs, one part of Kleinman’s time or mode of onset regarding women’s EMs of menopause. The average age at menopause among women in industrialized countries is 51 (North American Menopause Society 2000a). Responses, shown in Figure 3.1, are grouped according to those women who did not know, those who thought menopause occurs in a woman’s early 40s, mid- to late-40s, 50s, and even wide age ranges during which menopause occurs.

For example, eight women (20%) either did not know or could not recall what age women generally go through menopause. Frances (46 years old, Euro) told me that the age varies among women, while Jeanne (47 years old, Euro) explained that she did not know the answer for anyone besides herself: “I could only say for myself. I don’t know about other women. Some women are a little bit touchy about things like that.” Delia
(53 years old, Hispanic) explained that there is a “formula” for figuring out when to expect menopause: “I’m not so sure, I just hear around, the more early they have the period, the more early they start with the menopause.” Lucy (42 years old, Hispanic) also thought that there was a lot of potential variability in when a woman will have her last period. In addition, she drew on the fact that there may be a hereditary aspect to when menopause happens:

“I think, I don’t know, maybe the age. I don’t know really. Sometimes the doctor says they come premature, sometimes they come a little late, so maybe in my personal they come premature. Some medication cause it, sometimes the doctor says that some people, when they have another problem, they take some kind of medication that makes the body work different. Sometimes when ladies had early period in the past, they come in premature. The other thing the doctor says is maybe you have it in the past—your mother, your grandmother—they have the same problem so you have the same thing.”

Seven women (17.5%) stated that menopause occurs among women of a wide range of ages. For example, menopause could happen as early as age 25, somewhere in the early 30s, or in specific age groups like women 45 to 60, 20 to 60, or 35 to 50. Some women’s responses were admittedly guesses and others were more informed, either based on a friend’s experience or discussion with a health care provider. Alma has heard several conflicting reports about when menopause happens: “I used to always think it was over 45. I used to always think you had to be in your 50s. I was always told old women had it, in the 60s!” At age 45 Alma is perimenopausal and somewhat surprised that this condition of “old women” has occurred at a seemingly early age. Yvette based her response, that menopause can occur as early as age 25, on the fact that she had a friend of that age who started menopause.
Yvette also links her friend’s early menopause to the fact that she started menstruating at an early age too, around 8 or 9 years old. Sandra’s (48 years old, Euro) response consisted of the largest age range for menopause, 20 to 60. She is well-versed in the stages of menopause, which helps frame her response:

“From what I understand you could start having menopause in your thirties. You can be premenopausal from your late 20s and you can have menopause into your early 60s. I know my sister is still experiencing hot flashes and she’s 68!”

Harriet (46 years old, Euro) has also heard of menopause starting as early as the 20s, but points out that women’s ages at menopause will vary based on several behavioral and genetic factors, according to her doctor:

“what my doctor told me it depends on the time of your period and if you started smokin’ at an early age, and then, you know, your grandmother and your mother...It’s like it varies from woman to woman....you’re gonna hear a lot from different women.”

The decade of a woman’s 40s was a popular response about when menopause happens. A small group of women (n=4, 10%) thought that menopause happened in a woman’s early 40s. More women (n=9, 22.5%) were familiar with menopause happening in a woman’s mid- to late-40s. Generally, ages 45 and 45 to 50 were common responses. While some women in the study repeated anecdotal evidence of menopause happening as early as the 20s, Rita (50 years old, Euro) was fairly sure that women go through it in their 40s: “I’d say in their 40s, in the middle 40s. I don’t think it comes any earlier than that, does it?” Agnes (44 years old, Euro) also thought that age 45 to 50 sounded about right for menopause, though she too had heard of a formula for predicting age at menopause:
"I always thought about 45 or the age of 50. That’s what I always thought. Like I said, what I was taught in school, that you start 30 years from the day one of your cycle."

In her case, the formula seems to be fairly close. She first started menstruating at age 12 and first noticed her period becoming irregular at 42. She is still menstruating occasionally and realizes that it may take up to ten years for her cycle to completely stop.

The largest proportion of the women in the study (n=12, 30%) thought that women experience menopause around age 50. Responses included early to mid-50s; 49, 50 or 51; and even 50 to 60 years old. For example, Linda’s answer (47 years old, Euro) typifies the responses of women who think that menopause happens around 50: “It’s always been my understanding, you know, early 50s. You know mid-50s.” Athena (45 years old, African American) always thought that menopause occurred when a woman was around fifty, but she has also heard that “you start around your mother’s age,” that is, the age when a woman’s mother had menopause. She thinks this rule held true with her and her mother, both of whom started experiencing changes around 39 or 40.

Lisa (52 years old, Euro) had always heard that menopause happens at age 50, so she became concerned when her periods became irregular in her 40s. Her worries were not allayed even after consulting her doctor, who told her she was too young to be going through menopause:

“I had talked to a girl that was a nurse one time and she said her mother was goin’ through it, but most of the stuff that you read they say most women’s periods supposed to stop by 50, what I’ve read. But, when I went to my doctor and I was havin’ problems at 46, 47, he kept tellin’ me, ‘You’re too young, you’re too young, you’re too young’ and there are some cases where people have gone into menopause at 38, 39, 40. I had a friend that was a teacher that she said started at 38 and it probably had to do with her hysterectomy.”
Lisa brings up an important issue that several women mentioned—that a hysterectomy can cause a woman to have menopause earlier than when natural menopause occurs. Indeed, after this surgery women no longer menstruate and generally experience symptoms similar to those at menopause—moodiness, hot flashes, trouble sleeping. Hysterectomies may account for some of the early ages women mentioned for the time when menopause occurs. Agnes, for example, referred to her sister and mother having menopause “early” due to their hysterectomies at ages 27 and 38 respectively.

Athena’s comments indicate, as do those of several other women, that many women equate the start of menstrual irregularities or hot flashes with the “start” of “menopause” while the standard biomedical definition pinpoints menopause as occurring only after 12 consecutive months without a period (NAMS 2000a). As Kaufert theorizes, the biomedical definition attempts to impose discrete beginning and end points onto a process of biological change which does not have such clear and consistent boundaries. Conversely, most women think of menopause as a process while the biomedical definition assumes menopause to be a discrete point in time (Kaufert 1988). Instead, “climacteric” is the recommended term to describe the process of moving from a reproductive to non-reproductive state based largely on hormonal changes (NAMS 2000a).

While the median age of menopause throughout the world is 51 years old, there is a wide range of ages at which menopause occurs when comparing women in various environments and levels of development (Thomas, Renaud, Benefice, De Meeüs & Guegan 2001). There remains little evidence of any change in the age at menopause throughout history (Diers 1974; McKinlay 1996).
Genetics, economic status, health and lifestyle, seasonality, altitude, and nutrition can influence the age of menopause (Thomas et al. 2001; Shinberg 1998). Menopause may occur early, generally before the mid-40s, among smokers, nulliparous women and those with a short cycle length. Early menopause, defined as menopause before age 40, occurs among only 3 to 10% of women (NAMS 2000a; Cramer, Harlow, Xu, Fraer & Barbieri 1995, Harlow and Signorello 2000). Despite women's folk models of when to expect menopause, there is little evidence for any relationship between age at menarche and age at menopause (Snieder, MacGregor & Spector 1998). There is no clear hereditary relation between a woman's own menopause age and that of her mother's except in the case of early menopause (Cramer et al. 1995).

Etiology of Menopause

The etiology, or cause, of menopause is another component of women's EMs of menopause according to Kleinman's concept (1980). Knowing what causes her periods to stop may impact a woman's experience and expectations of menopause, so I asked what makes a woman's periods stop at menopause. Responses clustered around four main themes—not knowing, related to changing hormones, a sign of the end of reproduction, and a part of aging. One woman did not answer the question.
Figure 3.2 Causes of Menopause

Just under half of the women (n=17, 43.6%) did not know why menopause occurs or had forgotten what their doctor or other source had explained. Some of them were taken aback by the question or were slightly embarrassed that they did not have an answer to the question. In general, not knowing why menopause occurs did not seem to bother them since menopause is just something that happens. Rhonda’s (54 years old, Euro) response is characteristic of many women in this category: “Oh gosh, the doctor told me once, but I don’t remember. I just know it does!” Barbara (45 years old, African American) told me that she didn’t really know and that a woman’s periods “just stops automatically.” Mary (43 years old, Euro) probably had never thought about what I was asking as she repeated: “I don’t have no idea why. Different women. I don’t have no reason why. I don’t know why.” To Lisa (52 years old, Euro), menopause was a sign of change, but still she had no other explanation for the end of a woman’s periods:

“I really don’t know, I know your body is going through a major change of some sort, but I really don’t know why it stops, the blood or whatever. That’s a kind of a hard question, even though I’ve read a lot of articles.”

One quarter of the women (n=10, 25.6%) associated the end of menstruation with hormonal changes. Their responses range from a vague idea of changing hormones to
more informed views of the changes going on in their bodies. Debby (54 years old, African American) had a basic sense of what causes menopause: “I guess it’s gotta do with the hormones changing. That’s the only explanation I can say.” Diana (43 years old, Hispanic) too was aware that changes in a specific hormone trigger the end of menstruation: “When the estrogen level goes lower, that’s when the woman starts having some hormone changes and periods eventually stop.” Anita (47 years old, African American) replied that menopause is related to decreasing estrogen levels and was chagrined that she could not provide a better explanation:

“Well, from what I’ve been told, it’s your estrogen level. Your body’s not producing as much estrogen. Ok, let me see. That’s awful. I don’t know that much about my own body!”

A smaller group of six women (15.4%) specifically associated menopause with the end of reproduction. To these women, menopause was a sign from their bodies telling them that were no longer able to reproduce. Delores (46 years old, African American), who had recently been to the gynecologist for the first time in her life, said that menopause happens when a woman’s eggs are gone—“depleted, no more reproduction.” Meanwhile, Alison (42 years old, Euro) explained that menopause happens because there are changes going on in a woman’s body related to the fact that reproduction is no longer possible or necessary. Whether triggered by age (45 or 50) or by some other force, the changes occur:

“You don’t need your reproductive system and your body kind of, you don’t need your periods and it stops. Your hormones change, your body changes.”

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Frances believes that a woman gets to a point in her life when her body is no longer able to reproduce. Menopause provides the woman the message that her days of reproduction are over:

"Menopause happens because your body is no longer health and strong. The important nutrients to sustain a pregnancy are no longer produced. ‘The temple is now smitten.’"

Frances made this statement in an ironic tone of voice reflecting on the two pregnancies she aborted when she was younger and in unstable relationships. At age 51, single and alone, she now feels guilty about having no children and regrets not being able to have children anymore.

Three women (7.7%) described menopause in terms of aging (person or body). Linda (47 years old, Euro) says that menopause is simply a sign of “old age”. Eileen (39 years old, Euro) thinks of menopause as marking someone as old, providing a transition to old age:

"from what I understand about this is it’s a part of a woman’s, that it happens to every woman, it’s something that steps down, makes sure you’re older or somethin’, you know. Certain parts of your body just stop. I don’t know how to explain it.”

Janet (51 years old, African American) believes the body has its own timetable guiding what happens when:

"It’s just the time of life, I think, that we should just take it easy, I guess. Your body been doin’ this for so long, I guess it has a timetable in itself. I can’t explain it.”

Both Janet’s and Eileen’s explanations hint of an unknown force guiding their bodies through life and to the end of menstruation.

One woman combined the themes of aging and the end of reproduction in her explanation of menopause. Kathy (51 years old, African American) remarked that...
menopause happens because: “I have no idea other than getting older. Coming out of your ability to have babies anymore, I guess.”

Women in the current study are not unique in their range of knowledge about menopause. More than half of the women knew that menopause generally occurs when women are around their late 40s to early 50s. Almost half of the women did not have a clear idea about why menopause happens. On the other hand, just one-fourth of the women knew that menopause was due to hormone changes or that it marked the end of their reproductive abilities.

Appling et al. (2000) found that most of the African American women in their study knew that menopause was related to decreases in female hormones. Koff, Rierdan & Stubbs (1990) showed that most of the college-aged women in their study were able to define menopause as the end of periods or reproduction. They were less likely, however, to know that menopause is also the result of hormone changes and can cause irregular periods. Like the women in the current study, those in Koff et al.’s research listed a broad range of ages (34 to 70) during which menopause could occur.

First Signs of Menopause

Most women have some conception of what menopause entails and they could identify what signs they first associated with menopause. Perhaps a hot flash, irregular periods, unusual and unexpected moodiness made them realize that something different was happening. What women identify as these initial signs of menopause provide into women’s EMs of menopause, particularly regarding the pathophysiology as well as mode of onset of menopause. Women usually noted one or two specific signs or changes that they thought indicated menopause. Eight women told me that they did not think they
were going through menopause yet, so they were not able to pinpoint a sign or symptom
that they associated with menopause.

**Hot Flashes & Sweats**

Women cited hot flashes most frequently as their first indication that they were
starting menopause. For Rachel (47 years old, African American), whose periods had
been erratic for the last 15 years, the hot flashes were a dramatic message:

"Really it was the hot flashes. That was the first sign was the hot flashes.
Wakin’ up in the middle of the night soakin’ wet with sweat. Cause see it
never, cause like I said I haven’t been havin’ going through for 3 months
and didn’t really want to face it. But, when I woke up in the middle of the
night at first I thought it was cause of the weather too. But I woke up in the
middle of the night and I was like soakin’ wet and I have nothin’ on but a t-
shirt. I realized, hey, somethin’ s not right here, OK? So that’s what really
came to my mind. And when I explained the symptoms to the uh doctor at
the VA hospital, that’s what she told me, she asks me she says, ‘well you
realize you are goin’ through menopause don’t you.’ And I says ‘well I
kind of figured,’ but I didn’t really want to face it that’s what it was, you
know.”

The message, that she was nearing menopause, was one that she was not ready to face
until her doctor confirmed her diagnosis. Peggy (55 years old, Native American),
likewise, found hot flashes to be a real wake up call, literally and figuratively:

“When I started gettin’ hot flashes, I think. I guess that’s what you call
‘em, at night when I go to sleep and I’ll wake up and I’ll be all wet but I’m
not like sweatin’. It wakes you up, you wanta run in and take a shower or
somethin’! (laughs) I still do that, not every night.”

While some women may experience multiple signs of the onset of menopause, Marion’s
(51 years old, Euro) sole cue was the constant hot flashes at night.

“Just the hot flashes, startin’ to have hot flashes and stuff cause I never went
through any mood changes or nothin’, just hot flashes. Just very
uncomfortable hot flashes and night sweats….The last maybe year they’ve
gotten worse. Sleeplessness is terrible, night sweats are terrible, and the hot
flashes are ridiculous! I get ‘em once or twice during the night, but mostly
it’s the night sweats at night.”
Not everyone reports such severe hot flashes as Marion does. In general, they affect women both at night and during the day and are usually distinctly different from symptoms at other points in a woman’s monthly cycle.

**Changes in Menstrual Cycle**

Irregular periods and changes in menstruation were the next most frequent sign that made women aware that they were starting menopause. For instance, they noticed that their periods became irregular, skipping some months, or having the number of days in each cycle fluctuate. For the first few months, some women thought the irregularity of their periods might signal that they were pregnant. Even though she had her tubes tied several years earlier, Carol (42 years old African American) wondered if she might be pregnant:

“It’s because of my menstruation [sic], about every two weeks. It wasn’t even the next month for my menstruation. I called my doctor quick in a hurry. ‘Why is that back on again, am I pregnant or something?’ You know, like that. She said, ‘No.’”

Linda’s (47 years old, Euro) changing menstrual pattern was very apparent because her cycles had always been regular and suddenly changed dramatically.

“I just think I’m starting it. You know, I don’t know. Um, like I said, my periods is what triggered what made me start asking my doctors, ‘Am I starting?’ because my periods were so so very regular and to start getting erratic like that I figured something must be up cause I’m not doing anything different. You know, and I’ve been off the Pill for, I stopped taking the Pill when I was like 35. So, you know, can’t be something that just happened last year or something.”

Linda describes a fairly common pattern of periods becoming irregular during the years leading up to menopause. Because she had previously had a very regular menstrual cycle, knowing almost to the minute when to expect her period, the change to a cycle that varies from 15 to 35 days was quite noticeable.
Rhonda’s (54 years old, Euro) experience with variation in her cycle is very similar to Linda’s. However, another clue for Rhonda was the occurrence of hot flashes. She was curious to know more about the changes she was going through and decided to talk to her doctor about it.

“You know what, I probably guessed on my own. I’d heard it and people talking about it. I knew my periods were like real heavy and real irregular and I started feeling really hot sometimes for no reason. So I tried to talk to the doctor and he just really gave me a hard time. They didn’t want to hear about it, you know. So, gosh, I was like about 4 years into menopause before they finally did some kind of test and he says, “Oh, by the way, you’re in menopause”. It’s like, doctors just don’t really talk to you anymore. They get you in their office, out of their office. That’s it. So it’s kind of, I guessed. I wasn’t sure that’s what was going on.”

Unfortunately for Rhonda, the person to whom she turned for information and reassurance did not provide her with either, and it took several more years until she finally learned that she had been going through the menopause transition. Women receive mixed messages when bodily signs and medical advice do not mesh. A similar disservice occurs in the case of women whose doctors tell them they are “too young” to be transitioning to menopause in their early 40s despite the existence of hot flashes, irregular periods, and other changes.

Emotional Changes

Women reported a number of changes in their emotions that they associated with the onset of menopause. Seven women spoke of mood swings—different from changes they associated with premenstrual syndrome—as an indicator of the changes of menopause. The moodiness entailed crying, suddenly being very tense, short tempered, or being unpleasant company for others. For example, Rita (50 years old, Euro) noticed that her mood could change from one hour to the next and she did not know why:
“Just, uh, by my mood swings. They would change, you know. I would be in a good mood at a certain time, and a couple hours later, boom, it was just like something hit me, you know. I'd just sit and cry for no reason, and I don’t even know what I was crying about. I couldn’t even tell you, you know, feeling sorry for myself. Crying just about my mother dying, about different things that has happened in life.”

Harriet (46 years old, Euro) went to the doctor because of a wide range of signs and feelings she was experiencing, including a feeling of hopelessness:

“I was going there cause I got the mood swings, the sweats, the depression, anxiety, you name it. And there's times too where I just sit and cry I get the blues so bad. One time I could be out havin' a good time, enjoyin' myself, and then I just get this feelin' to where I don’t want to be around anybody and I just want to be at home and left alone. You just go through these swings where you’re up and you’re down. Suicidal thoughts. I mean it’s bad sometimes where you get so darned deep you don’t care if you even get up out of bed in the mornings. It’s bad.”

Harriet's mood swings were admittedly exacerbated by a husband who was impatient with her moodiness and often did not believe that she felt bad emotionally and physically. She also contends that he was going through a midlife crisis that changed him some.

Women felt a different and new type of anxiety, depression, or moodiness from what they were used to as part of their typical menstrual cycles. Looking back, they believe some of these differences made them realize they were starting to go through changes associated with menopause. They told of being anxious about things more often or feeling sad or depressed, often around the time they expected their period to start for those women who were no longer menstruating.

Sleep Problems

A number of women indicated that their sleep patterns had started to change which, along with different menstrual patterns, pointed to menopause. As a result of poor nights of sleep, women also noted that they often felt tired or exhausted. For example,
Lisa (52 years old, Euro) has developed a pattern of a lack of sleep, often spending most of the night awake. When she does not sleep at night, she is very tired the next day:

“Well, for one, precisely is my sleep pattern. I'm having problems with insomnia, you know. During the day I'm really, really fatigued. If I'm out say from 10 in the morning, by 4:00 anywhere between 4 and 6 I'll be falling asleep in the chair. I'm tired. And then I'll have to lay down take a nap, a little power nap, to get refreshed for the rest of the evening. Some nights I go to bed and I'm so restless I can't get to sleep. I'll have to get up and start doing something. Varies anywhere from—sometimes I go to be 11, 11:30—and I'm up til 2, 2:30 in the morning. And I don't understand it. And the next day I'm still waking up early instead of being able to sleep, I'm wakin' up early again. I get wired and then there are these days where I'm really tired. As a matter of fact, this one day last week I just felt like my hormones or my blood was so low I just couldn't do anything to wake up. I was just dragging.”

Combining her lack of sleep with her mood swings, Lisa often lacks the energy and motivation to do her housework or go on errands. While she would like more information about menopause, her doctor will only allow her to ask one or two questions per visit because she previously asked "too many" questions.

Women interpreted a number of common emotional and physical indicators as signs that their bodies were changing and starting the menopause transition. In addition, one woman relied on her friend's "diagnosis" that her missed period and other changes were probably menopause.

The next section discusses the sources from which women learn about what menopause might be like and what kinds of symptoms or changes to expect. As a number of women pointed out, menopause will be different for each woman because all women's bodies are different.
Information about Menopause

Many women had not generally given thought to menopause during the earlier years of their lives and menopause educational materials typically target women in their 40s and 50s. Prior to or at the time of menarche, girls often rely on someone to tell them about menstruation, sex, and reproduction. The women in the study learned about menstruation from both members of their own generation—sisters, cousins, and friends—and adults like their mothers, grandmothers, teachers or nurses at school, and even a father.

I was curious to know if the women in the study had received any information about menopause prior to beginning the transition and from whom they had received it. Other research shows that intergenerational discussions of menopause and aspects of sexuality are often considered taboo (Dickson 1991; Mansfield and Boyer 1991; Mansfield and Voda 1993). A recent survey shows that mothers and their adult daughters are unlikely to discuss menopause with each other (PR Newswire 2000). When they do talk about menopause, they focus on symptoms such as hot flashes and moodiness.

Women in the current study had spoken to their mothers or sisters, doctors, heard other women talking, read about it, or talked to friends. Some women never really knew what to expect at menopause. Women spoke of their lack of sources to discuss menopause, in addition to having received incorrect or negatively stereotyped information from their sources which risks negatively influencing their experiences of menopause (cf. Buchanan, Villagran & Ragan 2001; Kalbfleisch, Bonnell & Harris 1996).
I asked women to tell me what sources they turned to if they had questions about menopause or their health. I specifically listed friends, female relatives (mother, aunt, sister), doctors, nurses, books, magazines, TV, and the Internet, to which women added pamphlets and newspapers. The top response categories appear in Figure 3.3. The most frequently cited source is reading materials—books or magazines; women sought them out specifically for menopause information or read them with some regularity. Health care providers, female relatives (mother, sister, aunt, grandmother, cousin), friends, and pamphlets follow. Below I discuss women's views of these resources and the information they sought and received from the resources.
**Figure 3.3 Women's Information Sources**

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<th>Type of Source</th>
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<td>Pamphlet</td>
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**Nobody to talk to about menopause**

Several women had not talked to anyone about what to expect at menopause in terms of signs that they were moving toward menopause, symptoms they might experience, or how long menopause lasts. They responded matter-of-factly that nobody had told them what menopause would be like. One woman said she figured that her periods would eventually stop someday. Gina (49 years old, Euro), however, was very abrupt in responding that she does not talk to anyone about any health issues: "No, I never really talked to anybody about it. I don’t go to the doctor. Last time I went to the doctor, gosh, 10 years ago."

**Talking to friends about menopause**

Inevitably menopause comes up in conversations between women and their female friends. Some women rely on their friends to help them figure out what is causing their hot flashes or irregular periods or even what other kinds of symptoms to expect at menopause. Often women talked to their friends and used them as sounding boards or
even diagnosticians. Of course, there is mixed opinion regarding the value of a friend’s opinion about health matters. For example, Marion (51 years old, Euro) finds friends to be an invaluable resource: “The best information is by mouth that you get from different women.”

On the other hand, some women feel that their doctor would be a more authoritative source than another woman. Janet (51 years old, African American) would not consult her friends about health issues because they simply do not have the right information and knowledge about a topic like menopause: “I feel that really they can’t tell me no more than I already know, which that’s like a handful.”

Nonetheless, a number of women in the study described their symptoms to friends who confirmed that they were starting menopause. Rhonda’s (54 years old, Euro) friends clarified the nature of the symptoms she started having: “when I started having hot flashes and stuff, you know, after I’d had them a while when I was explaining it to somebody and they said, ‘well, that sounds like menopause.’” In addition, she found that her friends were always straightforward about things rather than candy coating the situation. One friend told her “You’re going through menopause. I can tell, because you’re a bitch.”

Women often sought the opinions and experience of friends to determine if their own experiences were “normal.” For example, Diana (43 years old, Hispanic) would consult a friend rather than her doctor if the problem she was experiencing was not serious or causing her pain. For something ordinary, “I think I would discuss this with a friend of mine and see if they have experienced the same thing and then maybe from there go to my doctor.”
The pictures that mothers, sisters, and other women paint of menopause run the gamut from containing few specific details to mentioning a few key symptoms to ranting about how awful menopause is. Women’s information sources told them mainly about hot flashes and sweats and that their periods would stop at menopause. Moodiness and depression were also common topics. A few information sources also told about vaginal dryness, breast changes, dry skin, lack of sexual desire, the end of reproduction, weight gain, and trouble sleeping. Some women also learned that there might be a hereditary aspect to menopause such that a woman might go through menopause around the same age as her mother and grandmother.

**Information from mother**

Several women had talked to their mothers about menopause. Typically, such a woman was in touch or even living with her mother when the mother experienced menopause. Some discussions were direct, though oftentimes women inferred from conversations they overheard or behaviors they observed that their mothers were going through menopause. The women said that their mothers mainly talked about hot flashes or told their daughters that they had not experienced any symptoms. Sandra’s (48 years old, Euro) mother painted menopause in a very negative light, almost as if to scare her daughter or get her to join in the misery:

“They said all the bad things, you know, you can go crazy, you can have mental breakdowns, you’ll be so miserable, you’ll be cryin’, you’ll be giggling. They didn’t say anything technical about changes in the chemistry and all that. They said it’s a terrible time. And then they felt like they weren’t women afterwards. Oh, that was a good one!...And they always wished somebody else had it. That was always it. They always wanted you to join them or, like I said, become part of that club!”
By contrast, Janet’s (51 years old, African American) mother told her she would be glad when menopause happens, though she did not give any specific information about what to expect, “no details.” Likewise, Marissa’s (40 years old, Hispanic) mother told her it was nothing to be scared about and that she had not had any uncomfortable times with menopause. Annie (42 years old, African American) and Athena (45 years old, African American) learned that their “periods would stop” and that they would go through some changes. As for what to expect specifically, they learned about menopause by reading about it.

On the other hand, some women found that their mothers were not satisfactory sources of information about menopause. In these cases, a woman simply did not talk to her mother about a personal topic like menopause. One woman described her mother as “secretive” and another said that the women in her family were “old school” and it was not proper to discuss personal things like menopause. For example, Linda (47 years old, Euro) said that “my mother never spoke too much about that, that was always kind of hush-hush in our house.” As a result she did not have any preconceived idea about menopause. Judy (51 years old, Euro) gave a witty description of talking to her mother or older women about menopause, her periods, or even sex when she said,

> “Occasionally an aunt or...but it’s real hard that generation to pry anything out of ‘em. You know, if it’s not a recipe, they don’t want to talk about it.”

Marion’s (51 years old, Euro) experience with the women in her family was completely opposite. Her mother described the symptoms she had at menopause—hot flashes, irritability. Marion’s own experience was much like what her mother explained. Both women also felt that they could get through menopause without hormone replacement and its risk of breast cancer. Marion felt that her mother kept her well
informed because she was a straightforward person. In fact, all of the women in her family helped each other out—“if you’ve got a problem, you talk to me, if I can’t handle it, we’ve got somebody else that can.” Marion’s experience of maternal and family support stands out from the other women in the study.

**Talking with sisters**

Women who had sisters often talked about their menstrual cycles and sometimes shared stories about menopause. Some women found these discussions positive and helpful, while others did not appreciate their sisters’ comments. Ruth (51 years old, Euro) felt that her sister’s assessment of menopause was not constructive. Her sister complained about the discomfort of hot flashes and the unpleasant mood swings she had. She told Ruth that menopause would be just the same for her. Consequently, Ruth does not like to tell symptom stories to other women to avoid influencing the symptoms they have or to put menopause in a negative light.

Arlene (47 years old, Euro) was the youngest of seven sisters, so by the time she went through menopause, she had heard of lot of information and talk about menopause. The general consensus among the sisters was that a woman’s periods would stop and that she would probably have hot flashes:

“My sisters all told me, ’cause I got six sisters, and they all told me that you start havin’ hot flashes and they told me that the periods stop…One told me she drinks some kind of vinegar water and says it stops her hot flashes.”

Arlene felt that over the years she had heard a good deal of information so that she was not worried or bothered by her symptoms. She also planned to get the vinegar water “recipe” from her sister.
Two women’s impressions of the end of menstruation came from their sisters who had hysterectomies. Delia (53 years old, Hispanic) learned about the end of her periods from her mother and sisters. She knew that her sisters had been relatively young, in their mid to late 30s when their periods stopped, and that this was due to surgery. She too had a hysterectomy in her 30s, so she had an experience similar to her sisters’. In Barbara’s (45 years old, African American) case, however, she thought that all women had hysterectomies to make their periods stop. She never knew what to expect when her periods stopped on their own since she did not have a hysterectomy and her sisters did.

Information from health care providers

Health care providers are another information source, though not always the a woman’s first choice. The majority of women would consult a health care provider with menopause and other health questions. However, eight women specifically said they would not talk to the doctor or nurse about menopause or symptoms of menopause. There are no differences across menopause status groups in terms of certain women being more likely to consult a health care provider. Women value providers for their medical knowledge but often resent doctors who do not want to listen or who patronize them, and one woman stressed that it is important to find a good doctor who will listen. Sometimes women felt that nurses were more satisfactory to talk to than doctors, because nurses were more patient, explained things better, and let them ask a lot of questions. A number of women mentioned using “Nurse on Call,” a service provided by a local hospital in which people can call and speak to a nurse.

Menopause was a topic women were not shy or ashamed to talk about with their providers. However, many indicated they would prefer to speak to a woman doctor, on the assumption that she might be more understanding and knowledgeable about the
female body. Other women were less particular, like Marissa (40 years old, Hispanic) who told me, “I’m not ashamed to ask anybody anything!” Anita (47 years old, African American) feels that her doctor is a good source of information whether she is looking for pamphlets to read or a live person with whom to speak. She attends a local government hospital which has “a good women’s clinic and resources.” Because office visits can be short and questions may be many, Linda (47 years old, Euro) devised a way to make sure that she asked all her questions since she did not see the doctor often: “I just write everything down and I ask my doctor when I go to see her. I just make sure I have all my concerns or whatever written down…”

When I asked Eileen (39 years old, Euro) whom she asks health questions, she was almost incredulous that I asked about friends as well as doctors. She stated that she saw no reason to talk to an unknowledgeable friend when she could talk to someone who knows something about the situation:

“I would, you know, because he knows my body and how, you know. For me to turn around and ask a friend about it, I mean, that person don’t know how my body is and my doctor does, you know what I mean, the inside and everything, so.”

There are several reasons women would not consult a health care provider. Many of the women in the study who said this do not have medical insurance, a regular doctor, or simply cannot afford to pay for care. Alternatively, Delores (46 years old, African American) prefers to take a holistic approach to her health care, relying on a guru, a holistic doctor, and a chiropractor. If she had questions or was sick, she would take care of herself and then turn to one of her trusted providers:

“I usually don’t talk to doctors about my health. I usually find a book, read it, see what it says, and self diagnose. And then, when I’m too sick to self-diagnose, I go to the doctor.”
Self-educating about menopause

Women used several varieties of print media to learn more about menopause and health. Women indicated that the local libraries were a good source of information, somewhere they could find information about almost any topic. One woman, in fact, cited the library as her first source of information followed by her doctor. By contrast, Athena (45 years old, African American) uses the library to check up on the information her doctor gives her:

"I usually will ask the doctor and if I don’t get the right answer that I’m comfortable with, I may go to the library, which that’s somethin’ I did for the first time in my life, with the menopause... I never got that curious enough to go get a book and read up on it. And I can’t read that well, but I went and got that book. Cause I got tired of them tellin’ me wasn’t nothin’ wrong with me."

Athena was proud of her breakthrough because she had been bothered by hot flashes, irregular periods, feeling depressed, and crying. She did not know what was wrong and her imagination was working overtime. She felt relieved after reading about symptoms of menopause and decided that she was starting "premenopause."

The most popular reading materials are magazines. Fifteen (37.5%) women indicated that they had read a magazine lately and had seen articles about women’s health or menopause. The most common magazines mentioned are Readers’ Digest (both English- and Spanish-language editions), Prevention, Ebony, Essence, Family Journal, Woman’s Day, and an AARP newsletter.

Pamphlets from a health care provider are another common source of information. Eleven (27.5%) women mentioned receiving pamphlets, though they do not necessarily read them. Pamphlets are easy to acquire at most clinics and doctors offices and are free. They provide women like Ruth with important information about menopause—"facts and
figures, what to expect, what could happen.” The information in these pamphlets helped Ruth recognize that the reason she was having a lot of fluctuations in her menstrual cycle was related to menopause and not stress. Unfortunately, however, the majority of pamphlets women receive (whether produced by national organizations, pharmaceutical companies, or private doctors) tend to be written at a reading level too high for their target audience, making their value questionable (Thomas and Corwin 1998).

A few women have read books specifically about health. Two women interested in herbal and natural medicine have read books on these topics. Other health related books women have read covered women’s health topics, menopause, and life after 50. Carol’s (42 years old, African American) doctor recommended a book about menopause that she could get at the library in addition to the pamphlets she received from the clinic.

The Internet is the least utilized resource among the women in the study. Most of the women in the sample know very little about computers and the Internet and are unlikely to have home computers. Only two women expressed any interest in using it to learn more about menopause. Lisa has heard that there are chat rooms and information on all sorts of topics, but she has never seen or used the Internet. Carolyn relies on her friend to do computer research for her. However, she only uses the Internet as a supplement to care provided by her doctor because she knows the information available is not necessarily accurate and is not a substitute for her doctor’s expertise.

Few women mentioned watching programs about women’s health or menopause on TV. However, there are a number of channels whose programming has included such shows, including Public Broadcasting, The Learning Channel, Discovery, and occasionally even talk shows. In talking about information available on the TV, one
woman spontaneously mentioned seeing commercials for hormone replacement therapy starring actress Lauren Hutton and sponsored by pharmaceutical company and Premarin manufacturer, Wyeth-Ayerst.

Menopause support groups are a growing source of information about which several women inquired. These groups typically provide menopause and health related information in much the same way as other health or disease-oriented support groups. These groups give women the opportunity to talk about menopause and share information and their personal experiences. One woman said she had benefited greatly from the diabetes group which she attended and wondered if something similar existed for menopause. Another asked me to recommend such a group to her. Unfortunately, I was unable to locate any menopause support groups in the Greater Cleveland area despite the assistance of a directory of groups provided by the North American Menopause Society which is headquartered in Cleveland.

Preparation for Menopause

Did the women in the study find that the information they had heard or sought from various sources prepare them for menopause? After talking about the various sources women consulted, I asked them if they would have liked additional information about menopause before they began experiencing changes. Eight of the forty women (20%) said that they felt they knew enough about menopause. Several of them felt that neither more nor less information would make any difference in their experience of menopause. One woman was not particularly worried about menopause and the changes it would bring. Linda (47 years old, Euro) did not want to hear about menopause from other women because their interpretations might influence her own experience, possibly in a negative way:
"I think sometimes you read that stuff and you talk yourself into having that all. I have a girlfriend that does that...And she tries to get me to have everything she's got. And when she don’t feel good, she don’t want nobody else to feel good."

However, the majority of the women would have liked to know more about menopause before they started going through it. Above all, women wanted to know more about what signs or symptoms they might expect at menopause. Most women were aware that hot flashes commonly occur at menopause, and to a lesser degree many were familiar with mood changes. But beyond these signs, they usually wanted to know what physical and emotional changes might be from menopause or from some medical condition. They were also curious about how long the transition to menopause can take and when the symptoms would end:

"Exactly the changes so I would know like how I’m feeling. Exactly what it’s telling me what I’m going through" (Alma, 45 years old, African American)

"How far up in age can you get menopause, when does it really stop, what can I expect as I get older.” (Rita, 50 years old, Euro)

“All the symptoms that I supposed to be goin’ through so I’ll be aware of it. So I know what to do, so I won’t be thinkin’ nothin’s wrong with me.” (Athena, 45 years old, African American)

"{I want to know} the reason why your period really—I mean there’s a reason why your period stops—I can picture all the charts about why you have a period, and the egg dropping and all this, but now that your body’s not doin’ that, I’d like to really see what your body’s doing. It’s going through a change, but how is it really changing. (Alison, 42 years old, Euro)

Women also wanted information about how they might get relief from their symptoms.

"It would have been nice to know, well, no there’s nothing you can do for it, or, yes, there is something you can do for it” (Carolyn, 47 years old, Euro)
“My three main concerns would be how to deal with the sweating, and the nervousness, tension, and sleep habits” (Lisa, 52 years old, Euro)

A number of women also wanted to know more about the long term changes in their bodies that they might experience as part of the menopause process.

“What’s going to happen later on in life. What’s going to happen after menopause.” (Rachel, 47 years old, African American)

“What else is gonna happen along the way.” (Arlene, 47 years old, Euro)

“I’d have like to known that there were more physical symptoms than just hot flashes. You know, I would have liked to have known if there was a higher risk of cancer at that time, or urinary tract problems. I just would have in general like to have known more about it.” (Judy, 51 years old, Euro)

As in the group of women who felt adequately informed, a woman who wanted more information also spoke of avoiding creating a negative portrayal of menopause.

Getting as much information as one can helps prevent this:

“I’d always like to have information. The more you become informed, the more you take away the fears and stereotyping of it.” (Sandra, 48 years old, Euro)

It is likely that menopause does not become a concern or curiosity for women until they being to notice changes in their menstrual cycles, in their bodies, or in their psychological well-being. Menopause is not visible and publicized in the same way menarche and childbirth are among the reproductive milestones in a woman’s life (Buchanan et al. 2001; Kaufert 1988). As several women in the study indicated, there is often very little cross-generational discussion of menopause, so information and experiences are not likely to be passed from mother to daughter. Additionally, most women are not likely to seek information about menopause until they notice unusual signs or symptoms. As Marissa (40 years old, Hispanic), who is premenopausal,
explained, “Until it happens to you, then you really don’t go out there and say, ‘Well, I’ll go get this {information}’ unless you’re more prepared than that.” Furthermore, as Debby (54 years old, African American) pointed out, menopause is not necessarily a hot topic of conversation among women: “It’s not something you just sit around talkin’ about, you know.”

Finally, as the discussion of symptom occurrences among the women in the study will demonstrate (Chapter 4), menopause is most likely not a problematic life event for many women. When there is a lack of concern, there is little urgency to seek additional information. However, when the time is right, many women take matters into their own hands and seek out information by going to the library or asking friends and health care providers specific questions.

Informing other Women about Menopause

A final examination of women’s knowledge and information about menopause focuses on the information they would provide a younger woman who sought details about menopause. Women who have started the transition to menopause have the opportunity to tell premenopausal women information that might be useful and prepare them for menopause. Most of the women in the study thought that it would be good to explain to another woman about menopause. Specifically, they would draw on their own experiences to describe some of the changes that would occur.

Several women warned that because menopause is different for each woman, they could only relate what their personal experiences had been, though there may be certain signs or symptoms which many women share. For example, the women said they would explain that menopause brings hot flashes to many women; that after a time of erratic periods, they would end; and that many women had times of mood swings or depression.
Menopause is also about getting older, another part of the aging process. As such, it is just "another chapter in your life and not something to be feared" (Sandra, 48 years old, Euro).

A number of women looked beyond the day-to-day symptoms that are often a part of menopause to explain menopause in terms of a grander philosophical view of menopause as a time of life and time of change. Joan (43 years old, African American) would tell another woman, like her own daughter, that menopause is a "different" stage of life, a time when a woman becomes more mature and nurturing. She is a more confident person than she was when she was younger. Rachel (47 years old, African American) is not convinced that menopause is a good thing—"It’s a change of life that they say you’re supposed to look forward to. But, I’ll be honest with you,...I have to tell myself it’s not nothin’ bad.” She finds that menopause has slowed her down because of various changes she has experienced. Her periods have become very heavy, she suffers from sweating and hot flashes, and her mood swings often leave her crying for no reason.

To Carolyn (47 years old, Euro), the negatives of the symptoms she went through give rise to a positive outcome—no longer having to worry about getting pregnant. From her point of view, “Well, as you go, when you’re going through it, you’re miserable. But when you’re done, it’s wonderful! And if you’re sexually active, you don’t have to worry about the consequences!” As these women’s perspectives on menopause demonstrate, each woman has a different experience of menopause whether in terms of symptoms or in terms of how they situate the end of menstruation in their philosophy of menopause.
Beyond what women would share about their own experiences of menopause, they would also stress the importance of consulting a doctor and reading about menopause. Their doctors can provide medical services to detect, treat, and prevent health problems. Books and magazines can provide additional insight into menopause beyond anecdotal recollections and descriptions to give women a more complete idea of what is involved with menopause.

Summary

The examination of what women know about menopause contributes to an understanding of the Explanatory Models (Kleinman 1980) women hold about menopause. In this chapter I examined questions which speak to the etiology, time/mode of onset, and pathophysiology of menopause. Results from this study indicate that almost half of the women do not have a clear idea of why their periods stop at some point during mid-life. As a result they may unintentionally get pregnant or mistakenly think they are pregnant later in life, and they may not be adequately informed about health care needs as they age. One-fourth knew that menopause was related to changing hormones. The remaining women attributed menopause to the end of reproduction or to the broader topic of aging.

Women also presented a wide variety of ages when they thought menopause could happen, that is the time of onset. These diverse answers may reflect what they have observed among women they know, particularly in terms of "early" menopause that is a result of a hysterectomy. Alternatively, they may not have been around during their own mothers' menopause and thus lack a role model for menopause experience and expectations. Women's general nonchalance about the age menopause occurs may also reflect the fact that menopause is not a major concern for them either when compared
with other aspects of their lives (e.g., existing health problems, searching for employment, financial instability, getting back on one’s feet), as well as because menopause in the US is a private transition, one that passes with little fanfare.

The mode of onset and pathophysiology are somewhat related in the case of menopause because many of the signs that made women aware of the start of menopause continue through the transition and even beyond the final period. For these women, hot flashes and sweating, changes in their menstrual cycles, trouble sleeping, and emotional lability were signs that they were starting the menopause transition. More information about the pathophysiology of menopause appears in the discussion of the signs and symptoms of menopause in Chapter 4.

The pattern of sources referenced by the women in the current study is similar to findings from other studies, particularly because doctors are not a primary source (Clinkingbeard et al. 1999; Kaufert et al. 1998; Padonu et al. 1996; Pham et al. 1997; Seidl 1998a; Walsh et al. 1997). In this study, women most frequently mentioned reading materials as the source of information on which they rely for questions about their health in relation to menopause. Women read books and magazines on the advice of a doctor or out of their own curiosity and concern. In one example, Athena did some research on her own when she was dissatisfied with her doctor’s insistence that nothing was wrong despite her feeling alternately hot and cold, having cold feet, and crying a lot.

Health care providers are the second most common information source that women said they would consult to get information about menopause. Here gender issues clearly appear. Women could be frustrated by doctors who do not spend adequate time answering their questions or who brush off their concerns. Additionally, some women in
the study indicated that they preferred to consult a woman physician about menopause or gynecological questions. They felt a woman would be more understanding and sympathetic, could relate to them better because she has periods too, and they would be more comfortable discussing aspects of their reproductive systems with another woman. Some had also had what they considered negative or unsatisfactory interactions with a male doctor. Other researchers have also found that women consider female doctors to be more understanding (Chandler, Chandler & Dabbs 2000).

Other common information providers included relatives and friends. Female relatives were an important source for some women though they often found that their mothers were reticent about discussing menopause and topics of a sexual nature. Women were equally likely to talk to friends and co-workers or to read medical pamphlets if they had a question about menopause. Friends acted as both an information source and a sounding board for complaints or concerns. Use of pamphlets enabled women to take information home and read through at their own time and pace.

Finally, some women chose not to talk to anyone about menopause. For them the end of their periods is not a weighty issue. Rather, it is something they know will eventually happen and which they will accept when the time comes.

Numerous studies have investigated women’s sources of information regarding menopause. The research often examines where women learn about menopause in conjunction with making a decision about taking HRT or in terms of their knowledge about disease risks (primarily heart disease and osteoporosis). Much research shows that women turn to print materials or friends in search of information about menopause rather than health care providers. For example, Mansfield and Boyer (1991) found that women
more often turned to popular media and then to their doctors, with friends or family their third source. The women thought that their doctors were uninformed and unsympathetic. Similarly, Mansfield and Voda (1993) discovered that women were likely to talk to friends, read books or magazines, or talk to their mothers more than their doctors in order to learn about menopause.

In a study of women’s knowledge about menopause and patterns of HRT use, Clinkingbeard et al. (1999) found that three-fourths of women preferred to read magazines to get information. Even women in a national survey of beliefs about menopause overwhelmingly turn to reading materials in their search for information (Kaufert et al. 1998). After reading materials, their other sources included doctors, family or friends, and TV or radio. According to the survey report, the pattern among women to prefer print media to discussion with their doctors may reflect a trend that from 1993 until 1997 women more actively sought information about menopause (Kaufert et al. 1998).

There are several ways in which physician gender and gender differences have been examined that can speak to women’s complaints about communicating with their doctors. One way is through studies of satisfaction with one’s doctor. Schmittdiel, Grumbach, Selby & Quesenberry (2000) found in comparing the satisfaction of male and female patients of male and female doctors that women who had female doctors were the least satisfied with the care they get from their doctors. The issue of physician gender also arises when women must choose an obstetrician or gynecologist. When asked outright if they have a preference regarding their obstetrician or gynecologist gender, many women would prefer a woman doctor. However, when asked to compare other
characteristics of their doctor, gender took second place to the physician’s experience and reputation (Chandler et al. 2000; Zuckerman, Navizedeh, Feldman, McCalla & Minkoff 2002).

One reason for these differences in satisfaction and preference may be that male and female doctors have different communication styles. For example, female doctors may focus more on their patients’ emotional and psychosocial concerns and encourage patient participation in clinical interactions than male doctors (Hall and Roter 1998). Similarly, some women in the current study preferred to interact with nurses whom they felt it was easier to converse. Nurses also seem to show more concern with psychosocial issues when interacting with patients (Campbell, Mauksch, Neikirk & Hosokawa 1990). Attention to gender is also important in terms of information exchange and women’s satisfaction with the care they receive. Khoury and Weisman (2002) lay out several issues critical to improving communication and satisfaction while being sensitive to gender: communication of the provider’s knowledge of women’s health problems, the necessity of physicians to pay more attention to women’s concerns, making women partners in joint decisions about their care, and providing women with full information about their health and care needs.

Level of education is an important variable when looking at information seeking at menopause. Most of the participants in studies of women’s information sources have been European American, educated women (Clinkingbeard et al. 1999; Kaufert et al. 1998; Mansfield and Voda 1993). These women are assumed to be more likely and motivated to seek information for themselves. Ironically, despite the fact that such women tend to be well-educated and well-informed, they too remain in need of more and
better information, particularly when it comes to making a decision whether to take
hormones or not (Clinkingbeard et al. 1999).

By the same token, even the less educated women who are in the current study
also seemed interested in learning more and may be at an even greater educational
disadvantage than more educated women. One-third of the women in the current study
did not have high school degrees which makes it likely that finding materials of an
appropriate reading level will be very difficult, particularly if they rely on pamphlets
from their local clinic or doctor (c.f., Thomas and Corwin 1998). In addition, if these
women do not get regular medical care, or if they feel intimidated by or unsatisfied with
talking to a health care provider, they can easily find themselves with inadequate
information regarding menopause and their health. Turning to other information sources
besides their provider may be part of a larger pattern among women to look for
information on their own. On the other hand, it may be an artifact of the lack of regular
medical care the women in the current sample receive.

Levels of knowledge about health and menopause vary across ethnic groups and
education levels. According to Domm, Parker, Reed, German & Eisenberg (2000),
African American women with a high school education are less likely to have access to
information about menopause than white, college-educated women. Furthermore,
women prefer different types of resources by level of education. For example, women
with more education prefer to watch informational videos or read pamphlets, while less
educated women prefer to talk about menopause, whether with doctors or with other
women.
Agee (2000) found class and ethnic differences in how women acquire information about menopause. The study compared information transmission practices among working and middle class women of European- and African-American descent. She found that working class European-American women were the least likely among the four groups to share information about menopause from mother to daughter. African-American women received information from their mothers and grandmothers, as well as from a network of women beyond their biological mothers. In addition, African-American women, across economic lines, learned to cope with menopause by applying broader life lessons. On the other hand, few European-American women had received information about menopause from family members, as part of a pattern of minimal dialogue about the female body and its processes.

It is impossible to make a direct comparison of Agee's findings with the current study because of the small number of participants in my study. Equal numbers of African American and European women in the current study indicated they had or would talk to their mothers about menopause. However, at the same time, a number of women indicated that intergenerational dialogue rarely occurred between themselves and their mothers. These women stated that their mothers and women of that generation did not talk about women's reproduction and menopause because of the sensitive and personal nature of the topic.

Low-income African American women in a study by Padonu et al. (1996) sought information about menopause primarily from books and other women. Because of past unsatisfactory experiences discussing menopause with their doctors, some women thought that a support group composed of both younger and older women would be a
suitable alternative, a source of both information and support. They felt that other women would provide a more satisfactory understanding of changes at menopause than physicians who downplay their symptoms and concerns.

Thus the low-income women in the current study share with higher income women in other studies the preference for reading materials as their information source when they have questions about menopause. The reading materials on which they rely remain relatively inexpensive, particularly if they receive pamphlets at health fairs or at a medical clinic. Many of the women relied on local libraries to read books about health or various types of magazines. Despite the popularity and convenience of reading materials, health care providers nonetheless remain a fairly popular choice as a theoretical information source. Few women in the study had actually discussed menopause with a doctor, in part because they are not regular users of medical care due to financial constraints. Therefore, the one area in which these women's low income may be a factor in their use of information sources is the low level of dependence on health care providers. This is an important consideration because information from providers helps shape what women know about menopause, particularly in terms of the onset and physical signs accompanying it.
CHAPTER 4

SIGNS AND SYMPTOMS OF MENOPAUSE

Women's bodies are different from one another, so there will be many variations in the signs and symptoms that demarcate menopause. Beyond biological changes leading to the end of menstruation, a number of sociocultural factors shape women's experiences of menopause, including ethnicity, marital status, socioeconomic status, education, life changes, and social support (Lock 1986a). Furthermore, cultural stereotypes may influence the signs or symptoms women attribute to menopause as well as shape the specific character of the signs or symptoms (Kaufert and Syrotuik 1981).

There has long been a search for a universal set of signs or symptoms due to estrogen loss that women can expect at menopause, a so-called "menopause syndrome." Much research, particularly from a cross-cultural perspective, shows that there is such variability that a universal set of menopause symptoms is highly unlikely (Avis, Stellato, Crawford, Bromberger, Ganz, Cain, Kagawa-Singer 2001; Lock and Kaufert 2001). The search for a menopause syndrome is further complicated by the fact that the majority of menopause "symptoms" are subjective (Kaufert and Syrotuik 1981).

Research on Symptoms Associated with Menopause

According to Utian (1980), there are three main causes for the symptoms which occur at the time of the menopause transition. The first cause is decreased ovarian activity and hormone deficiency leading to hot flashes and sweating. A second cause includes "sociocultural factors" associated with the woman's environment and consists of societal beliefs and norms which may shape the experience of menopause for a woman. The third component Utian identifies is the psychological makeup of the woman, and
consists of psychologic or psychiatric symptoms such as irritability, insomnia, headache, depression, trouble concentrating, mood changes, anxiety and fatigue. The actual symptoms a woman experiences are thus a result of the interaction of the three components Utian identifies. Furthermore, women's symptoms may vary along socioeconomic, ethnic, education lines. Determining which of the causal areas is at work in a particular symptom can assist in choosing the appropriate treatment option for the symptom.

Longitudinal research indicates that there are different rates and types of symptoms across the menopause transition. The time of greatest hormonal and physiological change—just prior to the final menses—results in the highest frequency of estrogen-related symptoms like hot flashes, sweats, and vaginal dryness (McKinlay 1996). Later changes like dry skin and hair, incontinence, changes to breast tissue, and increased facial hair typically occur after estrogen levels have dropped (Utian 1980).

Below I will discuss a number of the most common signs and symptoms associated with menopause in terms of the physiological mechanisms, their relation to hormone changes at menopause, and estimates of their prevalence.

**Menstrual Cycle Changes**

One of the first indicators for many women that they are approaching menopause is a change in their menstrual cycles. Menstrual variability may begin several years before the final menses. Depletion of a woman's ovarian follicles is the primary mechanism for menopause. Cycle variability occurs when follicles are released less often during certain menstrual cycles. Absence of follicles during a cycle affects the hormone profile, disrupting the interaction of ovarian steroids, hypothalamus, and pituitary
hormones. The typical results are cycles with no bleeding or cycles of longer duration (O'Connor, Holman & Wood 2001).

**Hot Flashes**

Hot flashes are the one menopause symptom clearly related to changing hormone levels. Long assumed to be a universal feature of menopause, increasing cross-cultural evidence questions this assumption. Hot flashes occur to some degree in the majority of menopausal women, and are reported in some studies to occur in 82% of women with natural menopause (Freedman 2001) and between 10 - 20% of women seek medical attention for hot flashes (Staropoli, Flaws, Bush & Moulton 1998). By some estimates, a woman can experience hot flashes for up to 15 years (Ginsburg 1994). Hot flashes seem to be most prevalent during perimenopause, peaking around the final menses, and declining rapidly in the years following the final period (McKinlay 1996).

Physiologically, a hot flash consists of an intense sensation of heat in the upper body, arms, and face. Skin temperature and heart rate increase during a flash and there may be some flushing of the skin. A hot flash is usually followed by sweating and sometimes chilling. Ginsburg (1994) estimates that hot flashes average 4 minutes in duration and can occur up to 20 times a day. Ambient temperature may make hot flashes last longer but does not seem to affect their frequency (Voda 1982).

While hot flashes occur in women during times of declining estrogen, estrogen does not seem to be directly responsible for causing hot flashes (Freedman 2001). Levels of estrogen (measured in plasma, urine, vagina) do not show any change during hot flashes. Instead, pulses of lutenizing hormone (LH) may cause hot flashes to occur
Nonetheless, estrogen replacement helps eliminate hot flashes. In general, however, the physiology of hot flashes is not fully understood.

There is no clear link between hot flashes and several characteristics of women. Socioeconomic status, race, parity, age at menarche, number of pregnancies, and age at menopause are not associated with hot flashes (Freedman 2001), nor are Body Mass Index, or mental status (Staropoli et al. 1998). However, tobacco use and maternal history of hot flashes increase a woman's risk of having hot flashes (Staropoli et al. 1998).

Sleep Problems

Poor sleep is a common problem related to menopause. The most common sleep difficulties include trouble falling asleep, waking in the middle of the night, and waking early in the morning. Women in their 40s and 50s report poor sleep at rates greater than women of other ages or men (Hollander, Freeman, Sammel, Berlin, Grisso & Battistini 2001). Quality of sleep is known to vary throughout a woman's menstrual cycle and during pregnancy (Owens and Matthews 1998). Aside from making a woman tired, poor sleep can affect other aspects of her functioning, leading to fatigue, irritability, and problems concentrating. A recent longitudinal study of sleep in middle aged women (the majority still menstruating regularly) found that about 17% of women reported poor sleep (Hollander et al. 2001). Their sleep problems were associated with African-American ethnicity, increased hot flashes, high caffeine intake, elevated levels of stress, depression, and anxiety, less education and low rates of employment. Hot flashes were linked with episodes of poor sleep, even in women as young as their late 30s and prior to noticeable changes in menstrual patterns. Examination of hormone levels revealed that older women
(45-59 years old) who slept poorly had low levels of the hormone estradiol, leading to the conclusion that use of HRT might improve sleep. While HRT helps decrease the frequency and severity of hot flashes, estrogen may also reduce insomnia by increasing REM sleep (Ginsburg 1994). In fact, women who use HRT often have fewer sleep problems throughout menopause than non-users of HRT (Owens and Matthews 1998), though there is evidence that improved sleep among HRT users is due not to estrogen but to the type of progesterone included in the HRT. Montplaisir, Lorrain, Denesle & Petit (2001) found that micronized progesterone led to improved sleep but the progestin medroxyprogesterone acetate did not.

**Depression**

Despite the longstanding link between menopause and depression, there remains little evidence that women become depressed during menopause or that there is any relationship between depression and decreasing estrogen (Avis, Crawford, Stellato, and Longcope 2001; Ballinger 1990; Holte, Mikkelsen, Moen, Skjøråsen, Jervell, Stokke & Wergeland 1994; Holte 1998; Kaufert, Gilbert & Tate 1992; Lennon 1987; McKinlay, McKinlay & Brabmbilla 1987; Neugarten and Kraines 1965; Powell 1996). Longitudinal studies like Kaufert’s Manitoba Project have found that despite changing hormone levels during the transition from pre- to peri- to postmenopausal, there was no related shift in depression levels (Kaufert et al. 1992). Research from the Massachusetts Women’s Health Study replicated this finding (Avis and McKinlay 1991; Kaufert 1994). Similarly, in a three-year study, rates of depression remained stable while hot flashes and sleep problems fluctuated (Avis et al. 2001). However, while there is no clear link between
natural menopause status and depression, women with surgical menopause are at risk for becoming depressed (Kaufert et al. 1992; McKinlay et al. 1987).

There is little evidence that taking estrogen improves depressed mood (Hunter 1994). Some research argues that estrogen improves well-being and mood, but when controlling for vasomotor symptoms, the supposed benefit of HRT on depression disappears (Holte 1998). To determine whether estrogen was useful for treating depression, Anarte, Cuadros & Herrera (1998) compared two groups of women from a menopause clinic after six months of treatment. The first group received HRT and psychological treatment, while the second group received only HRT. Women receiving the combination of therapies had improvements in insomnia, nervousness, melancholy, fatigue, emotional changes, anxiety, and depression, in addition to improvement in vasomotor symptoms. The women who received only HRT experienced no changes in psychological symptoms but had improved vasomotor symptoms.

Research shows that increased incidence of depression among mid-life women is related to social context and health status rather than menopause (Holte et al. 1994; Hunter 1994; Kaufert et al. 1992; Kaufert 1994; Vanwesenbeeck, Vennix & van de Wiel 2001). Specifically, Kaufert et al. (1992) found that women who were depressed at two points of data collection in their research had poorer health, problems in their relationships with husbands and other family members, and were under social stress. Similarly in four Norwegian menopause studies (Holte et al. 1994), mood problems were more frequent among women with poor social networks and among those who had experienced negative life events (e.g., death of spouse or parent). Other research points
to higher rates of depression among women with less education and lower income (Ballinger 1990; Hunter 1994; Lennon 1987; McKinlay et al. 1987).

**Symptoms Cross-Culturally**

While the meaning and experience of individual symptoms varies from woman to woman as well as across cultures, so does the presence of specific symptoms. Cultural expectations and constructions of menopause influence and dictate the signs and symptoms which characterize menopause. Hot flashes are considered to be a very characteristic and expected sign of menopause and are included on menopause study symptom lists worldwide. Women from a number of cultural groups find that hot flashes are a typical, common, and expected indicator of the menopause transition. This includes women who are British (Liao and Hunter 1995), Turkish (Carda, Bilke, Öztürk, Oya, Ece & Hamiyet 1998), Japanese-American (Kagawa-Singer, Wu, Kawanishi, Greendale, Kim, Adler & Wongvipat 2002), Filipina-American (Berg and Lipson 1999), Mexican-American (Bell 1995), Czech and Swedish (Nedstrand, Pertl & Hammar 1996), Greek (Beyene 1989); Euro-American, Navajo, and Hispanic (Mingo, Herman & Jasperse 2000); African-American (Freeman, Grisso, Berlin, Sammel, Garcia-Espana & Hollander 2001; Padonu, Holmes-Rovner, Rothert, Schmitt, Kroll, Rovner, Talarczky, Breer, Ransom & Gladney 1996), Indonesian (Flint and Samil 1990), and United Arab Emirate (Rizk, Bener, Ezimokhai, Hassan & Micallef 1998).

Depending on how symptom frequencies are determined in a given study, menopausal hot flashes can be one of the key indicators of menopause or can be one of the less prevalent symptoms a woman has. For example, in a study of menopause in Thailand, half of the women experienced general symptoms of dizziness, fatigue or aches at menopause, but just over one-fourth had hot flashes, making hot flashes simply one
among a number of menopause indicators (Punyahotra, Dennerstein & Lehert 1997). Among Greek women, by comparison, the majority (73%) experienced hot flashes, and fewer women noted having cold sweats (30%) or headaches (42%) (Beyene 1989). Perhaps hot flashes are a common symptom among Greek women because they are taken as a sign of blood (which no longer gets released through menstruation) boiling within a woman’s body.

Yet some populations do not recognize or observe a sensation of increased heat across the upper body and face as having any relation to menopause. For example, Mayan women do not experience hot flashes or anything aside from irregular menstrual cycles as part of the menopause transition (Beyene 1989). Similarly, Indian women experience very few signs or symptoms at the end of menstruation. They have no hot flashes, depression, dizziness, or other changes typically associated with menopause in medical circles and elsewhere (Flint 1975). Likewise, Chinese women have much lower rates of hot flashes than Western women (Ho, Chan, Yip, Cheng, Yi, & Chan 1999).

While there are a number of expected changes that Japanese women expect that mark the end of menstruation, hot flashes are not really one of them (Lock 1993b). For Japanese women, konenki (end of menstruation) is denoted by shoulder stiffness and headaches, among 52% and 28% of women respectively. By comparison, there is no specific Japanese expression for what Westerners call “hot flashes” and few women associated any heat sensation with the end of their periods. However, since Lock’s research, there has been an introduction of two expressions in Japan which are equivalent to ‘hot flash’ (Zeserson 2001). Possible explanations for the lack or minimal levels of estrogen-related symptoms include climate, diet, and fertility pattern issues (Beyene
1989), as well as the likelihood and diffusion of differences in local biologies (Lock and Kaufert 2001).

Some researchers have found that symptoms differ when comparing groups of immigrant or non-European women depending on their degree of acculturation to US society (Kagawa-Singer et al. 2002; Mingo et al. 2000). Japanese-speaking Japanese-American women experienced more emotional changes around menopause than did English-speaking Japanese-American or Euro-American women. Euro-American women noted a greater number of physical changes (e.g., hot flashes, dry skin/hair, lack of energy, weakness). Meanwhile, Euro-American women had a more negative outlook toward menopause than did either group of Japanese-Americans (Kagawa-Singer et al. 2002).

Mingo et al. (2000) compared Navajo, Latina, and “white” women on the basis of their degree of acculturation into mainstream American culture(s). They characterized the levels of acculturation in terms of cultural and linguistic elements, labeling them “Traditional” if they still spoke their native language and held onto specific customs, lived in isolated, rural areas, and used traditional medicine; “Transitional” if they were bilingual with English, lived spatially closer to other families, and used a combination of traditional and Western medicine; and “Modern” if they were fluent English speakers, lived in suburban or urban settings, and relied primarily on Western medicine. Traditional Latina and Navajo women did not discuss hot flashes or many other symptoms at menopause.

When Latina and Navajo women fit the Transitional or Modern categories, they began to mention hot flashes, anxiety, and mood changes. By contrast, white women in
all three categories discussed hot flashes and other symptoms in association with menopause.

In addition to looking at symptom occurrences across cultural groups, researchers compare symptom levels among women on the basis of their menopause status (Hunter, Battersby & Whitehead 1986; Kaufert and Syrotuik 1981; Neugarten and Kraines 1965; Vanwesenbeeck et al. 2001). Different stages are associated with different signs in that postmenopausal women have more vasomotor symptoms and perimenopausal women may have more psychological symptoms. Vanwesenbeeck et al. (2001) found that as women progressed from pre- to peri- to post-menopause they had an increasing number of vasomotor symptoms—hot flashes, sweats—while perimenopausal women had more psychological and somatic symptoms. However, psychological symptoms were less related to menopausal status than to social support, self-esteem, employment, and life satisfaction.

In another example, Bell (1995) found that across all types of symptoms, postmenopausal Mexican-American women had the fewest symptoms while women who had hysterectomies had the greatest number of symptoms. Pre- and perimenopausal women fell in between. However, when examining one particular symptom, like the hot flash, premenopausal women had the lowest frequency of hot flashes followed by perimenopausal, postmenopausal, and then women with surgical menopause with the highest. Among Japanese- and Euro-American women, pre- and perimenopausal women had more emotional changes than postmenopausal women (Kagawa-Singer et al. 2002).

Freeman et al. (2001) found differences in clusters of symptoms across both age and ethnic groups. African-American women in their forties (as a surrogate for
perimenopause status) reported more symptoms than did those from 35 to 39 (for premenopause). White women who were between 35 and 39, on the other hand, had more symptoms than those in their 40s.

Lock found that menopause status did not influence the number of symptoms the Japanese women in her study identified. This is in contrast to studies in Manitoba and Massachusetts by her colleagues Kaufert and McKinlay in which perimenopausal women reported the greatest number of symptoms (Lock 1993b).

For many women hot flashes, night sweats, or vaginal dryness may be hallmark signs of menopause. However, they rarely figure among the most frequent symptoms the women experience on any given day, as demonstrated when women discuss the range of symptoms they have rather than when a study focuses only on menopause symptoms. Thus menopause and its signs or symptoms are rarely an all-encompassing concern for women. The African-American and white women studied by Freeman et al. (2001) most often reported feeling fatigued (among 83%) while only 30% of them had hot flashes. Likewise among American women in a study conducted via the Internet, 89% indicated that they were tired and 83% lacked energy, whereas 63% had hot flashes and 54% had night sweats (Conboy, Domar & O'Connell 2001).

Menopause Symptoms in the Current Study

In order to determine the symptoms the women in the study experience and which ones they attribute to menopause, I presented a list containing both general health symptoms and menopause-specific ones adapted from a symptom list used by Leidy (1997). I asked women to indicate which symptoms they had experienced in the previous two weeks. Limiting symptom occurrence to a two-week time frame avoids the inaccuracy of a long period of symptom recall (Kaufert, Gilbert, and Hassard 1988).
Including both symptoms related to general health and those typically related to menopause avoids creating a stereotype of menopause based only on a few symptoms and provides a glimpse into other aspects of a woman's current health.

After asking some basic demographic and reproductive history questions during the interviews, I read a list of 27 symptoms and asked the women to indicate, one by one, which they had experienced during the previous two weeks. They responded “yes” or “no,” often with some qualifications—“sometimes,” “all the time,” “right now,” etc. After reading through all of the symptoms, I followed up by asking what they thought caused the symptoms. In some cases, we also discussed further what the symptom was like, particularly in the cases of symptoms associated with menopause. Having women themselves indicate which signs or symptoms they attribute to menopause provides insight into their Explanatory Models (Kleinman 1980) of menopause.

Table 4.1: List of symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
<td>Cold sweats *</td>
</tr>
<tr>
<td>Lack of energy</td>
<td>Hot flashes *</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Bladder problems, infections</td>
</tr>
<tr>
<td>Persistent cough</td>
<td>Memory loss *</td>
</tr>
<tr>
<td>Blue or depressed *</td>
<td>Pins &amp; needles in hands/feet</td>
</tr>
<tr>
<td>Backaches</td>
<td>Dry skin</td>
</tr>
<tr>
<td>Upset stomach</td>
<td>Breast tenderness *</td>
</tr>
<tr>
<td>Headaches</td>
<td>Irregular periods *</td>
</tr>
<tr>
<td>Short of breath</td>
<td>Bloating/ water retention *</td>
</tr>
<tr>
<td>Aches/ stiff joints</td>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Nervous tension *</td>
</tr>
<tr>
<td>Trouble sleeping *</td>
<td>Rapid heartbeat</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Vaginal dryness *</td>
</tr>
<tr>
<td>Menstrual problems*</td>
<td>* denotes symptoms commonly associated with menopause in menopause research</td>
</tr>
</tbody>
</table>

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Women in the study had an average of 15 symptoms from the total list of symptoms, reporting a range between 4 and 24 of the 27 possible symptoms. Looking specifically at the 16 general health symptoms, women reported an average of 9.07 symptoms (responses ranging from 1 to 14 symptoms). Women had nearly 6 out of 11 menopause symptoms (reporting between 2 and 11 symptoms). Among all women, menopause symptoms account for fewer than half of all symptoms reported and the general symptoms make up 60% of reported symptoms. The proportion of general and menopause symptoms remains similar across all menopause status groupings as well.

Perimenopausal women reported the greatest number of symptoms among all the women in the study, in both the total number of symptoms and when counting the number of general health and menopause symptoms. They averaged 17 out of 27 total symptoms, including 6.79 menopause symptoms and 10.29 general symptoms. The women who had hysterectomies had the fewest symptoms in the sample. They averaged 12.83 of the 27 symptoms, including 5 menopause symptoms and 7.83 general symptoms. Pre- and postmenopausal women fell in the middle in terms of the number of symptoms they experienced. Premenopausal women reported an average of 13.86 of all symptoms, 5.71 of the menopause symptoms, and 8.14 of the general symptoms. Postmenopausal women had the next highest number of symptoms overall. They reported an average of 14.38 symptoms, among which 5.54 were menopause symptoms and 8.85 were general symptoms.

The fact that perimenopausal women reported the greatest number of symptoms could be due to the fact that they are currently going through significant hormone changes and may be more sensitive to noticing symptoms and aware of such changes in
their bodies. A greater level of physical wear and tear or an increase in chronic conditions with increasing age are unlikely to be an important factor in the fact that perimenopausal women report more symptoms. One might expect the older women to report more of the general symptoms. This does not seem to be the case because perimenopausal women—who reported the greatest number of general symptoms—are actually younger (average age, 46) than the postmenopausal (average age 49.5) or hysterectomy (average age 49.2) groups, both of which reported slightly fewer symptoms overall.

The most common symptom among all women in the study was “aches” or “stiff joints” (n=34, 85%). The least common symptom was bladder or other urinary infections (n=5, 12.5%). Almost 75% of women had experienced a lack of energy, backache, feeling depressed, a sensation of pins and needles in their extremities, shortness of breath, hot flashes, or trouble sleeping (within the last two weeks). Half of the women noted cold sweats, bloating, and diarrhea or constipation as symptoms they had experienced. One-third of women reported nervous tension, dizziness, headaches, dry skin, difficulty concentrating, and memory loss in the two-week period. Less common symptoms included an upset stomach, rapid heartbeat, persistent cough, appetite loss, breast tenderness, vaginal dryness, irregular periods, menstrual problems, and sore throat. Table 4.2 below lists the symptom reports of all women in the study in order of frequency.

Those symptoms from the list above which are typically caused by menopause include hot flashes, trouble sleeping, nervous tension, feeling blue or depressed, cold sweats, memory loss, bloating, breast tenderness, vaginal dryness, irregular periods, and
menstrual problems. The remaining symptoms are of a more general nature and not
typically considered to be related to menopause. Among all women, 77.5% (n=31) had
felt blue or depressed within the previous two weeks and three-fourths had hot flashes or
trouble sleeping (n=30). Just over half of the women had experienced sweating, though
some preferred to call them “hot” sweats rather than “cold” sweats (n=22, 55.0%), and a
similar number (n=21, 52.5%) had felt bloated. About two-thirds of the women noticed
at least one episode of memory loss during the two previous weeks. Approximately one-
third of women mentioned breast tenderness (n=15, 37.5%), vaginal dryness (n=15,
37.5%), irregular periods (n=11, 27.5%), or felt they had some type of menstrual
problems (n=11, 27.5%).

Descent Group Comparison

Examining the symptom frequency by descent group, the most common symptom
among European women remains aches and stiff joints (n=16, 84.2%). The next most
common symptoms, occurring among approximately 75% of the women, include a lack
of energy, backaches, dizziness, depression, shortness of breath, hot flashes, pins and
needles, and trouble sleeping. Among African-American women, hot flashes and lack of
energy join aches and stiff joints as the most frequent symptom (n=12, 85.7% for all three
symptoms). Three-fourths of the African-American women had experienced some
depression, backaches, shortness of breath, trouble sleeping, dry skin, and pins and
needles in their extremities. By contrast, Hispanic women most often reported a feeling
of pins and needles in their hands and feet (n=6, 100%). Other common symptoms
include depression, backaches, headaches, aches, trouble sleeping, trouble concentrating,
nervous tension, and dry skin. Data for the American Indian woman is not included in
this comparison since she is the only member of that ethnic category.
Menopause Status Comparison

Grouping all of the women by menopausal status alters the frequency of common symptoms. Among premenopausal women (n=7), that is women who were still menstruating regularly, aches and stiff joints remained the most commonly cited symptom (n=7, 100%), followed closely by backaches (n=6, 85.7%). Four premenopausal women mentioned having hot flashes, cold sweats, or trouble sleeping (57.1%) among the potential symptoms of menopause. 71.4% of them experienced bloating, breast tenderness, or nervous tension (n=5).

Perimenopausal women (n=14), who experience irregular periods but have not reached menopause, listed pins and needles in their extremities or shortness of breath as their most common symptoms (n=13, 92.9%), followed by headaches (n=12, 85.7%). Hot flashes occurred in 11 (78.6%) of the women, as did trouble sleeping and memory loss.

Among the 13 postmenopausal women, those women who have not menstruated in at least 12 months, the most frequently listed symptoms included hot flashes and aches and stiff joints (n=11, 84.6%). A lack of energy, feeling depressed, and having trouble sleeping also occurred frequently (n=10, 76.9%).

The remaining 6 women in the sample had undergone hysterectomies. All of them had felt a lack of energy and had felt blue or depressed in the last two weeks (n=6, 100%). In addition, 5 of them reported aches and stiff joints and trouble sleeping (83.3%). Other common symptoms in the previous two weeks, noted by 66.7% (n=4) of the women with hysterectomies, include dizziness, persistent cough, backaches, hot flashes, nervous tension, dry skin, and feelings of pins and needles in their hands or feet.
The rates of menopause symptoms in the current study is comparable to other research. For example, hot flashes, sweats, mood changes, and sleep problems are usually the most frequent menopause symptoms reported by women, across ethnic and socioeconomic groups (Freeman et al. 2001; Leidy 1997; Padonu et al. 1996; von Mühlen, Kritz-Silverstein & Barrett-Connor 1995). However, in a comparison of symptoms among women of different menopause statuses, Leidy (1997) found that white, educated perimenopausal and postmenopausal women are more likely to experience hot flashes and sweating than were premenopausal women. In the current study as well, more peri- and postmenopausal women reported hot flashes than did premenopausal women. Freeman et al. (2001) found that African American reported a greater number of symptoms than did the white women in their study. Specifically, African American women were more likely than white women to report having hot flashes, regardless of weight and use of hormones. African American women were also more likely than white women to exhibit signs of depression in a self-report of depression. In the current study, African American women reported more hot flashes than did the Euro or Hispanic women. Slightly more African American women (11 of 14 or 78.6%) than white women (14 of 19 or 73.7%) indicated they felt blue or depressed, and the majority of the Hispanic women (5 of 6 or 83.3%) noted that they sometimes felt depressed.

What do women think causes their symptoms?

To learn more about women's understandings of their health and the causes of health problems, I asked women what they thought caused the symptoms they had, direct evidence of their EMs of menopause. In examining women's responses, I observed a number of categories into which ideas of causation fall. They include: menopause, side effects from medications, current chronic health problems (diabetes, asthma, heart or
blood pressure, arthritis, general back problems), stress, mental health problems, old age, smoking habits, diet, weight problems, work or other injury, cold or flu, menstrual cycle-related problems, other lifestyle issues (work schedule, family problems), or a combination of several problems. In addition, some women specifically stated that their symptoms were not related to menopause though they could be related to something else specific. Other women stated that they did not know what caused some of their symptoms. Symptom occurrence and causation appear in Table 4.2 below. The “not related” category in the table includes any cause besides menopause to which women attributed their symptoms. Symptoms highlighted under the “What causes the symptom?” column are those which a majority of women thought were caused by menopause.

Table 4.2: Symptoms during previous two weeks and ideas of causation

<table>
<thead>
<tr>
<th>Symptom</th>
<th>N</th>
<th>85.0%</th>
<th>2 (5.9%)</th>
<th>20 (58.8%)</th>
<th>12 (35.3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aches/stiff joints</td>
<td>34</td>
<td>85.0%</td>
<td>2 (5.9%)</td>
<td>20 (58.8%)</td>
<td>12 (35.3%)</td>
</tr>
<tr>
<td>Lack of energy</td>
<td>32</td>
<td>80.0%</td>
<td>7 (21.9%)</td>
<td>18 (56.2%)</td>
<td>7 (21.9%)</td>
</tr>
<tr>
<td>Feeling blue</td>
<td>31</td>
<td>77.5%</td>
<td>7 (22.6%)</td>
<td>16 (51.6%)</td>
<td>8 (25.8%)</td>
</tr>
<tr>
<td>Backaches</td>
<td>31</td>
<td>77.5%</td>
<td>0 (0%)</td>
<td>25 (80.6%)</td>
<td>6 (19.4%)</td>
</tr>
<tr>
<td>Pins &amp; needles</td>
<td>31</td>
<td>77.5%</td>
<td>0 (0%)</td>
<td>16 (51.6%)</td>
<td>15 (48.3%)</td>
</tr>
<tr>
<td>Hot flashes</td>
<td>30</td>
<td>75.0%</td>
<td>23 (76.7%)</td>
<td>4 (13.3%)</td>
<td>3 (10.0%)</td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td>30</td>
<td>75.0%</td>
<td>9 (30.0%)</td>
<td>12 (40.0%)</td>
<td>9 (30.0%)</td>
</tr>
<tr>
<td>Short of breath</td>
<td>29</td>
<td>72.5%</td>
<td>2 (6.9%)</td>
<td>23 (79.3%)</td>
<td>4 (13.8%)</td>
</tr>
<tr>
<td>Nervous tension</td>
<td>27</td>
<td>67.5%</td>
<td>6 (22.2%)</td>
<td>13 (48.1%)</td>
<td>8 (29.6%)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>26</td>
<td>65.0%</td>
<td>4 (15.4%)</td>
<td>16 (61.5%)</td>
<td>6 (23.1%)</td>
</tr>
<tr>
<td>Headaches</td>
<td>26</td>
<td>65.0%</td>
<td>1 (3.8%)</td>
<td>13 (50.0%)</td>
<td>12 (46.2%)</td>
</tr>
<tr>
<td>Dry skin</td>
<td>26</td>
<td>65.0%</td>
<td>2 (7.7%)</td>
<td>15 (57.7%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>Memory loss</td>
<td>24</td>
<td>60.0%</td>
<td>5 (20.8%)</td>
<td>8 (33.3%)</td>
<td>11 (45.8%)</td>
</tr>
<tr>
<td>Prob. concentrating</td>
<td>23</td>
<td>57.5%</td>
<td>4 (17.4%)</td>
<td>9 (39.1%)</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>Cold sweats</td>
<td>22</td>
<td>55.0%</td>
<td>12 (54.5%)</td>
<td>4 (17.4%)</td>
<td>9 (40.9%)</td>
</tr>
<tr>
<td>Bloating</td>
<td>21</td>
<td>52.5%</td>
<td>2 (9.5%)</td>
<td>10 (47.6%)</td>
<td>9 (42.9%)</td>
</tr>
<tr>
<td>Diarrhea/constipation</td>
<td>20</td>
<td>50.0%</td>
<td>2 (10.0%)</td>
<td>13 (65.0%)</td>
<td>5 (25.0%)</td>
</tr>
<tr>
<td>Upset stomach</td>
<td>18</td>
<td>45.0%</td>
<td>1 (5.6%)</td>
<td>13 (72.2%)</td>
<td>4 (22.2%)</td>
</tr>
<tr>
<td>Rapid heartbeat</td>
<td>18</td>
<td>45.0%</td>
<td>0 (0%)</td>
<td>9 (50.0%)</td>
<td>9 (50.0%)</td>
</tr>
</tbody>
</table>

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Women associated only a few of their signs or symptoms with menopause. As we might expect, women most often thought that hot flashes, irregular periods, cold sweats, menstrual problems, and vaginal dryness were related to menopause. For example, of the 30 women who indicated that they had hot flashes during the previous two weeks, 23 (76.7%) thought they were caused by menopause. The other four women associated their hot flashes to part of their menstrual cycle (n=2), that hot flashes were something they had always noticed (n=1) or that they were not related to menopause but were not more specific (n=1). Three other women did not know why they had hot flashes. Similarly, 12 of 18 women with cold sweats (54.4%) linked the symptom to menopause; the remaining 6 women either did not know what caused their sweating or they attributed them to another medical condition.

Women with menstrual problems or irregular periods generally thought that the situation was related to menopause. “Menstrual problems,” a purposely vague category designed to encompass anything women considered different or unusual about their menstrual cycles, includes such changes as unusually heavy bleeding, periods coming when they were not expected, periods that do not come at all, or pain at ovulation. For

<table>
<thead>
<tr>
<th>Symptom</th>
<th>N</th>
<th>%</th>
<th>N (%)</th>
<th>N (%)</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent cough</td>
<td>16</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>12 (75.0%)</td>
<td>4 (25.0%)</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>16</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>9 (56.2%)</td>
<td>7 (43.8%)</td>
</tr>
<tr>
<td>Vaginal dryness</td>
<td>15</td>
<td>37.5%</td>
<td>6 (40.0%)</td>
<td>3 (20.0%)</td>
<td>6 (40.0%)</td>
</tr>
<tr>
<td>Breast tenderness*</td>
<td>15</td>
<td>42.9%</td>
<td>0 (0%)</td>
<td>10 (66.7%)</td>
<td>5 (33.3%)</td>
</tr>
<tr>
<td>Menstrual problems</td>
<td>11</td>
<td>27.5%</td>
<td>6 (45.5%)</td>
<td>1 (9.0%)</td>
<td>5 (45.5%)</td>
</tr>
<tr>
<td>Irregular periods**</td>
<td>11</td>
<td>29.7%</td>
<td>7 (63.6%)</td>
<td>1 (9.0%)</td>
<td>3 (27.3%)</td>
</tr>
<tr>
<td>Sore throat</td>
<td>9</td>
<td>23.1%</td>
<td>0 (0%)</td>
<td>9 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Urinary infection</td>
<td>5</td>
<td>12.5%</td>
<td>1 (20.0%)</td>
<td>4 (80.0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

* Missing data for 5 women  
** Missing data for 3 women  
~ Missing data for 1 woman
example, 7 of the 11 women who reported irregular periods (63.6%) attributed them to menopause. Among the other four women, one had always had irregular periods and three did not know why their periods were irregular. Women with menstrual problems equally attributed the problems to menopause (n=5, 45.5%) or they did not know the cause; the eleventh woman related her menstrual problems to the time of her menstrual cycle.

Fifteen women reported having vaginal dryness, another symptom commonly attributed to menopause and the changing levels of a woman’s hormones. Again, the women were evenly divided between linking it to menopause (n=6, 40%) and not knowing the cause (n=6, 40.0%). Two other women, while not directly stating that menopause was the cause of their symptoms, thought that “old age” was the reason they had vaginal dryness. The fifteenth woman who reported the symptom noted that vaginal dryness was something she had always had, rather than something she could say was caused by menopause.

Women in the current sample did not consider menopause to be the cause of several other signs which are commonly linked with menopause—fatigue, sleeplessness, depression, irritability, and dizziness (Lock 1985; Utian 1980)—despite the fact that a majority of the women reported them. For example 80.0% (n=32) of the women reported feeling a lack of energy, yet only 22% (n=7) thought the problem was caused by menopause. Instead, they blamed their fatigue on the stress in their lives, work schedules, and even weight problems.

Another symptom many women experienced (n=31, 77.5%), feeling blue or depressed, had many causes beyond menopause. While 7 of the women (22.6%) thought
that their depression stemmed from menopause, many of the other women (n=16, 51.6%) believed that depression was not related to menopause. Instead, several women thought it was caused by their mental illness—at least six women in the sample had been diagnosed with a mental illness, including depression, manic depression, and bipolar disorder. Women additionally attributed their blue or depressed feelings to stress or worrying, timing with their menstrual cycle, or family health problems.

Women who had difficulty sleeping (n=30, 75.0%) related their problem to a number of causes, including discomfort due to arthritis, a medical condition, or stress and worry. However, menopause was a frequent response among them, with 9 of the 30 (30.0%) stating that their sleep problems were due to menopause. Specifically, hot flashes or sweating episodes often woke them several times a night and prevented them from sleeping soundly.

While other research has shown that women believe that episodes of dizziness are related to going through menopause, the women in the current study overwhelmingly attributed dizziness to other causes (n=16, 61.5%). These women blamed medical conditions or medications for their episodes of dizziness. Several other women (n=6, 23.1%) did not know why they were dizzy, and even fewer (n=4, 15.4%) thought that their dizziness was caused by menopause. For example, one woman who believed dizziness was caused by menopause did so because she became dizzy during her hot flashes.

While more than a third of the women (n=27, 67.5%) reported a feeling of nervous tension, fewer than one-fourth of them attributed the symptom to menopause. Instead, many women (n=13, 48.1%) felt moody or irritable because of stress in their lives, because of a mental illness, or because it was “just something they always felt.”
Nonetheless, 6 women (22.2%) thought they had become more moody since they had been going through menopause or that they had a shorter temper or were just a “crabbier” person since their periods stopped.

Stereotypical Menopause Symptoms

A different picture of menopause and potential symptoms emerges from asking women to identify symptoms they think are related to menopause, based on their own experience, what others have told them, what they have read, or what they otherwise know about. Toward the end of the interview, I read women another list of symptoms, borrowed from Clinkingbeard et al. (1999). The list contains symptoms that women in a study about knowledge of menopause most often considered to be associated with menopause. Many of the symptoms in the list also appeared in the first symptom list I read to women, discussed previously.

Table 4.3 below summarizes women’s responses regarding what symptoms are associated with menopause in a general sense. As in the case of the symptoms they had actually experienced in the previous two weeks, women overwhelmingly associated two particular symptoms with menopause—hot flashes and night/cold sweats. Almost all of the women (n=39, 97.5%) thought that hot flashes were related to menopause. Even the fortieth person thought that at least some of the time hot flashes are related to menopause. Similarly, 92.5% of women thought that menopause caused night sweats (n=37); again, one woman thought this to be the case sometimes. Only 2 (5.0%) women thought that night sweats were unrelated.

We can also see that many women link to menopause another cluster of symptoms. Tiredness (n=34, 85.0%), depression (n=31, 77.5%), and vaginal dryness (n=29, 72.5%) round out the symptoms most commonly related to menopause. Over
two-thirds of the women also thought that headaches (n=25, 62.5%), weight gain (n=25, 62.5%), dizziness (n=24, 60.0%), and a low sex drive (n=24, 60.0%) could be caused by menopause.

Several symptoms which women reported with great frequency based on the previous two weeks of their lives, but did not associate with menopause, are again only weakly associated with their stereotype of menopause. For example, fewer than half the women thought that joint pain (n=19, 47.5%) was related to menopause. Likewise, only 45.0% of women (n=18) thought that backaches were related to menopause.

Table 4.3: Are these symptoms related to menopause?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Possibly (%)</th>
<th>Definitely (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot flashes</td>
<td>39 (97.5%)</td>
<td>0 (0.0%)</td>
<td>1 (2.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Night sweats</td>
<td>37 (92.5%)</td>
<td>2 (5.0%)</td>
<td>1 (2.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Tiredness</td>
<td>34 (85.0%)</td>
<td>5 (12.5%)</td>
<td>1 (2.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Depression</td>
<td>31 (77.5%)</td>
<td>6 (15.0%)</td>
<td>2 (5.0%)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Vaginal dryness</td>
<td>29 (72.5%)</td>
<td>8 (20.0%)</td>
<td>1 (2.5%)</td>
<td>2 (5.0%)</td>
</tr>
<tr>
<td>Headaches</td>
<td>25 (62.5%)</td>
<td>10 (25.0%)</td>
<td>2 (5.0%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Weight gain</td>
<td>25 (62.5%)</td>
<td>11 (27.5%)</td>
<td>2 (5.0%)</td>
<td>2 (5.0%)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>24 (60.0%)</td>
<td>12 (30.0%)</td>
<td>1 (2.5%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Low sex drive</td>
<td>24 (60.0%)</td>
<td>11 (27.5%)</td>
<td>2 (5.0%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>23 (57.5%)</td>
<td>11 (27.5%)</td>
<td>0 (0.0%)</td>
<td>6 (15.0%)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>23 (57.5%)</td>
<td>9 (22.5%)</td>
<td>2 (5.0%)</td>
<td>6 (15.0%)</td>
</tr>
<tr>
<td>Breast tenderness *</td>
<td>21 (58.3%)</td>
<td>11 (30.5%)</td>
<td>2 (5.6%)</td>
<td>2 (5.6%)</td>
</tr>
<tr>
<td>Memory loss</td>
<td>19 (47.5%)</td>
<td>16 (40.0%)</td>
<td>1 (2.5%)</td>
<td>4 (10.0%)</td>
</tr>
<tr>
<td>Tingling skin</td>
<td>19 (47.5%)</td>
<td>14 (35.0%)</td>
<td>4 (10.0%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Joint pain</td>
<td>19 (47.5%)</td>
<td>13 (32.5%)</td>
<td>3 (7.5%)</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>Backache</td>
<td>18 (45.0%)</td>
<td>14 (35.0%)</td>
<td>2 (5.0%)</td>
<td>6 (15.0%)</td>
</tr>
<tr>
<td>Dry skin</td>
<td>17 (42.5%)</td>
<td>14 (35.0%)</td>
<td>4 (10.0%)</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>Urinary problems</td>
<td>15 (37.5%)</td>
<td>15 (37.5%)</td>
<td>3 (7.5%)</td>
<td>7 (17.5%)</td>
</tr>
<tr>
<td>Weight loss</td>
<td>13 (32.5%)</td>
<td>24 (60.0%)</td>
<td>2 (5.0%)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Problems seeing</td>
<td>10 (25.0%)</td>
<td>22 (55.0%)</td>
<td>2 (5.0%)</td>
<td>6 (15.0%)</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>10 (25.0%)</td>
<td>26 (65.0%)</td>
<td>1 (2.5%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Tightness in chest</td>
<td>10 (25.0%)</td>
<td>22 (55.0%)</td>
<td>4 (10.0%)</td>
<td>4 (10.0%)</td>
</tr>
<tr>
<td>Heart disease</td>
<td>9 (22.5%)</td>
<td>22 (55.0%)</td>
<td>0 (0.0%)</td>
<td>9 (22.5%)</td>
</tr>
<tr>
<td>Strokes</td>
<td>9 (22.5%)</td>
<td>22 (55.0%)</td>
<td>2 (5.0%)</td>
<td>7 (17.5%)</td>
</tr>
</tbody>
</table>
A comparison of my results with Clinkingbeard et al.'s (1999) shows some similarities. However, the data from the current study are not completely comparable to those of Clinkingbeard et al. (1999) who wanted to know whether a woman has an increased risk of certain problems as a result of menopause. I asked the question in terms of determining what symptoms women typically thought were part of menopause, mainly to facilitate a comparison with which of their own symptoms they considered to be due to changes at menopause. Furthermore, Clinkingbeard’s sample was both older and younger (ranging from 21 to 77), almost exclusively white, and was highly educated, consisting of only 2% without a high school education.

Fifty to seventy percent of the women in Clinkingbeard’s study identified osteoporosis, hot flashes, night sweats, and vaginal dryness most often as problems associated with menopause. By comparison, women in the current study most often associated hot flashes, night sweats, tiredness, depression, and vaginal dryness with menopause. Over half of the women mentioned osteoporosis as a problem related to menopause. Other common problems mentioned by about 40% of Clinkingbeard’s sample, are heart disease, depression, low sex drive, and dry skin with menopause. The women in my study often noted depression and low sex drive as related to menopause. However, fewer than one-fourth of the women associated heart disease and menopause. Despite the fact that several women watch their cholesterol, have high blood pressure, or

<table>
<thead>
<tr>
<th></th>
<th>Notice</th>
<th>Recall</th>
<th>Follow-up</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrinkled skin</td>
<td>9 (22.5%)</td>
<td>28 (70.0%)</td>
<td>0 (0.0%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Blood clots</td>
<td>7 (17.5%)</td>
<td>20 (50.0%)</td>
<td>4 (10.0%)</td>
<td>9 (22.5%)</td>
</tr>
<tr>
<td>Trouble with hearing</td>
<td>4 (10.0%)</td>
<td>32 (80.0%)</td>
<td>3 (7.5%)</td>
<td>1 (2.5%)</td>
</tr>
</tbody>
</table>
* 4 missing cases
heart disease, the women in general are not aware that they have a greater risk of heart disease as they age and in association with hormonal changes at menopause.

Menopause Symptoms in Everyday Life

Many women told me that irregular periods, hot flashes, depression, and crying were the first indicators that they might be starting menopause. At this point, I would like to allow the women in the study to describe the symptoms they have and attribute to menopause. In addition to changes in their periods, hot flashes, depression, and episodes of crying, I will examine their descriptions of cold/hot sweats, sleep problems, and emotional issues including mood swings, nervousness, and short temper as they occur and affect their daily lives.

Identifying a Sign with Menopause

Other women—friends, co-workers, mothers, sisters—often helped women interpret their symptoms. When women talked to others about menstrual irregularities they were experiencing, these friends or family often reinforced the notion that the women might be going through menopause. Many women had also heard from others what to expect at menopause. For example, one woman’s friends had been straightforward in telling her about mood changes at menopause:

“Mostly people talk about the hot flashes, rest of the stuff... and being a bitch. The moodiness. That’s the word they use too, they don’t pull punches.” (Rhonda, 54 years old, Euro).

Another woman’s co-workers provided a long list of possible symptoms to anticipate:

“Yeah, at work, they much older than me, the rest are like 51, 52. They say about hot flashes, shortness of breath, and they gets tired. Lack of energy, not hungry. And they say, one day you will get your hot flashes and you ain’t gonna think it’s funny. Because I be laughin’ at them, now they’re laughin’ at me!” (Carol, 42 years old, African American)
While many of the women did not know what menopause was like from observing their own mothers—it was often taboo to talk about it—they frequently shared observations and information with their sisters: “My sisters all told me, cause I got six sisters, and they all told me that you start havin’ hot flashes and they told me that the periods stop” (Arlene, 47 years old, Euro).

Many women also relied on health care providers to confirm or refute the start of menopause. For example, Barbara (45 years’ old, African American) skipped a few periods and then talked to her doctor to find out what was happening. At times women’s bodies and doctors’ diagnoses send conflicting messages. Marisol (47 years old, Hispanic) thought that because she was having hot flashes and mood changes she was going through menopause. However, tests performed by her doctor do not support Marisol’s suspicions. One woman, Joan (43 years old, African American), got different responses to her menopause questions when she asked a male doctor and then a female doctor. After missing some periods, she asked her doctor to do an estrogen blood test and he would not. She asked again and he said that he did not think she needed it done. Subsequently she saw a female doctor who performed the test. Joan’s hormone levels indicated that she was in premenopause.

Ir regular Periods

One of the first indicators women noticed and attributed to menopause was irregular periods and unusual menstrual periods. Many women found that the timing of their periods became unpredictable. Several women noted that in the past they had had very regular menstrual cycles and always knew when to expect their periods:

“That’s what makes me think I’m starting menopause because my periods were so regular, I mean almost to the minute I could clock ‘em for many,
many years. And here the past couple few years, very erratic. It will go from 15 to 35 days. Real erratic. I get all the symptoms that I’m gonna start my period, you know, and then like last week, oh I was in so much pain, I had cramps and this and that. Nothing. I haven’t started yet. Now the cramping’s gone, you know, and all the symptoms that started, that’s all gone. It’s like I was ovulating, you know how you can almost feel that? And then it just went away and I haven’t started my period as of yet, so, I don’t know.” (Linda, 47 years old, Euro)

“Sometimes it comes at the beginning of the month, then it’ll come at the end of the month the next month. I don’t know why it does that. My doctor says that if it keeps coming like that, it’s got to be a couple times it comes like that, like 3 or 4 months like that, then he’ll put me on the birth control pills.” (Mary, 43 years old, Euro)

“They started comin’ on when they felt like it. It’s not on a cycle. It just comes on when it feels like it. One day I come on, whew, for one day and that’s it. Then some days I come on, and then I be just spottin’ and that’s it.” (Athena, 45 years old, African American)

Noticeable irregularities include no period at all, menstruating two times a month or several weeks in a row, having periods that are much heavier than they used to be, or even going for several months without a period and then having it return only to stop again.

“Last month I had it twice, we’ll see what happens this month!” (Athena, 45 years old, African American)

“Yes, unfortunately, I thought it had stopped a long time, every time I keep thinking it will stop. Still bleeding, I’ll be 50 in May. They’re very heavy, like you turn the faucet on full force. I just bleed and bleed. I have to change all the time. Cause I bleed all over my pants, all over the sheets. I sit down and it’s blood there. I have to scrub all the time, I’m always scrubbing….I don’t think I’m bleedin’ a full week like I used to, but it’s still heavy.” (Gina, 49 years old, Euro)

“I get it bad…there’s times too when I don’t even want to leave the house because I just {gestures that she gushes blood}. You think you’re gonna bleed to death.” (Harriet, 46 years old, Euro)
Heavy bleeding could be interpreted as a woman’s body “lettin’ {her} know it’s happenin’.” (Janet, 51 years old, African American)

While most women usually thought menopause was to blame for these changes, they also worried that they might be pregnant or that unusually heavy bleeding might be an indicator of “female cancer,” generally cervical or uterine cancer:

“But when I didn’t have it on time, I thought, well 2 months, I thought I might be pregnant so I went and took the pregnancy test. Well, I wasn’t and then the period come back again and then the next month it didn’t come, and then I haven’t had it since then, so.” (Arlene, 47 years old, Euro)

“My doctor, he would always ask me “Have you stopped yet?” and I’d spot sometimes and I thought that I had, but then, you know, you hear so many different diseases you can get, like cancer, if you’re spottin’ and stuff like that, like female cancer, so I would always get it checked out. But it was, I guess, just part of the process of going through the change. Because there was a year where I thought I had stopped and I’d go two or three months and boom I’d have another period, but now finally it hasn’t happened in two years.” (Rita, 50 years old Euro)

A number of women also knew that some of their menstrual problems were due to fibroids, sometimes leading to a hysterectomy. Lucy (42 years old, Hispanic) began having periods for 2 weeks or more each month. A biopsy revealed that she had fibroids and she began to take Depo-Provera (a contraceptive injection) to regulate the bleeding. Now her “periods” come at the same time each month though they still last two weeks long, leaving her dizzy, tired, angry, and suffering frequent headaches.

**Hot Flashes**

For many women, hot flashes are a “dead giveaway” that they’re starting menopause. Hot flashes can be very disconcerting for a number of reasons. They happen at any time of the day, usually without warning. They tend to last a very short time, 20 or
30 seconds, but they can make a woman miserable, hot, sweaty, uncomfortable, and even embarrassed when their faces turn red or sweat beads on their foreheads.

"Hot flashes were horrible. They come on at any time. Doesn’t matter. It would be like you’re standing and talking to somebody and they would actually think they embarrassed you cause your face is getting red and it’s like ‘hot flash!’" (Rhonda, 54 years old, Euro)

“They come and they go. They last maybe 20 seconds or so, and it’s about every two or three days I’ll get one of those. And they just, I don’t know, it’s kind of a warm glow and then a cold sweat comes over you. From my head all the way down to my toes it feels like.” (Rita, 50 years old, Euro)

“That’s embarrassing, especially in the dead winter and you’re sitting somewhere you just break out and you look down and your chest right here is all wet like in the summertime. Your arms and everything, your face is all flushed and red, sometimes you’ve got this sweat pourin’ down your head. My husband’s lookin’ at me like ‘What is wrong with you?’” (Harriet, 46 years old, Euro)

There is a lot of variation in the frequency of hot flashes. Some women may have them two to three times a day, others may only have 3 or 4 flashes a month or only around the time of their periods.

“They hit me when you don’t, I don’t know when mine’s comin’. They just hit me and I get real hot and I stay that way for maybe a minute or two, then they go away, then they’ll come again. I guess I have them hot flashes about 3 to 4 times a month. I guess during the time when my cycle comes around.” (Yvette, 52 years old, African American)

Some women provided very vivid descriptions of what a hot flash felt like as it was happening. For example, Barbara (45 years old, African American) says that a hot flash feels like being in a warm, stuffy room with the windows closed. When one starts, she has trouble breathing and feels sweat on her face. Ruth’s (51 years old, Euro) hot flashes give her a feeling of heat running all over her and leave her with a clammy feeling.
and a chill running up her back. The heat of a hot flash is usually concentrated in a particular part of the body and sometimes spreads and makes a woman uncomfortable.

“It seems like the heat comes from the inside out because I get hot on the inside to the point that I feel like I need to start taking off clothing.” (Cheryl, 47 years old, African American)

“I mean, all of a sudden you feel warm. All over. My whole, right now, this top part of this body right now, I could get the fan and just fan. OK? It’s like, it’s like a heat wave just done come over your body all of a sudden...And it don’t last that long. It really don’t. It lasts for a minute or two and then it’ll go away. Feels like I’ve got a fever or something, you know.” (Rachel, 47 years old, African American)

“(I get) dizzy almost, like a dizzy sweat, just moving around or just sitting around, comes and goes, never wakes me up, when I gets one ‘it’s like I’m shaky.’” (Eileen, 39 years old, Euro)

“They just come on. All of a sudden you feel it’s like heat radiating right in your face. Like a heater is right in your face. Sometimes it just spreads, spreads all over your body. My back gets so hot sometimes I don’t know what to do. If I’m in my room, I just strip down. Sweating. Sometimes you be sitting somewhere and right across your forehead you feel yourself breaking out in a sweat.” (Kathy, 51 years old, African American)

“It’s an internal hot, like your blood’s boiling almost. And they come on quick and they leave just as quick. You know, they last like 30 seconds maybe, somethin’ like that. But there is no cooling it down, to my knowledge. You know, I don’t know if they have medications for it, but, I’ve always been a non-medicating person.” (Judy, 51 years old, Euro)

Deciding what to wear can be difficult because a woman’s temperature can fluctuate many times during the day. Oftentimes, women found it helpful to wear several layers of clothing so that when a hot flash came along they could remove a layer or two of clothes, replacing them when their temperature went down and their bodies cooled off.

“Sometimes I’ll be sittin’ there reading a book or writing, doing some writing or something and I’ll just get excessively hot and then I take off if I’m wearing a couple of sweaters, I take them off ‘til I start feelin’ chillin’ and I’ll put my sweater back on.” (Lisa, 52 years old, Euro)
“I have an underblouse like this, an overblouse, and a sweater, I’ve got a great big cotton scarf.” (Kathy, 51 years old, African American)

Another way women try to stay comfortable in the face of a hot flash is to use fans, go into a cooler room, or open the windows—even in cold weather. Having the windows open can, unfortunately, irritate others living with them!

“You know, I had the doors all open, the fan on, and everybody complaining about they’re cold and I’m sweatin’!” (Debby, 54 years old, African American)

“When I came in it was like really cold, so I turned the heat on. Then it got too hot so then I opened the window. I always have my window open a little at night.” (Anita, 47 years old, African American)

“Then I can be in an air conditioned room and all of a sudden a sweat will break out on my face and I be the only fool in the room fannin’, you know, with the air conditioning on.” (Kathy, 51 years old, African American)

“I just get up and go into the “cold room.” I call it the cold room cause I keep the window open.” (Rachel, 47 years old, African American)

On the other hand, Judy finds that not even a fan or a cool room will make her more comfortable during a hot flash:

“It’s not like you could go stand in front of the fan and get cold. Cooled off. It’s an internal hot, like your blood’s boiling almost.” (51 years old, Euro)

As the examples indicate, the way hot flashes feel and when they occur differ from woman to woman. To some, a hot flash is simply a sign that menopause and the end of periods are near. For other women, hot flashes are disturbing and annoying. However, women may feel like there is little they can do but live with the symptom. Often a woman’s attitude toward the hot flashes and how she deals with them are closely linked. Despite hearing her sister and aunts talk about how horrible hot flashes are and having the women try to scare her with their stories of menopause, Sandra refuses to be
drawn in: "I don’t have a fear of it at all. It’s just a change in life. It’s a different part of your life" (48 years old, Euro). Many of the women, regardless of how much they were bothered by hot flashes, were equally philosophical about living with hot flashes:

“I like not havin’ the periods, but I don’t like the hot flashes.” (Arlene, 47 years old, Euro)

“You can make it miserable for you or you can make it a living hell for yourself… You gotta take it day by day. Just like the same way with these hot flashes, you gotta try to control ‘em.” (Agnes, 44 years old, Euro)

“I just dealt with ‘em. You know, I knew they’d be leaving soon, so I just basically dealt with ‘em. You know, like I would never go to a doctor and ask for a medication for it because it’s just not that big of a problem. Like I said, if it would go on for 20 minutes or you know somethin’ like that I might think ‘I better go to the doctor,’ but they don’t last that long.” (Judy, 51 years old, Euro)

“But I haven’t been to the doctor or nothin’ for ‘em because I knew that as a woman I was gonna go through this and it’s to me just a thing you have to go through with. So I haven’t been to the doctor about it. I know a lot of people go to the doctor, but I haven’t been to one yet.” (Yvette, 52 years old, African American)

**Hot or Cold Sweats**

Hot or cold sweats also aggravate women around menopause. Most often they notice the sweating at night because it disturbs their sleep. However, some women do sweat during their daytime hot flashes. Some women also attribute the sweating to diabetes, blood pressure problems, and exertion during bike riding. Like hot flashes, sweats can come at any time and without warning.

“Those just come from time to time. They’re not as often as the hot flashes… You know, like I’ll be sweatin’ and then all of a sudden I get this chill but I’m still sweatin’.” (Debby, 54 years old, African American)

“It’ll be like after I have a hot flash maybe. Then all of a sudden I’ll get real cold.” (Anita, 47 years old, African American)
“Yeah, ‘bout 42, 43, somewhere around that time that’s when I started gettin’ real cold, but that went on for about two years. Then I started gettin’ hot now, but not that wringing hot, but a warm sensation. You know, I still get chills, but it be mostly warm and I sweats, not that wringin’ one.” (Athena, 45 years old, African American)

Sleep Problems

At night, women’s sleep cycles may be thrown “out of whack” by hot or cold sweats. While many said their sleep problems were related to menopause, others found that their work schedules, mental health, or aches and pains kept them from getting sufficient sleep. Hot flashes and sweats cause an uncomfortable night’s sleep for many women. They noted the unpredictable nature of when they would wake up during the night, and stated that these disturbances were multiple events most nights. Women told about waking up sweating, needing to take a shower to cool off and clean off, and often changing their night clothes during these episodes.

“Those few nights it was cool, when it went down into the 30s. I sleep with this one window open cause I like fresh air. I was still soaked! I was miserable. I was hot.” (Agnes, 44 years old, Euro)

“Sometimes I wake up in the middle of the night and I’m sweatin’ all over the place and that gives me a little problem from time to time.” (Debby, 54 years old, African American)

“I wake up with wet all around. My clothes, my bedclothes is soaked. I’m soaked.” (Kathy, 51 years old, African American)

“...the problem with the hot flashes and cold sweats, especially during sleeping hours—it happens during the day too but at night it’s worse cause it hinders you from gettin’ a good night sleep.” (Lisa, 52 years old, Euro)

“It’s why I’m havin’ a lot of problems sleeping lately because a couple of nights a week at least, I cannot sleep because I’ll go from hot to cold to hot. Can’t sleep.” (Anita, 47 years old, African American)

“Oh, you get real sweaty, sometimes you have to get up and actually change your sheets because you’re soakin’ wet. So, you get up, change your bed,
put clean pajamas on and you’re all wet again. It’s ridiculous sometimes. It gets very uncomfortable. I sleep even during the winter with the fan blowin’ me. Cause I can’t, well I don’t, sleep at night hardly at all and when I do sleep I sweat so much I wake myself up.” (Marion, 51 years old, Euro)

“Sometimes I’m lucky if I get 3 to 4 hours a night sometimes. Sometimes 2. I’m up and down and it’s not like a real peaceful sleep either. Another they say it’s somethin’ women go through. I’m not really sure, like I say, I’m not a doctor. That’s what a lotta people say, what I’ve heard, you lose sleep, so I don’t know.” (Harriet, 46 years old, Euro)

Some common solutions to the sleep problems are the same ones women use to get through hot flashes—use a fan, open the windows, or use several layers of bedcovers. A number of women also said that they try to wear very light weight clothes to sleep in. Heavy t-shirts or ones with designs appliqued on the front can be hot and stuffy.

“I sit up on the side of the bed and I look around ’til it comes down. And I sit here and fan, and then I lay back down.” (Janet, 51 years old, African American)

“When the weather gets cold I usually don’t turn the heat on at all, only to take the chill off. I sleep with just a sheet because if I put a comforter on, I waken up during the night cause I’m sweating and have to take it off. And sleep in very light clothing. I mean the whole nine yards. It’s horrible!” (Cheryl, 47 years old, African American)

“Yeah, I don’t have a lot of blankets on my bed. The bed sheets are fine, you know, cause you could do the layers thing if you’re really hot, just sleep with the sheet. I would do that {sleep with the window open}, but my husband don’t want me to. I would love to crack the window about a half an inch, a little bit of air circulating, but he don’t want to.” (Lisa, 52 years old, Euro)

“I always have my window open a little at night. And I layer my bed because I’ll be cold and I’ll be hot and I’ll end up throwing all that off.” (Anita, 47 years old, African American)
Lack of Energy

Feeling tired or lacking energy are often a direct result of women’s disturbed sleep patterns. Eighty percent (n=32) of the women in the study often lacked energy or were tired regularly. Most of them attributed their fatigue to work schedule or being overworked or to health problems like diabetes or being overweight rather than directly to menopause. However, a number of women thought that menopause and hormone changes caused their lack of energy. Several women listed a lack of energy along with hot flashes and mood swings as common symptoms at menopause, as illustrated by Lisa’s comment:

“I kinda had this thing in my head that I thought, well, when you go into menopause, it’s gonna change you physically by you bein’ tired all the time, that you would have to maybe take more vitamins or go to the doctor for something just to keep you goin’ cause it was takin’ somethin’ away from you or something.” (52 years old, Euro)

Others specifically associated their lack of energy to the fact that they did not sleep well because of their hot flashes. Waking up multiple times with hot flashes or sweats results in restless and sleepless nights, leaving women without energy for their daily activities. Agnes (44 years old, Euro) feels sleepy during the day and says that her hot flashes prevent her from sleeping well at night, something particularly distressing since she used to be a heavy sleeper. A lack of energy makes it difficult for women to follow through on work and affects their ability to concentrate.

Emotional Issues

Many women reported a variety of emotional disturbances which had either increased since their periods stopped or had occurred more often in recent weeks and months. Emotional volatility is also affected by other elements in their lives, including
mental illness, stress of looking for a job, family relations, and family illness. One woman likened her fluctuating emotions to the time when she was pregnant. Now, as then, her “moods were totally out of whack...it was just confusion. But it was the same symptoms emotionally and psychologically as when I was pregnant.” (Judy, 51 years old, Euro) For some women, emotional changes were not an unexpected aspect of menopause. Women learned from others—family, friends—common symptoms of menopause, and they also started to recognize relationships between their own moods and changing menstrual cycles.

“Like I was telling my boyfriend, I’ve never had the really symptoms yet, just the hot flashes and sometimes the depression. I guess the depression would be one of the symptoms of it.” (Betsy, 52 years old, Euro)

“[I feel depressed] all the time, more or less when I started going through the menopause the depression started kickin’ in more. Can happen out of the blue.” (Harriet, 46 years old, Euro)

“Weird mood swings and I don’t want to be on nerve pills. I used to be on nerve pills, you know I’m not takin’ anything for that now. It’s just, I think it has a lot to do with menopause. It’s like sometimes little things set me off. It didn’t used to be that way. I mean, it just like, sometimes I just get so frustrated. I am so like overwhelmed with things, and then I cry. Sometimes it’s good too because it releases something to calm you naturally. And then you get back on track again.” (Lisa, 52 years old, Euro)

Women felt that they went through a number of moods—happy, angry, sad—often in a short period of time. They got angry, upset, wanted to cry for no reason, and needed to retreat from other people. In addition to mood swings, depression and periods of crying are the most prevalent expressions of emotional upset that women describe:

“During that time, first of all, it’s like, maybe one time you wanna cry, next time you mad at the whole world. And you can become very angry in that short period of time or very depressed in a short period of time.” (Agnes, 44 years old, Euro)
"I can go from one swing, mood swing, I swear. I can be sittin' here watchin' TV and be watching just a comedy and all of a sudden I just start cryin'. Any teeny weeny sad thing come on, I'll start cryin'...cryin' like a baby. I'm serious. It's unreal. It's just amazin'. That's one thing that really gets me sometimes when I do that. And I tell myself, "Stop this! What's wrong with you?" But it is a mood swing. It is definitely it's a mood swing." (Rachel, 47 years old, African American)

"Just by my mood swings, they would change, you know. I would be in a good mood at a certain time, and a couple hours later, boom, it was just like something hit me, you know. I'd just sit and cry for no reason, and I don't even know what I was crying about. I couldn't even tell you, you know, feeling sorry for myself. Crying just about my other dying, about different things that has happened in life." (Rita, 50 years old, Euro)

"I got the mood swings, the sweats, the depression, anxiety, you name it. And there's times to where I just sit and cry I get the blues so bad. One time I could be out havin' a good time, enjoyin' myself, and then I just get this feelin' to where I don't want to be around anybody and I just want to be at home and left alone. I mean it's bad sometimes where you get so darned deep you don't care if you even get up out of bed in the mornings." (Harriet, 46 years old, Euro)

However, not all women felt at the mercy of their emotions or wanted to let their mood swings get the best of them. Debby told me that "I don't have time to feel depressed, too much life around me." (54 years old, African American) Another woman said that as long as she keeps occupied with activities or projects she feels pretty good:

"I was just thinkin' today how blessed I was because I have so much to do now. That's the thing the doctor said, if you get depressed, find a hobby, find something to do to take your mind off of it...It's not as bad, the depression is far and few between...It seems like sometimes menopause can be a good thing!" (Lisa, 52 years old, Euro)

Agnes, the same woman who believes a woman must try to control hot flashes, said the bigger battle is for a woman to take control of how she feels, to get the upper hand on her emotional states:

"But it's tryin' to control your emotions. That's where you've got to fight. Cause it does take a hold of your emotions, anger or depression, or crying
jags. It does take hold. It’s up to the individual now to try to cope. Don’t let it take ‘em all the way in. I mean, you’ve got a long time to put up with it yet.” (44 years old, Euro)

Emotional outbreaks can be triggered by a hot flash or have no known source at all. Those around a woman may become targets of the woman’s unpredictable emotions.

“It’s (hot flash) the most aggravatin’ thing. I’m just irritable all the time anyway. I get angry with myself mostly. I could drop somethin’ and get angry or I could see somethin’ on TV that makes me angry.” (Kathy, 51 years old, African American)

“You can really get ticked off real fast. For no reason. Short fuse.” (Rhonda, 54 years old, Euro)

Sons, daughters, husbands, or even coworkers need to watch out or heed a woman’s warning. Women felt that they had developed short tempers and were not always able to keep from lashing out at whoever happened to be near.

“I don’t know if other women have experienced that with menopause, to me it was just the emotional part was real hard to deal with cause you never knew where it was comin’ from. You know, like, you didn’t have a chance to say “Gee before I say this, I better think about where this is comin’ from.” You just blurt stuff out. You know, it’s almost like hot flashes come on like that {snaps fingers}, shit comes out your mouth that you don’t even, you wouldn’t normally say it. And even though you apologize after you said it, you still have hurt somebody’s feelings.” (Judy, 51 years old, Euro)

“But yesterday during the early part of the day, one of the few of my coworkers came up to me and asked me if I was feeling OK. I said “No, I’m having hot flashes and I don’t feel right. And I don’t feel like I need to be around y’all because I’m not...” well I actually told them that I feel like I’m operating at a deficit...Please don’t bother me. Please, under any circumstances cause I’m not responsible for what’s going to come out of my mouth.” (Cheryl, 47 years old, African American)

“When I’m feeling miserable and it’s hittin’ that once. There’s one group of people I got in with down there {at a job site where she worked}, I always try to get in that group and when I’m goin’ through the flash, I holler “I’m havin’ one!” And they all know, leave me alone. And then
when it’s all over, I say, “Y’all come back now! I’m not gonna cry and goin’ to crank at you.” If you’ve got a male boss there, you’re not gonna holler. The women understand when you say “I’m havin’ one.”” (Agnes, 44 years old, Euro)

“The irritability. I keep to myself a lot cause I don’t like to hurt people’s feelings, I don’t like to snap at anyone. Sometimes I feel that way, you know, so I just keep to myself.” (Kathy, 51 years old, African American)

“I don’t get that bad, I don’t think. I do get depressed and down, but I don’t take it out on other people. I try not to anyways, you know.” (Rita, 50 years old, Euro)

Concentration & Memory

Memory loss and trouble concentrating are common symptoms discussed in menopause research, in light of both women’s report of the symptoms and research investigating the relationship of estrogen and Alzheimer’s disease. While the women in the current study did not overwhelmingly attribute their experiences with these symptoms to menopause, some women did remark on a causal link. Many women felt that their memory loss was an issue of aging or that they had always had a bad memory. It is often difficult to distinguish between aging and menopause as the cause of forgetfulness, particularly when a woman states “[I’ve been forgetful] the last few years more so than ever. It’s just I can go…into the next room for something and when I got there I forget what I went in there for” (Rita, 50 years old, Euro). In this case, does the woman consider the phrase “the last few years” to indicate an aging effect or the time since she noticed menstrual changes?

Others associated memory problems with their mental health problems or even a head injury. However, some women noticed that they began to have trouble remembering names or forgetting appointments around the time they noticed other menopause symptoms:
"It's been wild. I know the memory loss, I was having some of that before, when I first started going through the menopause, when I first figured out that's what I was going through." (Rhonda, 54 years old, Euro)

Women in the study often described their concentration problems as a combination of confusion and forgetfulness. They found it very difficult to remain focused on a project or conversation and could quickly become frustrated with a task or other people. Barbara (45 years old, African American) has noticed that since she began going through menopause, she has a short patience and can easily get frustrated by people she knows or situations in which she finds herself. A few minutes alone help her regain her composure. Delores (46 years old, African American) is a project person, whether it involves crafts or housecleaning, but she has difficulty following through on a project. She often moves to a new project without ever completing the previous one, a problem she attributes to having trouble concentrating and getting distracted easily.

In the current study, memory loss, forgetfulness, and concentration problems occurred in more than half of the women, though most women felt that these symptoms were not related to menopause. Nonetheless some women felt that there was a link between their symptoms and menopause, as their narratives illustrate.

**Vaginal Dryness**

Vaginal dryness is one of the least frequent symptoms among the current sample of women. However, most of the women who experienced this dryness (n=6, 40%) thought it was related to changes at menopause. Ruth mentioned that she had noticed a big difference in her levels of vaginal moisture since she has been going through menopause (51 years old, Euro). Another woman, who has had a hysterectomy, remarked that she has noticed an increase in vaginal dryness since her surgery, a common side effect of the procedure (Anita, 47 years old, African American). Vaginal dryness
was enough of an uncomfortable and unpleasant sensation that two women were using a cream prescribed by their doctors for relief of the dryness. One woman, by contrast, looks forward to the potential for menopause-related vaginal dryness. She stated that she was “tired of being juicy” as part of her regular menstrual cycle (Sandra, 48 years old, Euro).

*Phantom Periods*

A pattern emerged among women in the study who described experiencing some of the indicators of their periods without actually having periods anymore. This phenomenon, which I call “phantom periods,” rarely appears in literature about menopause and women’s experiences (Leidy 1997 names “phantom PMS” among postmenopausal women but does not elaborate). Women described the situation such that around the time of the month when they previously would have expected their periods, they had some of the same symptoms although they were no longer menstruating. For example, women told me that they experienced bloating, breast tenderness, vaginal discharge, cramps, got some pimples, were nervous or anxious, and often could feel when they ovulated.

For women who were still unclear about whether they were in menopause yet, these phantom periods were a teaser. Women thought that they were going to have a period, but, despite the bloating or breast tenderness, for example, they never did. Some women’s hot flashes increased in frequency around the time of the month when they used to have their periods.

“You still have all your symptoms, you think you’re gonna have a cycle…” (Agnes, 44 years old, Euro)
"I have night sweats and still when I'm supposed to have my period I get real nervous. I don't have my period no more...but I can tell it's time. I still have all the symptoms but I don't have the period!" (Peggy, 55 years old, American Indian)

"And like I was telling her {a co-worker}, you know, I don't have periods anymore, but I knew how she felt because I still get uncomfortable like around the time I guess when my period would be. That I also thought I was maybe going into menopause." (Anita, 47 years old, African American)

"I still get the bloating feeling like I was having menstrual periods. I still get that feeling but I never have a period though. I never have any blood with it or anything, just bloating. And I get that once a month like regular clockwork." (Rita, 50 years old, Euro)

Few of the women who told me about their phantom symptoms were distressed by the phenomenon, but instead found it a bit disconcerting and it left them somewhat unsure about whether their periods would return unexpectedly at some time in the future. However, one woman revealed that her doctor had told her that she could expect to continue having menstrual symptoms for up to a year after her periods actually stopped:

"I was complaining {to my doctor} that under here {breasts} was more sore and she told me, "You can still have certain symptoms after you stop up to another year." And it seemed that my underarm pits would swell and breasts would get tender around the time you should have a period and then would go away." (Carolyn, 47 years old, Euro)

She was not thrilled to learn that she would continue to have breast tenderness, and even some cramping, but was reassured that the symptoms were expected and not the result of something more serious like breast cancer.

Summary

While the variation among symptoms by comparison along ethnic lines or menopause status are very small, they point to several types of symptoms common to all the women in the study. For one, many of the women experience physical pain, whether in their joints or backs, possibly related to the fact that many work in physically
demanding jobs or ones that result in repetitive motions. Many of the women in the total sample mention feeling depressed. This is difficult to interpret or to associate directly with menopause since at least nine women indicated that they had been diagnosed with a mental illness.

Among the symptoms typically associated with menopause—hot flashes, feeling depressed, or having trouble sleeping—there appears to be a slight increase in frequency through the menopause transition. While only 57.1% of premenopausal women (4 out of 7) experience hot flashes, 78.6% of perimenopausal women (11 out of 14), and 84.6% of postmenopausal women (11 out of 13) have them. This pattern is in contradiction with other research which finds hot flash frequency peaking at menopause and declining rapidly after the final period (cf. McKinlay 1996).

The physical and mental health of the women in the study affect their experience with menopause, particularly in terms of the number of symptoms they report. Low socioeconomic status is shown to affect both the health and health care of poor individuals (Coulton et al. 2001). Similarly, economic difficulties are related to poor mental health.

Research shows that throughout their lives, women have a higher risk for and incidence of mental illness than men (Birkhäuser 2002; McGrath, Keita, Strickland & Russo 1990; Eaton, Muntaner, Bovasso & Smith 2001). For example, women have twice the rate of major depression than men (McGrath et al. 1990). These differences hold true regardless of ethnicity. Similarly, low income adults have higher rates of mental disorders than do higher income adults (Coiro 2001; McGrath et al. 1990; Eaton et al.
Young, low income women with small children are particularly at risk for depression (Coiro 2001).

These differences in rates of mental disorders are not fully understood, particularly regarding the relation between socioeconomic status and increased rates of depression (Eaton et al. 2001; Siefert, Heflin, Corcoran & Williams 2001). However, job strain, poor health, physical limitations, and stressful life events (e.g., finding a job or housing) have a strong impact on the lives of low income individuals (Coiro 2001; Siefert et al. 2001).

A number of the women in the current study indicated feeling blue or depressed, and six had been diagnosed as having a mental illness. Likewise, half the women also consider themselves to be in poor or fair health and many of them report having chronic health conditions (e.g., high cholesterol, diabetes, asthma). Therefore, it is possible that their economic situation negatively impacts their physical and mental health and may result in menopause and its signs and symptoms being of less impact or concern.

There is growing evidence that healthier women and those with higher incomes report fewer symptoms related to menopause. Recent research shows that women who report better health experience fewer symptoms than less healthy women (Avis, Stellato, Crawford, Bromgerger, Ganz, Cain & Kagawa-Singer 2001). Furthermore, women who felt that they had trouble paying for their basic needs had higher symptoms levels than women who had fewer financial difficulties. However, there remain few studies that directly compare menopause symptoms among healthy and less healthy women. As Kaufert (1996) indicates, the reliance on urban, white, generally healthy, middle class women is a shortcoming of menopause research because it leaves out poor, sick, refugee,
and ethnically diverse women. While the current study examines menopause among lower income women, it remains difficult to make direct comparisons with other research.

Exploration of women’s Explanatory Models of menopause continues through examining the symptoms or signs which they attribute to menopause. The women in the study may not have a clear idea of symptom etiology because they may just become accustomed to living with some symptoms or attribute them to a broader cause—aging, stress, or other medical conditions they may have. Furthermore, for most of the women, menopause symptoms were certainly an annoyance but hardly a major health problem.

Hot flashes, for example, were only the sixth most frequently mentioned sign or symptom women reported. As shown in Chapter 2, many of the women had other health issues with which to contend: high blood pressure, diabetes, cancer, debilitating back or other joint pain. Additionally, health problems may take a back seat to social and economic problems in their lives—lack of jobs, job searches, paying heating bills, providing food, relationships with husbands or partners and children. The ability to pay for medical care is also a problem for a number of women in the study, perhaps explaining why they are willing to endure something like unusually heavy monthly bleeding when they can hardly afford to visit the doctor except for grave emergencies.

One particularly interesting observation which arose relates to women’s association of depression or emotional changes with menopause. A number of studies show that women commonly associate depression and menopause (Avis and McKinlay 1991; Clinkingbeard et al. 1999; Kaufert et al. 1998), despite a lack of specific hormonal or other causal relationship between depression and menopause (Avis, Crawford,
Stellato, and Longcope 2001; Holte et al. 1994; Kaufert et al. 1992). The association of depression and menopause may be part of women’s expectations and cultural construction of menopause rather than with the reality of their experiences. As Kaufert and Syrotuik explain, a “cultural stereotype of an event…will structure what is experienced and how this experience is reported” (1981:177).

In the current study, I asked women both about the actual signs or symptoms they had in the two weeks prior to the interview, and the symptoms they thought were related to menopause (either from their own experience or from what they had heard from other women or sources). Many of the women (n=31, 77.5%) had felt blue or depressed in the two-week time frame, yet only slightly fewer than one-fourth (n=7, 22.6%) attributed these feelings to menopause. Low income women like those in the study are at high risk for mental illness, particularly depression, and six (15%) have been diagnosed with a mental illness. Approximately 15.8% of the general population has experienced an episode of major depression, so the rate of diagnosed depression in the current sample is no different (Macotte, Wilcox-Gök & Redmon 1999).

Next, when I asked women to indicate which signs they thought were related to menopause, 77.5% (n=31) identified depression. This example demonstrates that women’s own experiences do not necessarily correspond to the stereotype of menopause which society upholds and which shapes women’s expectations.

Lock (1993b) discovered a similar difference in Japanese women’s responses to questions about the end of menstruation and depression. Women responded differently to questions Lock posed in a survey compared to those in in-depth interviews. In Japan, many women believed that “Many women become depressed and irritable during
"komenki," according to a survey Lock administered to rural and urban women, farmers, homemakers, and factory workers. However, when Lock asked women to indicate the symptoms they experienced in the two weeks prior to their in-depth interviews, few women actually stated that they were either irritable (12%) or depressed (8%) (1993b:220). Thus, Japanese women subscribe to and reinforce a negative stereotype about menopause as a time when women are likely to become depressed. Lock argues that Japanese women's expectations of depression and irritability at komenki are related to a general pattern whereby the women prepare themselves for the worst experience to prepare themselves to deal with whatever situation or experience arises.

These examples demonstrate the importance of examining an issue from a number of angles. They show that there may be dissonance between cultural stereotypes or expectations of menopause and women's actual lived experiences.
CHAPTER 5
ATTITUDES TOWARD MENOPAUSE

Negative stereotypes and myths about menopause and midlife women abound in current American society, some enduring for many years, others of more recent origin (Bowies 1990; Dickson 1991; Formanek 1990a, 1990b; Greene 1990; Mansfield and Boyer 1991; Martin 1992; Notman 1990; Whiting 1992). These stereotypes are derived from medical and non-medical sources alike. They portray menopause as a time when women become aimless, are lost with the end of their maternal role, dry up physically and sexually, and are a case of heart disease waiting to happen. At menopause, women are thought to be on the brink of “going crazy” or at the mercy of their hormones. Voda (1993) calls the presumed necessity of hormone replacement therapy the “menopause myth for the 1990s”. Unfortunately, these stereotypes are difficult to combat and are passed from one generation of women to another.

Such negative beliefs about menopause, along with other sociocultural factors, have the potential to shape women’s menopausal experiences. Because of the highly impressionable nature of menopause experiences, it is critical to examine menopause in the broad context of women’s lives, taking into consideration cultural and personal attitudes and beliefs about health, aging, menstruation, reproduction (Dickson 1991; Goodman 1990; Kaufert et al. 1986). While the prevailing belief is that menopause is a preoccupation and difficult time for American mid-life women, little research bears this out (Formanek 1990b; cf. Avis and McKinlay 1991, Barnett and Baruch 1978, Griffen 1982, Kagawa-Singer, Wu, Kawanishi, Grreendale, Kim, Adler & Wongvipat 2002, Leidy, Canali & Callahan 2000, Logothetis 1993, Neugarten et al. 1963, Notman 1990).
Cross-cultural research provides a glimpse at the great variability in women’s experiences of menopause and the cultural interpretations of the mid-life of women. For example, sociocultural research points to midlife and menopause as bringing women in some cultures the possibility of increased freedom and influence, and new roles or statuses within society (Brown 1992; Griffen 1982). On the other hand, American women may not experience changes in power or influence over their families, or see an end to restrictions on their social spheres and activities. Nonetheless they are faced with changes in their lives with regards to their health, family structure, employment, and social networks concurrent with menopause (Brown 1992).

In this chapter I investigate women’s attitudes and perceptions of menopause from the perspectives of changes in their physical and mental wellness, the end of reproduction, and as a part of growing older to highlight the context in which menopause occurs. I also discuss the literature on the meanings of menopause cross-culturally.

Attitudes toward menopause

In order to learn how women conceive of menopause, whether there is an underlying model of what menopause is and what it means to them, I presented a series of statements and asked the women to indicate how much they agreed or disagreed with the statements. A number of the statements and the sentiment they project are adapted from Woods and Mitchell (1999) who sought women's definitions of menopause and their expectations of menopause. The statements, listed below, describe menopause in relation to reproduction, the end of menstruation, aging, the types of changes that may affect women, and whether menopause itself is a disease or a cause of disease.
Table 5.1 Statements about menopause

Menopause is the end of having periods
Menopause marks the end of reproduction
Menopause is a medical problem
Menopause is a time of hormonal change
Menopause brings positive changes to a woman’s life
Menopause is a very emotional time for women
Menopause is a disease that you need to see a doctor for
Menopause leads to a lot of changes in my body
Menopause is a sign of aging
After menopause a woman has an increased risk for disease

I asked women to identify the degree to which they agreed with the statements using a scale ranging from 1 (strongly disagree) to 10 (strongly agree). Most women gave a specific response to each statement regarding how much they agreed or disagreed with the statement. In a few cases, women did not feel they could respond; these were coded as missing values.

Women most strongly agreed with the statements “Menopause is a time of hormonal change,” “Menopause leads to a lot of changes in my body,” and “Menopause is a very emotional time for women.” The strong agreement with the statements demonstrates that women recognize the changes in their hormones (as represented by irregular periods, hot flashes) and the concomitant changes in their bodies (e.g., hot flashes, vaginal dryness, dry skin, weight changes, changes in hair and skin quality) and emotional states (e.g., moodiness, depression, crying jags) during the menopause transition. Women qualified their responses regarding menopause as an emotional time by saying that there can be a lot of emotional changes at the start of menopause and that it can be a time of emotional upheaval for some, but not for all, women.
Table 5.2 Responses to statements about menopause +

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menopause is a time of hormonal change</td>
<td>9.23 (± 1.89)</td>
</tr>
<tr>
<td>Menopause leads to a lot of changes in my body</td>
<td>9.18 (± 1.60)</td>
</tr>
<tr>
<td>Menopause is a very emotional time for women</td>
<td>8.93 (±1.91)</td>
</tr>
<tr>
<td>Menopause is the end of having periods</td>
<td>8.00 (±2.80)</td>
</tr>
<tr>
<td>Menopause marks the end of reproduction</td>
<td>7.78 (±3.16)</td>
</tr>
<tr>
<td>Menopause is a sign of aging</td>
<td>7.78 (±3.35)</td>
</tr>
<tr>
<td>Menopause brings positive changes to a woman’s life *</td>
<td>6.95 (±2.76)</td>
</tr>
<tr>
<td>After menopause a woman has an increased risk for disease **</td>
<td>5.57 (±3.30)</td>
</tr>
<tr>
<td>Menopause is a medical problem</td>
<td>4.95 (±3.30)</td>
</tr>
<tr>
<td>Menopause is a disease that you need to see a doctor for</td>
<td>4.43 (±3.54)</td>
</tr>
</tbody>
</table>

+ 1= strongly disagree, 10 = strongly agree
* n=39
** n=37

Women also agreed with the statements that “Menopause is the end of having periods,” “Menopause is the end of reproduction,” and “Menopause is a sign of aging,” and “Menopause brings positive changes to a woman’s life,” though the responses were not in as strong agreement as the first group of statements. While most women agreed with these statements, other women had reservations about them. For example, some women did not fully agree that menopause was the end of having periods because they continued to have periods throughout the transition. Women questioned whether menopause was truly the end of reproduction because they had heard news stories about women in their late 50s and 60s giving birth, generally with the assistance of medical technology. Both the women who questioned menopause as the end of periods and the end of reproduction did so because they had also heard of women getting pregnant during the last few years before the end of their periods—the so-called “change of life babies.”

Women’s responses to the idea that menopause is a sign of aging varied as well. One woman’s sister essentially went through menopause when she had a hysterectomy in her late 20s. As a result, Agnes did not equate menopause with aging. Cheryl, on the
other hand, partly agrees that menopause is a sign of aging, yet she was not willing to "give it a 10." A woman who strongly disagreed with the statement believes that if a person takes care of herself, eats right, and exercises, she will always look younger.

The statement that menopause could bring positive changes resulted in a number of interesting responses. One woman could not answer the question because she did not feel that any number represented her feeling adequately. Many women indicated that there are both positive and negative changes that come with menopause, and that they had "mixed feelings" about the statement. One woman who agreed with the statement felt that the positive aspect occurs once menopause is done. Eileen, who disagreed completely, had only negative things to say about the changes menopause brings: "it drags you down, makes you feel a lot older."

Women disagreed to some degree with the statements that "Menopause is a medical problem," "Menopause is a disease that you need to see a doctor for," and "After menopause a woman has an increased risk for disease." While several women strongly disagreed that menopause is a medical problem, many women were not sure how they felt about the statement. These women knew that some women have trouble at menopause and may even need to take pills. They also felt that menopause was both a medical problem in that it was related to changes in estrogen, and an emotional problem because "it plays a lot on your psychological mind." Eileen’s sense of menopause is that it is a medical problem but it is also a fact of life, so these two views balance each other in her mind.

Few women agreed that menopause is a disease for which they should see a doctor. In general, they agreed only with the second part of the statement. For example,
Frances and Debby both agreed with the second part of the statement but not the first: they stressed that menopause is not a disease, but because of the changes going on, a woman should go to the doctor in case "your body needs somethin'," according to Frances. In fact, whether women agreed or disagreed with the full statement, many stated that menopause is not a disease, that it was something natural. Anita agreed with Frances and Debby that it is important for a woman to be examined by a doctor, but went on to say "I wouldn't call it a disease. Sounds like you got something nasty!" Clearly few of the women subscribe to the biomedical notion of menopause as a disease condition or as putting them at risk for future disease as proposed in the deficiency disease and risk models of menopause.

While no woman fully maintained that menopause is a disease, a number of them indicated that the number of symptoms and problems a woman has would dictate whether she should go to a doctor for menopause. Others who neither disagreed nor agreed with the idea of menopause as a disease felt that going to the doctor was not really necessary since they had not needed to go to a doctor or get any medications for their menopausal problems.

In general the women neither agreed nor disagreed that a woman has an increased risk for disease after menopause. Three women did not even answer the question because they said they did not know. Many of the women who answered with a 4 or 5 also qualified their responses with "I don't know." On the other hand, regardless of whether there is validity to the statement, Rhonda was not concerned: "I'm not gonna set around worrying about that." Several women told me that my reading of the statement was the first time they had ever heard that women might have an increased risk for disease after
menopause. Like Rhonda, Judy does not seem concerned by the prospect of disease risk and completely disagrees with the statement. She does not have any proof about the validity of the statement and admits her answer is probably due to her own ignorance: “I disagree with it, but that might be ignorance on my part cause I don’t really know if it does.”

Only one woman mentioned a specific example of disease risk which biomedicine attributes to menopause, that of osteoporosis. Another woman spoke of a woman’s risk for sexually transmitted diseases, but felt older women’s risks decrease since they should not be sexually active anymore. Despite the fact that heart disease is a leading cause of mortality for women, and that its incidence increases after menopause, none of the women I interviewed talked about heart disease as a possible health risk for them or other women of their age.

Woods and Mitchell (1999) asked women to define menopause and describe their expectations of it in order to determine what kind of explanatory model women employed in anticipation of menopause. The women, part of a community-based study of women’s midlife health in Seattle, were mostly well-educated and of European American descent, with a smaller portion African Americans and Asian Americans. In their study, the women most often defined menopause in terms of the end of menstrual periods, the end of reproduction, or as a time of hormonal changes. Fewer women considered menopause to be a new stage in life or part of aging. Only a few women defined menopause in terms of a perceived disease risk in the years after menopause or as a condition which warranted medical care. Woods and Mitchell found that women were more likely to consider menopause in terms of a developmental perspective (as defined by McKeever
1991) characterized by a change in menstruation, the end of reproduction, and changing body and emotions.

Woods and Mitchell contrast the developmental perspective with the biomedical model of menopause as an estrogen deficiency disease. The deficiency disease model does not apply because so few women considered menopause to be related to future disease, hormone changes, or requiring medical care. In the cases of both Woods and Mitchell’s research and mine, menopause is considered a hormonal change and the end of a woman’s periods. Likewise few women in either study make an association between menopause and an increase in diseases. As both studies show, the majority women do not subscribe to the deficiency disease model of menopause.

Perceptions of Menopause

How do women perceive and rate their overall experience of menopause or their expectation of menopause? Taking into account the symptoms they have, do the changes impact their lives in a positive or negative way? Women’s responses to this question ranged from positive to mixed (sometimes positive, sometimes negative), to neutral (neither positive nor negative), to negative. A few women had no specific thoughts about the question. In the first part of the discussion of how women perceive menopause, I will examine women’s responses along the positive-negative continuum. Then I present the perspective of looking at women’s responses by ethnicity and menopause status.
Figure 5.1 Perceptions of Menopause

<table>
<thead>
<tr>
<th>Perception</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>35%</td>
</tr>
<tr>
<td>Positive</td>
<td>25%</td>
</tr>
<tr>
<td>Mixed</td>
<td>17.5%</td>
</tr>
<tr>
<td>Neutral</td>
<td>12.5%</td>
</tr>
<tr>
<td>None</td>
<td>10%</td>
</tr>
</tbody>
</table>

Menopause is Negative

Over one-third of women (n=14, 35%) felt that menopause was a negative experience. Typically the signs and symptoms they associated with menopause made them feel that menopause was a negative thing. The women did not like the hot flashes, irritability, mood swings, sleep problems, and night sweats. Joan's (43 years old, African American) perception of menopause as a negative experience was reinforced by the mental image she had of menopause, one which she worked hard to avoid in her own life. In the back of her mind, she always pictured women going crazy when they went through menopause. As a result she works hard to pull herself together to avoid the "craziness" when she begins to feel moody or upset.

Carolyn (47 years old, Euro) found menopause to be a negative experience because her symptoms regularly made her an unpleasant person to be around:

"...you have loss of sleep, those night sweats. I could, I'd change the whole bed a couple of times. It just drove me nuts! And when I don't sleep well, I'm grouchy. Actually downright nasty!"

A number of women dislike menopause because it is a clear sign that they are getting older. While they accept being at a point where they no longer have periods, they are not happy with getting older.
"I look at that like a grandma thing. That’s the way I look at it! I don’t see no positive in it.” (Alma, 45 years old, African American)

"It first of all makes you remember that you’re gettin’ older. And second of all there are too many things that go along with it that are not comfortable, such as sweating, the irritability.” (Kathy, 51 years old, African American)

Another negative aspect of menopause is that it hampers some women’s abilities to carry on with their normal activities. They feel uncomfortable to the point of that they cannot depend on their bodies as they have at other times:

"Very negative. Cause I feel like my body’s falling apart! Only thing positive I see about it is that my cycle is gonna eventually stop!” (Rachel, 47 years old, African American)

"Negative because I think that it immobilizes in terms of doin’ certain activities, bein’ around other people and just how I feel overall.” (Cheryl, 47 years old, African American)

Menopause is Positive

One-fourth of the women felt that menopause was a positive time in their lives (n=10, 25%). These women had accepted menopause as a natural and inevitable occurrence. They were glad to find their periods coming to an end, looked forward to the day when they no longer had to buy pads or tampons, and did not regret the end of their reproductivity. Most accepted their symptoms as a natural part of the process, while at the same time acknowledging that there were other women who probably had a more uncomfortable or worse time of menopause than they did. To Carol (42 years old, African American), menopause is a natural part of being a woman:

“Menopause—it’s not a disease. Just the facts of life. Just gotta go through it. It’s a positive because you’re going to get it anyway.”
Likewise, Yvette (52 years old, African American) knew that menopause would one day 
“happen” because she was a woman. Hearing her mother talk about menopause enabled 
er her to prepare herself for its eventual occurrence:

“It’s a positive experience. Because, you know, like I said, I knew as bein’ a woman that these kind of things was going to happen...So it was something that I was looking forward to, so it was nothin’, no surprise.”

Other women associated their positive experiences of menopause with their relative lack of distressing symptoms. Rita (50 years old, Euro) felt she was having an easy time with menopause:

“You know, I don’t really suffer as bad as I’ve heard women that do. Mine is kinda mild from what I hear of other people, you know.”

Diana (43 years old, Hispanic) also accepted menopause as a normal occurrence. Her experience was more positive than some other women’s because she had not had the negative symptoms she had heard other women talk about.

“I think it’s something positive because it’s just normal changes that every woman has to go through. Positive if the symptoms don’t drastically affect your life.”

For someone like Judy (51 years old, Euro), hindsight makes all the difference. Looking back, she now thinks that menopause is a positive occurrence, but if she had been asked the same question while she was going through menopause, she would have given a different answer:

“In hindsight it was positive. When I was going through it, it was real negative. But in hindsight, it’s like anything else, you know that expression ‘If it doesn’t kill you, it just makes you stronger,’ you know!”
One premenopausal woman had high hopes for menopause as a time when she would be free of the pain and discomfort of menstruation. Marissa hoped that the fact that her periods were unpleasant would be an omen for an easy menopause:

“if I’m goin’ through all this pain and dealin’ with all this pain because I’m told that it cleans and cleanses my body, well, I better not go through no more pain in menopause if I’m goin’ through all this.” (40 years old, Hispanic)

Her sense of the purpose of menstruation almost sounds like punishment or a trade-off for the years of childbearing and sexuality of youth.

Although Delia (53 years old, Hispanic) considers menopause to be a natural part of life, and hence a positive thing, she feels that it is important to get checkups and simply talk to the doctor about the changes a woman experiences. In her view women sometimes need a little help, and she suggests that they seek the advice of a doctor.

**Mixed Feelings about Menopause**

Several women (n=7, 17.5%) had mixed feelings about menopause, often contrasting their unpleasant symptoms or physical changes with the anticipated end of monthly periods. The only positive thing about menopause for Rhonda (54 years old, Euro) is the end of her periods; otherwise, menopause has made her feel lousy:

“Irritable. Really irritable. Oh man, you can really get ticked off real fast. For no reason. Short fuse. And, uh, the memory, the forgetfulness and stuff.”

Agnes (44 years old, Euro) also welcomed the prospect of her last period, particularly since she has spent several months where her period occurred two or three times. In exchange, she has been having mood changes that remind her that she is not completely through menopause.
“In one way, you say, ‘Well, thank God I don’t have to go through this monthly thing.’ In another way, it’s just you’re irritable until you’re totally through it. ‘Til it’s totally out of your system, it has its ups and downs to it.’

Alternatively, women often realize that their symptoms and menopause experience are minimal compared to other women. That realization gives them some comfort in the face of annoying hot flashes or problems sleeping. For example, Barbara (45 years old, African American) considers herself lucky in menopause because she knows other women who have a more difficult time than she does. Consequently, to her menopause is neither positive nor negative—it’s half and half with hot flashes and moodiness balancing out with the end of her periods. Similarly, Arlene (47 years old, Euro) likes not having her period anymore but is not fond of the trade-off—hot flashes.

While Linda (47 years old, Euro) finds that menopause “doesn’t really bother me either way,” she does not like the fluctuating hot and cold that she feels and would prefer to know if and when her period is going to happen. These aspects of menopause, though, are not extreme enough to bother her overall. Similarly, Janet (51 years old, African American) says that “sometimes I’m OK, then sometimes I’m not” in terms of her mood swings and how they make her feel. So, the good days and bad days combined make her feel that menopause is neither positive nor negative overall.

Neutral Perception of Menopause

Some women (n=5, 12.5%) felt that menopause was neither a positive nor negative experience, rather it was simply another aspect of life. They generally felt that menopause was just one experience among many, so there was nothing about it that could be considered positive or negative. For example, Gina (49 years old, Euro) does not have a particular image of menopause in mind, other than to say that it is just part of nature:
"I can’t really say, I mean, that’s somethin’ nature does. I mean, that’s just somethin’ everybody goes through, I imagine.”

Meanwhile, Ruth (51 years old, Euro) accepts that menopause is a sign of aging, but at the same time, she feels that it is simply just part of life and not something on which it is easy to put a value:

“It’s just an experience—there’s no way to put a quantitative value on it. It is what it is.”

Of course, perceptions of menopause vary from woman to woman, as Lisa (52 years old, Euro) pointed out. Furthermore, her husband or friends see different changes in her which she herself may not notice. Consequently, the changes women notice and the symptoms they associate with menopause vary daily as does their ability to cope with them.

*Don’t Know*

Four women (10%) responded that they did not know if menopause was positive or negative. They were either pre- or perimenopausal and did not think that they knew enough about menopause or had really begun to experience menopause enough to make a broad statement about their perception of menopause.

Perhaps the largest group of women in the study found menopause to be a negative experience because they did not care for the disruptions to their lives produced by their physical and emotional signs and symptoms. The women felt that their lives had been changed—or at least interrupted—by hot flashes, depression, moodiness, and sleep disturbances. They also felt that menopause was a sign of aging or felt that their bodies had let them down since they were not able to keep up with the activities in which they had previously engaged without pain or fatigue. By contrast, women who considered
menopause to be a positive experience often welcomed the end of their periods and the hassles of monthly bleeding. Women with positive attitudes also accepted menopause as a normal change that happens to all women, bringing with it some symptoms that might be troublesome occasionally.

The women whose responses fell in between positive and negative show similar contrasts with the other women. For example, women who had mixed feelings about menopause were usually glad that they would no longer be having periods, but they complained about the symptoms they had experienced, considering sweats, moodiness, and hot flashes to be a negative part of menopause. Women who perceived menopause to be a neutral experience, much like the women who felt that menopause was positive, accepted menopause as a natural part of life and counted themselves among the lucky women who do not have severe symptoms.

Woods and Mitchell (1999) asked women what they expected menopause to be like and classified their responses as positive, negative, mixed, and neutral. They learned that almost one-fourth of women were uncertain about what menopause would be like and almost as many had no notion of what to expect, compared to just 10% of the women in my sample. Of the 508 women in the sample, 21% anticipated menopause being a negative experience compared to over one-third of the women in the current study. Woods and Mitchell found that 17% the women in their sample thought it would be positive while one-fourth of the women I interviewed did. Even fewer women (15%) anticipated menopause with mixed or no specific feelings.

While the question I asked was not exactly the same, the sentiment that is examined, that of expectations and perceptions of the concept of menopause, is similar.
In both studies, a negative attitude toward menopause prevails over a positive one, and a mixed perception of menopause was more frequent than a neutral attitude. More women in Woods and Mitchell's sample were uncertain about menopause than women in the current study, perhaps because of differences in menopause status in their sample and mine. For example, more women in the current study were postmenopausal while Woods and Mitchell interviewed women who had menstruated in the past year.

It is often revealing to examine women's attitudes toward menopause according to their age, ethnicity, and menopause status. Several researchers have found that younger women often have a more negative view of menopause compared to older women (Cate and Corbin 1992; Formanek 1990b; Greene 1990; Neugarten et al. 1963). They attribute younger women's negativity to the cultural stereotypes of menopause to which they have been exposed and to their unfamiliarity with menopause. By contrast, older women, generally those who have experienced menopause, view menopause as a positive time of life. In the current study, however, women 45 to 49 overwhelmingly considered menopause negative compared to the younger (40-44) and older (50+) women in the study. The 45- to 49-year-old women could be experiencing more physical and emotional changes than the other women, particularly regarding the uncertainty of their menstrual cycles. Nonetheless, women over fifty most often had a positive attitude, rather than mixed or neutral, toward menopause, a finding which echoes other research.

Another perspective from which to examine attitudes toward menopause is to look at the pattern of attitudes across menopause status groups. Results are summarized in figure 5.2 below. From this perspective, one would expect that premenopausal women—typically younger women—would be more likely to consider menopause
negative than would postmenopausal (hence older) women (Cate and Corbin 1992; Neugarten et al. 1963). However, in the current study, perimenopausal women—those women currently experiencing menstrual irregularities and emotional changes—more often had a negative or mixed opinion of menopause. Postmenopausal women were the next most likely group to view menopause in a negative light. Nonetheless, they were equally likely to consider menopause to be positive. Unfortunately, the number of women in each menopause status group is very small as is the range of responses, so the pattern is not generalizable beyond the women in the study.

Figure 5.2 Attitude and Menopause Status

There are patterns regarding who considers menopause positive and who considers it negative. When examining women’s attitudes across ethnic groups, African American women overwhelmingly considered menopause negative, as shown in Figure 5.3. By contrast, Standing and Glazer (1992) found that low-income African-American women had a somewhat positive attitude toward menopause. Women of European descent in the current study were much more likely to view menopause in between positive and negative in the “mixed” and “neutral” categories. Hispanic women were mainly split between positive and negative attitudes toward menopause. Analysis of
attitudes by ethnicity within the current study may be misleading because the samples are very small.

The number of African American women who find menopause negative may be inflated by the fact that several of them were experiencing major life transitions, involving job retraining, financial uncertainty, and treatment for mental illness. However, other studies, including a large multi-ethnic national project, have shown variability in positive and negative perceptions of menopause across ethnic groups (Sommer, Avis, Meyer, Ory, Madden, Kagawa-Singer, Mouton, Rasor & Adler 1999).

Figure 5.3 Attitude and Ethnicity

Menopause and the End of Reproduction

The physiological and hormonal changes that distinguish menopause eventually result in the end of a woman’s ability to reproduce (unassisted by technology). Most women realized and acknowledged this reality during the interview. The change in their potential to reproduce made a mixed impression on women considering the broad range of their reproductive pasts. Seven women had never given birth to any children (though one adopted toddlers), while thirty-three of the women had given birth to at least one
child. Consequently women approached the end of their reproductive years with differing attitudes.

Most of the women in the study indicated that they would not miss their ability to reproduce after they had reached menopause (n=27, 67.5%). Only four of these women had no biological children. These twenty-seven women insisted that if they were still able, they would not want to have another child. Their explanations focused on four general themes—that they had grandchildren now, that they were too old, that they would not want children in today’s social and economic climate, and that they no longer had the temperament to be a parent to a young child.

Eight of the women had grandchildren with whom they had contact. To these women, their grandchildren provided a good substitute for children of their own. Debby (54 years old, African American) cared for her two young grandchildren while their mother, her daughter, went to school. Consequently described her grandchildren as “just like my own kids” since she was around them and caring for them most of the time.

Rhonda (54 years old, Euro) also had a lot of contact with her 23 grandchildren, seeing at least some of them every weekend. While she enjoyed the children, she was glad they were not her full-time responsibility: “I wouldn’t want that responsibility again.” She appreciated the fact that the children were merely on loan and could be returned at the end of the weekend. Janet (51 years old, African American) echoed Rhonda’s sentiment about enjoying her granddaughter’s visits and appreciating that it was only temporary—“She can go home! I love to have them visit.”

Several women indicated that they considered themselves to be too old to have another baby. For some, the first hurdle would be to actually get pregnant at their age.
Annie (42 years old, African American) stated that given her age (42), if she got pregnant “It’d be a miracle baby.” Other women are not interested in the work of having children. At the age of 46, Harriet (Euro) feels she is too old to have any interest in caring for a small child. If she feels the need to change diapers, she will help with her grandchildren. Marisol (47 years old, Hispanic) felt no sense of loss in her inability to have children anymore due to the combination of her age and the fact that she has grandchildren:

“I had many and with my age and all the grandchildren, I wouldn’t want anymore.”

Gina (49 years old, Euro) feels that she is too old to have children because she might not be able to keep up with children as she gets older. If she were younger, she might still want children:

“...when I was younger. Not now, I’m too old. I would be too scared to try to raise a kid cause I’d probably be in a wheelchair or somethin’, couldn’t keep up with ‘em.”

Similarly, despite her son’s pleading for a younger brother or sister, Arlene (47 years old, Euro) simply laughs and says she has told him many times that “Mom’s too old!”

Babies and children require more patience than some women want to expend at this point in their lives. Linda (47 years old, Euro) knows that raising children requires a lot of hard work, but she also knows that she no longer has the patience to raise one. Eileen (39 years old, Euro) indicated that she “can’t handle that stuff no more,” and does not want any more children. Babysitting her grandson makes Marion (51 years old, Euro) realize the amount of work needed to raise a child and it is more than she wants:

“I don’t think I have the patience to raise any more kids and I can only take {my grandson} in little spurts then he gets on my nerves.”
A number of women indicated that they would not want to bring a child into the world today. For Agnes (44 years old, Euro), the economic costs of raising a child shape her disinterest in more children:

"I'd be afraid. Times are getting worse. Medical expenses are getting higher—the cost. And with the way income is, I wouldn't want the child suffering."

As it is, her youngest child gets upset if Agnes is unable to buy him the things he wants. She tries to teach him that, just like when she was a child, sometimes you have to do without some of the things you want. Lucy (42 years old, Hispanic) also cited financial hardship as a deterrent to having more children. She has enough trouble providing the things and education that she wants to provide her children.

Cheryl (47 years old, African American) would not want more children because she believes children today are unruly and do not have enough respect for adults.

"They're too disrespectful, no sense of responsibility, just everything. Hmm mm. Even startin' like this (indicates very young children). You know, and I wouldn't tolerate it. Cause my mother wouldn't tolerate it. My grandmothers really didn't tolerate it. So I feel like I have a lot of their tyrant ways, you know. And it wouldn't be good in this day and age!"

Her mother and grandmothers were strict disciplinarians, and used corporal punishment. Cheryl thinks that physical punishment and strictness are not popular today.

The social climate of the world today makes women seriously think about whether they want more children. Linda (47 years old, Euro) lives in a neighborhood that is not safe enough for raising children. It is not safe enough to go out at night and the area is a source of drug activity and violence. Rita (50 years old, Euro) sums up the feelings of women who do not want to bring children up in today's world when she says,
“...the way the world is now, I wouldn’t want to raise them in this society the way it is.”

One-third of the women (n=13, 32.5%) indicated that they are still interested in an opportunity to have children during the years approaching and reaching menopause. These women want to have children because they have new partners with whom they do not yet have a child, they consider themselves young enough to still have children, or they feel like they would be a better parent now than they were when younger.

Several women have partners and would like to have a child with them or are hopeful of finding a new partner and starting a family. However, a number of these women have had tubal ligations and will probably never be able to have a child. An operation to reverse that sterilization procedure is prohibitively expensive for these women and the surgery is not always successful in restoring a woman’s fertility. Among the women who have a new partner and want a child with him, Frances is ambivalent both because she sometimes thinks she would like to have another child, and because she realizes that she never will because she had her tubes tied after her last child was born:

“In a way, sometimes I do and sometimes I don’t. I’ve been with this guy for a while and he’s different, very different. He wants another baby. He’ll have to settle for the one he’s got. I don’t think it’s a big issue. That’s what I told him up front, you know, I can’t have no more kids. If you’re not comfortable with that, let’s not take the relationship any farther. Lookin’ back now, I wish I never did {it}, but it’s done and over with, so I’ll deal with it.”

Alison (42 years old, Euro) wishes she did not have her tubes tied because she would still like to have a child with her new partner. However, she also realizes that her dream is not a realistic one for a number of reasons:

“Sometimes I regret having my tubes tied. I didn’t think I could support any other children. But, as relationships ended and a new one started, now I wish I wouldn’t have had my tubes tied, and my future guy, I would have
had other children, but that's just not real... And then I have grandchildren. I take care of them a lot so that kind of fills in the gap!

So, Alison and her new partner will not be able to have a baby together, but she has several grandchildren for the days when she wants a baby around in addition to her teenage children who still live at home.

Lisa (52 years old, Euro) has also come to terms with the end of her fertility because she knows she cannot afford the surgery to reverse her tubal ligation even though she and her new husband would have liked a child together. Nonetheless, she is happy with her four adult children and never saw herself as having more than about four children.

Some women believe they would be better parents now in their 40s than they were when they were younger. For example, Anita (47 years old, African American), whose only son died in his teens, has thought about trying to have another child—"I wouldn't mind having a kid, I really wouldn't. I think I'd at my age right now I'd probably be a better parent, you know." Similarly, Joan (43 years old, African American), who had her first child when she was 18, and now cares for her young son, grandson, and a nephew, thinks she would be a much better parent today. At her current time in life, she is older, wiser, and she feels she could raise a child well and have a smart child. Nonetheless, she is happy with her two children; but for reasons unknown to her, she would still like to have children. For now, she is happy to have the opportunity to be a nurturer to the other children in her household.

Not all women in their 40s consider themselves too old to have children. Carol (42 years old, African American), who is 42, would consider having more children with her husband if he gets himself together and finds a job: "I don’t think I’m too old, I think
I’m still young enough to have kids.” Whereas, Barbara (45 years old, African American) realizes that while she would still like to have another baby, she is too old to keep up with the demands of her young grandson. After two days caring for him, she is physically exhausted and needs an entire day to recover from his stay.

In addition to the women who clearly do or do not want more children are several for whom childbearing and its end at menopause is a complicated and emotional issue. These women, some of whom have had children and others who have not, expressed a feeling of sadness and regret in their current situations. Motherhood is a very important and now troubling role for Gina (49 years old, Euro) who has six daughters and was widowed a few years ago. Her youngest daughter still lives at home but will probably be moving out when she graduates from high school in two years. Soon Gina will be alone and she is searching for meaning to her existence:

“I enjoyed being a mother. I had all of these beautiful girls—they’re gorgeous, beautiful. They all have jobs, they all have lives of their own. And here I’m stuck. I spent all my life around them, protectin’ them and raisin’ them and now I have no life. I though me and my husband would be together after the kids were gone and he would be retired and layin’ around, but it didn’t work that way.”

Among the women in the study, Gina is the only one who expressed a profound loss of identity with the prospect of the end of her role of mother. Gina’s expression of loss at having her daughters all move out, compounded with being a widow, corresponds to the notion of the empty-nest syndrome. According to this concept based on a biological determinist view of women’s roles, the maternal role is important in influencing a woman’s well-being. Consequently when their children have left the home, women are likely to experience a sense of loss, depression, and other types of diminished physical and psychological well-being (Adelmann, Antonucci, Crohan & Coleman 1989).
Researchers have attempted to determine the peculiarities of any particular cohorts of women who are likely to be affected by the empty-nest syndrome. However, the research shows that there are no clear trends among cohorts of women or any patterns of who is likely to suffer decreased well-being due to their empty-nest status (Adelmann et al. 1989; Barnett and Baruch 1978; Kaufert et al. 1992; Neugarten et al. 1963).

Ruth (51 years old, Euro) too finds herself alone at midlife. She is divorced and never had any children with her husband or subsequent partners. Instead, she had two abortions because she was not married and wanted to avoid a life of single motherhood and poverty. She now feels guilty about her abortions because she is unable to have children anymore because of menopause. She also regrets not having any children because she is alone and has few close family members. In the last few years, however, she has come to terms with the end of her childbearing years. While she still wishes she could have a child, she no longer has the “heavy regret,” depression, and periods of inconsolable crying that she had in the past. She has also come to the realization that a child would not necessarily fill the void she has in her lack of a family unit.

Peggy (55 years old, Native American) also feels a loss because she never had any children. Her two pregnancies ended in miscarriages and she recently had a hysterectomy because of cancer. For Peggy, the surgery put an end her dream of having a child:

“Yeah, but because of the surgery, I never... I feel like I didn’t, I lost somethin’. I love kids.”

She has thought about adoption as a way to start a family, but feels that her age and marital status are barriers to this option as well:
“Maybe I’d like to adopt a baby, but probably can’t do that when you’re single.”

Menopause and Aging

How do the women feel about their age and stage of life? Is menopause a marker of aging for these women? Do they find anything positive about getting older? How do they compare their lives now to when they were younger or to younger women today? I explored these issues in discussing how they felt about their age. The topics or concerns that women voiced included not being worried about getting older, concern about physical challenges associated with aging, aging as a positive change, worries about providing care for self and family, regrets about their lives, dislike of aging, desire for a better job or skills, worries about financial situation, and fear of being alone. The chart below presents the frequency of the different responses; women often expressed more than one opinion about their age and aging.

Figure 5.4 Feelings about Aging

Many women think of aging or getting older as a natural part of life, something that is simply going to happen. They are not worried about getting older and accept this life change for what it is. Rarely do these women mention physical changes or declining health when they talk about getting older. They described their feelings as:
“Just accept it. That’s part of living” (Rita, 50 years old, Euro)

“I don’t feel old yet” (Delia, 53 years old, Hispanic)

“Oh, it doesn’t matter to me. It’s gonna happen anyway” (Eileen, 39 years old, Euro)

“Doesn’t bother me at all. I just miss my kids when they were little” (Teresa, 54 years old, Hispanic)

Some of them not only accepted their increasing years, they were grateful to be living and have reached their age. Barbara feels good about getting her life back together and staying clean after several years of alcohol abuse. The change in her life is a blessing and she feels that she is on track to “age gracefully.” Similarly, after having her own mother die at a young age, Janet is herself glad to be alive:

“I thank God that I am getting this age. I lost my mother, I was only 17. I told {my daughter} and I tell my other boys, I’m only here on loan in the first place. I’m not yours to keep” (51 years old, African American)

One woman chose to wear her graying hair as a badge of honor:

“I don’t care if my hair turns all gray. I’m gonna leave it. To me that’s maturity…and I’m still a kid at heart” (Agnes, 44 years old, Euro)

By contrast, a number of women found that as they got older, they began experiencing health and physical problems that caused them concern they look to the years ahead. They no longer had the energy they did when younger and this makes it difficult for them to keep up with the activities they want to do. Some of the women consider themselves older physically than they are mentally or chronologically because of their physical problems.

“It’s a shame that when you’re young you have all that energy that you don’t use and when you’re old, you don’t have all that energy. It’s like, I don’t know, your body starts giving out, falling apart.” (Rhonda, 54 years old, Euro)
“I feel physically I know my body’s gettin’ older, but mentally I don’t feel like I’m gettin’ older.” (Delores, 46 years old, African American)

“I want to live as long as I can, but, I have enough problems now as far as arthritis and all that now. That’s what gets me now—I’m worried about health problems. As people get old, they start havin’ all them problems.” (Alma, 45 years old, African American)

“Just healthwise you wonder what’s gonna happen next. I feel like when I turned 50 I started fallin’ apart. I’ve had all kinds of medical problems. And then it’s something that’s gonna happen. You’re just as old or as young as you feel.” (Marion, 51 years old, Euro)

“You get scared, I mean, you don’t like bein’ weaker and stuff. You like bein’ able to do what you did when you’re 20. Energy you had, the strong, you don’t have that strongness.” (Gina, 49 years old, Euro)

There are also women who enjoy the age they are and who consider getting older a positive part of living. They exhibit positive attitudes about the prospect of turning 50 years old or being in their 50s, and consider aging to be a natural life process. To them, a woman’s perspective and attitude about life shape her experience of aging:

“You know what, the older I get, each birthday I celebrate is as if I was 15 years old. I’m a firm believer that you only as old as you feel, OK? I look forward to bein’, I don’t look forward to bein’ 100, but I look forward to each year.” (Rachel, 47 years old, African American)

“I don’t feel bad about it at all. I think—I was just talkin’ to Roger {her partner} about this the other day. When you’re 16, 17 and you think about somebody bein’ 50, I can remember thinkin’ ‘I hope I die before I’m that old.’ But God is so good that what he does is by the time you’re 50, you’ve gone through so many tragedies and heartaches you have no desire to go back and do it again....I really don’t feel bad about bein’ older at all.” (Judy, 51 years old Euro)

“I think it’s a normal process, I think that it depends on the concept that you have about getting old. I believe that once you are born, each day you get older. And I think that it’s something beautiful.” (Diana, 43 years old, Hispanic)

“Tell you the truth, I like to be a hip grandma!” (Harriet, 46 years old, Euro)
Furthermore, another asset to increasing age is the wisdom and experience a more mature woman has:

"only one thing I like about gettin’ older: I feels much, much wiser. I feel very, I think before I do this thing. I still make my mistakes, but I’m not as naïve as I was." (Athena, 45 years old, African American)

In conjunction with concerns about their physical states and possible declining health, women worry about who will care for them as they get older and who will care for their families after they are unable. Women hope that if they lose the ability to care for themselves that their families—siblings, children—will assume the responsibility for their care and not put them into nursing homes.

“Only thing is I get so old I hope my family’s there for me and will take care of me. Don’t throw me away.” (Janet, 51 years old, African American)

“I just hope that I can’t get so old that I have to be put in a nursing home or that I can’t care for myself. And I don’t want to be a burden on my children either.” (Rita, 50 years old, Euro)

“(I hope) that my son take[s] care of me. Yeah, that’s about it. I wouldn’t like to be in a nursin’ home as I get older.” (Delores, 46 years old, African America)

Many of those women believe that their family members owe it to their mothers who raised them and cared for them their entire lives to take care of their mothers in a similar manner rather than placing them in an institution.

Whether women’s children are young or grown, they share the wish of security and care for their families. On the one hand, Arlene (47 years old, Euro), who has had a bout with cancer, worries about who will care for her pre-teen son if she dies. Likewise, Debby, whose children are grown and have children of their own thinks about her family’s well-being above her own:
“You know, it {aging} don’t bother me. Just that my family be secure as
best they can before I ride out. Other than that, you know, I’m not
concerned with myself.” (53 years old, African American)

Another common theme in women’s narratives about getting older is a sense of
regret that they have not accomplished all of the things they had hoped. When they were
younger the women did not take advantage of opportunities they received, particularly
regarding their education. These women felt like they lacked confidence in themselves at
a younger age, they made poor decisions due to lack of maturity and wisdom, or they
were sidetracked by starting families. Anita exemplifies many of these elements:

“I mean, I remember thinking, you know, in younger years, ‘47, that’s old!’
I don’t feel old, I don’t feel like I thought maybe that would be. You know,
but I think and I’m like, ‘Oh my God, you’re almost half a century old!’
And of course there’s some things that I would have liked to done more
with my life at the age that I am now. I’m like right now just going back to
school. I mean, I went to college right out of high school, blew it off, it
wasn’t important. Now I’m like 47 years old, I’m working in a laundry, I’m
like ‘Your body is not going to hold up.’ I don’t want to do a physical job
for the rest of my working life. There’s also, now I know what I would like
to do. I never was the type of person, I never had a goal. You know, some
people just know what they want to be. I never knew what I wanted to be.
I know what I want to be now.” (47 years old, African American)

Like Anita, several women were in the process of returning to school after
dropping out of high school or never going to college. They seek an education and
improved skills which they hope will move them beyond low paying, and often
physically demanding, jobs. They want to earn enough money to be able to move out of
the projects or stay off welfare. Now that they have fewer responsibilities to their
families, they are turning their attention to themselves and their own ambitions.

Finally, the least frequent themes that arose in women’s discussions of aging were
worrying about their financial situations and fear of growing old alone. Lucy’s main
concern about her age is the fact that despite working since she was 16 years old she has
no money (42 years old, Hispanic). Because of her health she is unable to work, but tries to remain positive about her physical problems. She hopes her health problems, which she attributes to excessive menstrual bleeding, are only temporary and will come to an end when her periods do. Ruth (51 years old, Euro) finds herself in poor financial circumstances with a low-paying, labor-intensive job. She knows that she will have to work until the day she dies. Yet, she is also overwhelmed by being alone. She has no children and no companion and regrets her “slim prospects” of finding a man with whom to grow old.

A wide variety of themes arise from women’s discussions of their feelings about getting older. Women spoke frequently about the increasing health problems they had or anticipated as they got older and who would take care of them, of aging being a positive experience, about making changes in their lives by going back to school. The notion of change unites many of these themes. Women’s increasing years coincide with changes in their health to a time when they worry about physical decline that may leave their families with the burden of caring for a mother in poor health. Women’s changing age may lead to new ways of seeing themselves as wiser, stronger, and having a positive sense of self. In addition, women take an active part in enacting changes in their lives by returning to school in mid-life as a way to improve their economic status or learn skills for a new career.

**Younger Age vs. Older Age**

I asked the women how they would compare their lives currently to when they were younger and if they thought that life was easier or more difficult for one age group or another. I wanted to stimulate women’s thoughts about how they feel about aging and whether they view menopause as an indicator of getting older or as another stage of life
like any other, whether they preferred being younger or their current age. Figure 5.5 shows the range of responses.

The largest proportion of women (n=12, 30%) felt that neither older or younger women had advantages or disadvantages, mainly because each phase of life has its own benefits or difficulties. Just under a third of the women (n=11, 27.5%) thought that life is easier for younger women because they have more energy and are less likely to face discrimination. A number of women (n=8, 20%) felt that their lives had improved as they had gotten older. They felt that they had more life experiences and knowledge to go on and had more freedom since their children were grown up. Five women felt that being both younger and older had benefits, and four women did not have an opinion about the issue.

Figure 5.5 Younger vs. Older Ease of Life

Neither Age is Easier

Women who thought that neither being younger nor older provided an advantage to a woman's life thought so because each woman makes of her life what she can regardless of her age. A woman's specific life circumstances also have an effect on the life she leads, particularly in terms of opportunities offered to her as well as timing—
when she chooses a specific path or opportunity. For example, Frances did not feel that it was possible to generalize that all women of a particular age, whether young or old, will act the same:

“Well, I think it all depends on the person because everybody’s different. Some younger women are willing to settle down quicker than some older women. And then some older are quicker to settle down than younger women.” (46 years old, Euro)

Debby believes that a woman’s success or failure depends on the opportunities she receives and how much she makes of them. She uses the case of work and education opportunities that her children’s generation has that she did not have when she was their age:

“I really don’t see it as being easy for either one. You just more or less have to make whatever you can...I think both generations have it both ways. It just depends on what you’re doing. I mean, you know, like the generation now has it better than my generation. A lot of things my son or daughter have, the opportunity wasn’t there for me when I was their age and younger” (54 years old, African American)

Two women believe that the timing of activities in one’s life plays an important part in a woman’s development and her success or failure, as Lucy’s statement illustrates:

“I think nothing is easy. Everything comes with time. I think if you do things at the right time, it’s easier. If you do things prematurely, it’s not easy.” (42 years old, Hispanic)

For Carolyn, economics is the main element influencing the lives of both younger and older women. In this respect, one’s socioeconomic position is important because of the educational and work opportunities, as well as its impact on one’s health:

“Depends on your income bracket. It doesn’t matter if you’re young or old, if you have the resources to care for yourself and this and that, it doesn’t matter. But if you don’t, you’re stuck either way” (47 years old, Euro)
Younger is Easier

Some women think that younger women have better health and more job opportunities compared to women in their 40s and beyond. For one thing, these women have found that as they have gotten older, they are more likely to face job discrimination based on their age, as Betsy explains:

“Probably younger. Employment-wise, easier to get jobs than the older women.” (52 years old, Euro)

Furthermore, women often develop health problems (arthritis or diabetes, for example) as they get older, which, along with decreasing amounts of energy, makes it harder for older women to find good work or lead an unencumbered life:

“I think life should be easier for older women. I think that it is in a lot of ways except for the health concerns. You know, when I was young I had no health concerns. Nothing. I was disgustingly healthy and I didn’t appreciate it.” (Rhonda, 54 years old, Euro)

“I’d say younger women, wouldn’t you. Well, they can get out and get jobs, good jobs, and support ‘emself. I don’t know, they have youth on their side and seems like when you get older you get people who don’t really want to hire you or anything or give you a chance, you know.” (Rita, 50 years old, Euro)

Older is Easier

A number of women felt that their lives were a little easier because they were older, more mature, and wiser. A common theme among these women is that as they get older, they have more experience in life, enabling them to get through most life events with less difficulty than they would have as younger women. Yvette’s remarks exemplify this belief:

“I would say older women. Because you done went thru it. You know when you get a certain age, all you got to do is sit back, relax and enjoy life. You don’t have to go thru the headaches of breakin’ up or cryin’ over a
man, or wonder where I'm going to, how I'm going to do this, what I'm gonna do with this situation, alright, cause you've been thru it. It's all over with. When you get a certain age, I don't think there's no problem too great for a woman to handle it at a certain age, cause she done been thru it already.” (52 years old, African American)

Some women thought that younger people today have a more difficult road ahead of them than they did at the same age because society places greater demands on today's younger women. For example, in the past, a young person could get a job regardless of whether she or he had a high school diploma. But today, even low-paying jobs often require the equivalent of a diploma. Similarly, women in particular face pressure based on physical appearance according to Cheryl.

“I think it's easier for older women now because younger women, I believe, have so many pressures that they have to compete with like with weight, looks, and though that's been around for years you know in terms of that your size and all, but I just think there's so many other things out there now that makes it hard even though women are able to do a lot more” (47 years old, African American)

Implicit in her statement is the idea that “looks don't count” for older women, but in a positive sense because they no longer feel pressure to be thin, young looking, and beautiful.

Sandra enjoys the freedom that she has because her children are grown up. Her main responsibilities are to herself, though she does help her daughter by babysitting her granddaughter. She enjoys being able to go on trips whenever she wants, knowing that her children can care for themselves.

“I think it's easier for older women because like now, my kids are grown! I don't have to worry about them. Even though my son's 16, he's as big as a grown man. It switches. I was under extreme pressures just because of my life and how everything worked out and all that, but I have personally found a relief in getting older, yeah. More of a freedom (laughs). I can get the hell out of here anytime. I can go here for a month, go here for a few
weeks, I can get up and go, even though I’m still babysitting. (48 years old, Euro)

She looks forward to extending her new freedom by handing over “head of the family” responsibilities to her daughter in the next few years, at which point she hopes to spend the winter months in Florida and travel even more.

_Same for Both_

Perhaps age, per se, is not the main factor in whether younger or older women have an easier life. Rather it is the decisions a woman makes based on her maturity level and the knowledge she has acquired. For example, both younger and older women are wise, but they have different types of wisdom that can guide their decisions:

“Well, lotta times, the womens that’s young, they have a lot of knowledge and know what’s goin’ on. Older womens knows because they was here a little longer than the other ones... {and younger women have} school knowledge and worldly knowledge and stuff like that.” (Carol, 42 years old, African American)

Marissa thinks the difference between younger and older women is an issue of maturity of thinking. In her experience, maturity is not sole property of older women, and not all young women are inherently irresponsible:

“So I think that can go both ways, cause you got some that are out here takin’ better care of theyselves now, and then when they get older they get old and reckless. So, I think that can go both ways, and then it depends on how mature your mind is and then I think that would have to go through your background.” (40 years old, Hispanic)

Finally, Barbara thinks that all women are likely to encounter difficult times when they are first entering the workforce:

“It’s tough for older women who are starting out late... At the same time, it’s tough for younger women because you have to work for what you want when you’re young” (45 years old, African American)
The themes that evolve out when looking at women’s attitudes toward aging revolve around health (problems, worries, body wearing down) and economic and job issues. While women may gain wisdom, maturity, and experience as they age, they also become subject to greater difficulties finding employers who are willing to hire a middle-aged woman rather than younger one. Overall, however, few women felt that being younger was a necessarily easier or preferable to being in one’s middle years.

Meanings of Menopause Cross-Culturally

A great deal of cross-cultural evidence illustrates the variety of ways menopause experiences are constructed in different cultures (Bell 1995; Beyene 1989; Bonetta, Cheung & Stewart 2001; Boulet, Lehert & Riphagen 1988; Chen, Voda & Mansfield 1998; Davis 1989; du Toit 1990; Flint and Samil 1990; George 1988; Gifford 1994; Kagawa-Singer et al. 2002; Kaufert and Syrotuik 1981; Lock 1986b, 1993a; Mingo, Herman & Jasperse 2000; Punyahotra and Dennerstein 1997; Wright 1982). These examples document a wide range of experiences, from increased freedom, to little acknowledgement of the biological occurrence, to a highly developed set of metaphors for discussing one's symptoms. They also demonstrate that the biologically inevitable end of menstruation is predisposed to many interpretations and constructions.

The Rajput women of Rajasthan and Himachal Pradesh of India rarely experience any difficulties with menopause, nothing comparable to the ‘menopause syndrome’ of American women (Flint 1975). The Rajput women’s lack of symptoms is attributed to the fact that the end of menstruation brings a role change. These women no longer observe purdah because they are not considered contaminated since they no longer menstruate or bear children and can thus join in activities outside of their home and with men. Flint indicates that as among the Rajput “the menopausal woman is rewarded for
having achieved menopause" (1975:163). In the West there is no reward for the
menopausal woman, who is in a sense punished for natural aging in a culture which
emphasizes youthfulness.

The immigrant Sikh women in British Columbia studied by George (1988)
consider the end of menstruation to be a natural biological event in their lives. These
immigrant women did not seem to be affected by the experience of migrating, largely due
to the strong ethnic communities into which they moved, joining their families who had
arrived previously. The Sikh women expressed relief from the mess and constraints of
menstruation and childbirth and the opportunity to be "clean and free". The women
voiced some concern over early or late menopause, the former considered unhealthy and
the latter “draining all the energy out of [a woman]” (George 1988:112). Menopause
provides Sikh women liberation and the transition to being an elder in the family.

For Indian women in South Africa, menopause is closely linked to aging and their
roles as women (du Toit 1990). Indian women are not considered complete unless they
have children, particularly a son. Motherhood allows a woman to care for and cultivate
her children and promises a future as a grandmother. Thus, since menopause marks the
end of reproduction, it is not positively regarded among these women for whom
motherhood is a critically important role. Indian South African women expressed the end
of their ability to bear children as the loss of an important potential, leaving them feeling
like a “shell of a woman” (duToit 1990:268). Menopause and childbirth are further
intertwined because it is commonly believed that women who never have children will
never have menopause, and conversely that the more children one has the earlier
menopause will occur.
Since by the time menopause occurs an Indian South African woman is considered an elder and has an advisory role within her family, menopause is also indicative of aging. These women are fearful of aging because it is associated with being infirm, sick, and a burden to one's family. Thus, although Indian South African women may have a negative experience with menstruation, they do not welcome its end. Menstruation is missed because of its importance in getting rid of "old blood" and its impurities. After menopause, these impurities, when no longer purged monthly, are believed to cause hot flashes, high blood pressures, headaches, and heart attacks. Adding to their negative attitude toward menopause is the fact that these women are not prepared for it since they do not discuss the topic with each other (du Toit 1990).

It is not uncommon for women not to discuss menopause with each other. Among the Papago Indians of Arizona, menopause may come and go and women will not discuss the issue with each other or their daughters (Kearns 1982). There is no Papago word equivalent to 'menopause.' Instead women refer to the cessation of menses as 'old age' or the 'change of life.' Because discussing menopause 'just wasn't done,' most of the women interviewed did not have a clear conception of what constitutes the 'change of life' of among Papago women. The most common signs of the change are irregular periods, hot flashes, and a fever/general sickness. Women acknowledged that menopause could be difficult for a woman to accept because it meant that she was no longer able to have children.

Papago women may seek advice during menopause from the Indian public health service, from older women in the tribe, or from a medicine man. However, menopause is not readily discussed with other family members. The Papago women in this study did
believe that their children should be informed about the change of life at some time. One's children should be told about menopause at least by the time they are twenty years old, preferably while in high school. The information should come from their parents—for girls from their mothers, boys from their fathers—or at school.

From her analysis of the experience of menopause among Papago women, Kearns concludes that having incorrect information or lacking any of knowledge about menopause may be due to the fact that “Papago attitudes and knowledge of menopause appear to be governed to a large extent by traditional values and practices” (1982:82). This may partially explain the difference in the knowledge of menopause held by the older, more traditional women, and that of the younger women who are less tied to traditional Papago beliefs and lifestyle.

Beyene's (1989) research among Mayan and Greek peasant women indicates that menopause is a time when women are freed from taboos and restrictions (for example, Mayan women no longer fear inducing sickness in others, and Greek women are no longer felt to pose a sexual threat to the community or family) and from worrying about unwanted pregnancies (Skilogianis 2001) and the bothers of menstruation. The Mayan women experienced no physical or emotional symptoms at menopause. The Greek women, however, reported hot flashes and cold sweats, though they did not consider these to be symptoms of disease but merely a temporary discomfort. Among the Mayan sample, premenopausal women did not have pre-formed expectations regarding menopause, other than the fact that menstruation would cease. For Greek women, menopause is a sign of old age, which itself is respected in Greece, though the process of
growing old takes one out of the mainstream of society, and the thought of it causes mixed feelings among premenopausal women (Beyene 1989).

Beyene warns that comparing the menopausal experiences of her two samples, particularly those of the Maya, that “one may mistakenly attribute the differences to different attitudinal factors and to gain or loss in status at middle age” (1989:130). However, status changes may be due to factors other than age, including the marital status of one's sons. Moreover, comparing the two samples in her study, Beyene attributes the difference between the Mayan lack of symptoms at menopause and the presence of some among the Greek women to dietary and childbearing habits.

Mayan women have many years of amenorrhea due to numerous pregnancies and extended lactation. Their diets are low in protein and dairy products and many people have high vitamin deficiencies. On the other hand, Greek women marry late and have fewer pregnancies (Skilogianis (2001) shows that Greek women have many abortions) and shorter periods of lactation. Their diets are more well-rounded, including several protein sources, and an abundant amount of dairy products. She concludes her comparison of menopause in these two cultures by stating that her work—"points to the fact that research on menopause should consider biocultural factors such as environment, diet, fertility patterns, and exercise levels which could also affect the production and equilibrium of hormones in a woman's body" (Beyene 1989:139).

Skultans' study of menopause and menstruation in an isolated village of Wales shows that "[f]emale body processes seem to serve in Abergwyn as a source of metaphors for making statements about women's place in the social structure" (1988:139). There are two prevailing trends in women's attitudes toward menstruation, and these
subsequently affect how women view menopause. “Unhappy” women view menstruation as an unwanted occurrence which detracts from their sense of well-being. These women seem to have unstable marriages or are unmarried or childless, situations which make it difficult for them to fulfill the traditional feminine role. “Happy” women, on the other hand, consider menstruation an important part of their physical and emotional well-being. It serves as a corrective device, hence these women wish for copious losses of menstrual blood. The happy women have successful marriages and menstruation allows them to “nourish the feminine role” (Skultans 1988:145).

Complications in menopause could be considerably reduced if one experienced hot flushes, which women thought would “carry you through the change more quickly and safely” (Skultans 1988:154). A lack of flushes was interpreted as a deficiency of menstrual blood.

For both happy and unhappy women, menopause was potentially a time of changing social roles. Happy women, those who successfully fulfilled the traditional feminine role and spoke positively of the loss of menstrual blood, deemphasized their menopausal experience. The unhappy women, on the other hand, welcomed the change in status and the chance to conform to a role with few risks of failure, and were, therefore, more willing to discuss their experiences and symptoms.

The new postmenopausal role for women is one which does not depend on a woman’s reproductive function. For the unhappy women acceptance is not problematic since they desire a new role. However, “denial or underplaying of menopausal symptoms seems to be associated with rejection of the transition to a postmenopausal role and the role’s culturally defeminized basis” (1988:155). While menopause among the women of
Abergwyn can be considered akin to a rite of passage with the redefinition of the feminine role, the fact that there are no ‘rituals of incorporation’ in menopause means that “despite the appearance of choice there is an absence of clearly defined and socially accepted alternatives to the traditional domestic feminine role in Abergwyn” (Skultans 1988:160).

Women in a Newfoundland fishing village have created a communication network within which they define and discuss their health concerns, including those associated with ‘the change’ (Davis 1989). The middle-aged women in this study are unique among Westerners because they grew up prior to the introduction of easily accessible modern health care. Therefore they were accustomed to relying on traditional lore and practice. This reliance continues to be evident in their use of the terms ‘blood’ and ‘nerves’ as metaphors for expressing health and character. Nerves may be referred to as tight, unstrung, or strong; while the volume, color, viscosity, and quality of blood affect one’s health (1989:58). At menopause somatic complaints are usually expressed through discussions of blood, while psychological symptoms are characterized as nerves, though the elements these two terms comprise is not always used consistently (it is unclear if hot flashes are blood or nerves).

Communication networks among the women in the village legitimize women’s complaints at menopause. In the process of discussing each other’s problems through the discourse of blood and nerves women become experts on health issues. Menopause becomes a metaphor in the networks. To some women it may indicate old age and being sick. To others the suffering accompanying menopause is healthy. Enduring the symptoms of menopause, rather than treating them, gives one strength. The most
important component of menopause is not the cessation of the menses, the end of fertility, or the symptoms, "[r]ather it is social comportment at menopause or how women cope with the changes that catches local attention" (Davis 1989:61). In this way, if a woman does not handle menopause well, this information will enter the communicative networks to the effect that "a great deal of collective pressure [is] put on her to get out of the house and participate in what [is] thought to be the pleasurable rounds of female public life" (Davis 1989:61).

Datan, Antonovsky & Maoz (1981) examined the issue of aging and menopause among five subcultures in Israel to determine the effects of varying levels of modernity on their perceptions of this time of life. The groups, on a continuum from modern to traditional, include Jews of Central European, Turkish, Persian, and North African origin and Israeli-born Muslim Arabs. Datan’s co-authors expected the more modernized women to regret menopause because of the hypothesized loss of youth accompanying it. Datan, on the other hand, assumed that menopause would affect traditional women more since they were still actively involved in reproduction. In general the women in these five groups considered middle age to be a time of transition rather than one of loss or liberation. To varying degrees, they all responded positively to the end of fertility.

The Central Europeans wished they had had more children, but enjoyed their current roles as grandmothers. The Turkish women experienced greater personal freedom at middle age, though the Persians did not find this to be the case as many still had children at home. The Persian women were concerned with the health consequences of menopause, because their bodies would no longer be cleansed regularly. North African women welcomed the respect and independence of menopause, but were worried
about changes to their health. The Arab women considered the end of fertility to be the best part of menopause. They typically had a long span of childbearing and still had many young children at home (Datan et al. 1981:95).

Lock's work in Japan demonstrates how konenki, the change of life, has become a "rich, condensed, polysemic concept around which people weave narratives about aging in which mind and body, self and other, past and present, can be reflected on and partially reconciled" (1993b:22). The term ‘kconenki’ was created to reflect the European concept of climacterium (the transition from regular menstruation to the final period). Konenki is a life-cycle transition, a natural part of the aging process. Consequently, women are typically more concerned with such signs of aging as graying hair, changing eyesight, and faulty short-term memory than in their loss of sexual attractiveness (Lock 1993a).

As a transition, the process of konenki can begin in a woman's late thirties and last until the late fifties. Experiencing konenki, however, is not inevitable, particularly since women do not relate it directly to menstrual cycle changes. Because konenki does not indicate the end of menstruation, women believe that they can avoid it. One woman stated it thus: “It depends on how you let yourself feel about it” (Lock 1993b:6).

The symptoms commonly associated with konenki are thought to be a result of the "destabilization of the autonomic nervous system induced by fluctuations in estrogen levels" (Lock, Kaufert and Gilbert 1988:319). The symptoms most women attribute to konenki include, in order of frequency, headaches, shoulder stiffness, lumbago, irritability, loss of energy, tiredness, weakening eyesight, and changes in the autonomic nervous system (Lock 1986b).
The absence of hot flashes among the common symptoms of konenki leads Lock to question whether these symptoms are truly universal. While doctors conceptualize symptoms of konenki as associated with decreased estrogen, unstable emotional states, and instability in the autonomic nervous system, women largely consider symptoms to be most common in bored women, those with no sense of self, or those with few activities to occupy themselves (Lock et al. 1988).

In Lock’s study, konenki was commonly portrayed as a ‘luxury disease.’ Some doctors believe that women with more time on their hands are less likely to exercise self-control and thus be bothered by symptoms (Lock 1992). According to a Kobe gynecologist, “Women who have no purpose in life have the most trouble. Housewives who are relatively well off, who have only one or two children and lots of free time come to see me most often” (Lock 1993a:348).

Middle-aged housewives are stereotypically portrayed as passing their time playing tennis and making plastic flowers while everyone else works (Lock 1993a). In addition, Japanese doctors believe that rural and urban women are differently able to cope with konenki. Rural women are too busy working in their homes and fields to experience any distress, while the easier lifestyle of urban housewives allows these women to think about themselves and notice any discomfort (Lock 1993a, 1986b). However, upon comparing the opinions of doctors and lay people in Japan, Lock found no evidence to support the common assumption that women with more time on their hands are more attentive to and report more symptoms associated with konenki (1986b).

The issue of self control is a key factor in how konenki affects Japanese women. The importance of self-control is related to the fact that “personal conduct can directly
affect physical functioning of the body" (Lock 1993b:204). A woman's ability to exercise self-control is related to her genetic endowment and her personality. Thus women may ignore any physical distress as a display of self-control and discipline. Therefore, “konenki remains overwhelmingly a social category, and it applies only when a woman cannot control herself, cannot preserve discipline and order— when she is no longer normal” (Lock 1993b:379).

Konenki, as the change of life, is a time for reflection on life and human relations. At this point women have a brief time of relative freedom between caring for their children and caring for aged parents. In this examination of the mid-life transition, social change in Japan can be observed through women's perceptions and expectations of konenki. There is some conflict in women's roles between those of mother and homemaker and the present trend of working outside the home. The generation of middle-aged Japanese women Lock studied are the first for whom the traditional roles of conveyors of cultural tradition and minder of children is no longer needed (Lock 1992). At the same time the government continues to encourage middle-aged women to fulfill their familial duties by caring for the elderly rather than seeking outside employment (Lock 1993a).

Summary

The attitudes women in the study exhibit towards menopause are in part a result of their Explanatory Models of menopause. These EMs, constructed with input from historical, social, and cultural forces (e.g., negative stereotypes), shape and guide women's experiences of menopause, as well as their attitudes toward menopause and the changes it brings to their lives.
Women in the current study recognize menopause as a time of change—in hormones, menstrual patterns, body, and emotions. Yet most of them view this change as normal and natural rather than as a disease or medical problem. While many women consider menopause to be a negative change because of the symptoms that accompany it, others welcome the end of menstruation and reproduction.

Worries of physical decline and poor health are commonly expressed as women discuss menopause, aging, and the end of reproduction. Many of the women have other health problems which they fear will make their aging years difficult and painful. Health worries also lead to concerns about their future living and care arrangements. Beyond their health concerns as they get older, most women have a positive outlook about aging because it presents a new phase of their lives with new opportunities and time to enjoy their grandchildren.

Use of the series of statements about menopause draws out their overarching views of menopause. This exercise also provides evidence to the fact that menopause is not a medicalized condition for these women. To them, menopause is within the medical realm because it involves changes to the physical and psychological health and well-being, but it is not a disease. Likewise, receiving medical care is only necessary if a woman has difficulty with the changes she experiences.

There are a number of possible reasons the women do not consider menopause to be a medical problem or disease, including the fact that the changes, signs and symptoms they associate with menopause are not a major problem in their daily lives. Additionally, it is possible that the view of menopause as a disease is not forced on them by media and medicine as it might be for women at higher income and education levels. The women in
the study rarely expressed sentiments about loss of beauty, a reverence for youth, or becoming aimless at this stage in their lives. Again, there is a lack of the authoritative voice of Biomedicine that is presumed in some feminist and other research (Davis-Floyd and Sargent 1996; Nunley 1998; Rhodes 1992).

Finally the exploration of women’s attitudes and perceptions of menopause also provides some insight into the sense of self and identity of the women in the study. The broadest theme that emerges is that of change. They experience and notice a number of changes in their lives. The most basic level of change is due to their signs and symptoms of menopause. To a degree the person they have been has become moody, sometimes unpleasant to be around, and may cry for no reason. Women who have very irregular periods, especially heavy flows or unpredictable starting times, may find their lives hampered. They worry about going out of their homes and experiencing unexpected, noticeable bleeding. Sometimes they feel too tired to complete the day’s activities because they are so tired. Women may stay away from the people in their lives because they know their mood might change suddenly and make them angry or short-tempered.

Another kind of change is that associated with the aging process. As their comments indicated, women view aging in both positive and negative ways. The negative side of aging brings physical decline—aches and pains, health problems. Women sometimes feel like their bodies are falling apart and they are too tired or unable to take part in activities because they cannot get around as they did in the past. These women may feel older than their actual age. For other women, aging brings positive changes. They feel a sense of wisdom based on years of experience. Women are glad to
have time to spend on themselves, working on projects or travelling, instead of caring for their children on a daily basis.

The sense women expressed of menopause as a positive or negative time in life, their anticipation of the end of reproduction, and acceptance of aging as a natural part of life provide a glimpse at middle age among a group of American women. Their views contribute to the great variability of middle age and menopause described in the cross-cultural perspectives of this time of life.
MENOPAUSE TREATMENT CHOICES

What are a menopausal woman’s options if she suffers from hot flashes that occur numerous times during the day or if her “moodiness” negatively impacts her relationships with family and friends? Are her symptoms severe enough that she seeks medical intervention? Panidis, Rousso, Kourtis, Giannoulis, Mavromatidis, & Steriopoulos (2001) estimate that approximately 20% of women have severe enough menopause symptoms to seek treatment.

There are a number of ways to treat the wide ranging effects or symptoms associated with menopause, including ignoring them, behavioral modifications (i.e., wearing layers, fanning oneself), non-hormonal, and hormonal therapies. In the current study, the overwhelming majority (n=37, 92.5%) of women employed one of the first three options (see examples in the discussion of hot flashes in chapter 4), while only two women currently took hormones, and one woman had used hormone replacement in the past but was not currently using HRT.

A primary medical concern for postmenopausal women’s health revolves around the long-term use of hormone replacement for preventing heart disease, osteoporosis, and dementia. However, most of the women were unfamiliar with the idea of using hormones for prevention of heart disease and osteoporosis.

There is no consensus among medical groups as to whether all women should take HRT for menopause symptoms and beyond. However, there is agreement that a woman should be given information about her own health and HRT to make an informed decision regarding using these medications (Kaufert et al. 1998; Nawaz and Katz 1999; North American Menopause Society 2000a; Shapiro 2001).
hormone formulations flood the media—television, women's magazines, health magazines, not to mention medical journals. Premarin, a product of Wyeth-Ayerst, is the most common estrogen supplement: it was the second most frequently prescribed brand-name drug in 2000 (Anonymous 2001a), second only to Lipitor (which is for cholesterol reduction). Sales of Premarin earned $1,146,808 (ranking it 16th among earnings of brand-name drugs) (Anonymous 2001b). Jolley and Olesen (1996) estimate that as many as 20% of American women take HRT, but fewer than half of women continue to take the medication beyond one year (Faulkner, Young, Hutchins, & McCollam 1998).

There are also no hard and fast guidelines regarding what age women should or can begin taking HRT. However, particularly in terms of the potential preventive health benefits of HRT, the US Preventive Services Task Force recommends that doctors counsel all peri- and postmenopausal women about HRT (1996). Likewise, the North American Menopause Society (2000b) recommends counseling for all women. They suggest a number of treatment options including hormones, lifestyle changes (e.g., diet), and alternative therapies. In their guidelines regarding hormone therapy, they caution that little clinical research is available regarding the effects of hormone therapy on perimenopausal women. They suggest that providers extrapolate clinical data from postmenopausal women and rely on their own clinical experience when recommending hormone therapy for perimenopausal women. In addition, they advise prescribing the lowest effective dose of hormones when necessary.

In this chapter I examine women's familiarity with and use of hormone replacement therapy and over-the-counter herbs and supplements designed for menopausal women. I will also examine the reasons women were or were not using
hormone replacement at menopause, what information they had about HRT that informed their decision, and what other treatment options women had used. First, however, I will briefly review some hormonal and alternative treatment options for menopausal symptoms and postmenopausal health.

Treatment Options

The question of whether to take medications at menopause to relieve long- and short-term symptoms is expanding from the choice of different types of hormones to the growing (in number and popularity) collection of herbal and other alternatives. Hormonal and alternative treatments are intended first to relieve uncomfortable or annoying short-term symptoms such as vasomotor, urogenital, and psychological changes. Secondly, hormone replacement may act as a preventive agent for common long-term health problems related to estrogen decrease, including osteoporosis, cardiovascular disease, and dementia.

Hormone Replacement Therapy

Hormone replacement therapy (HRT) is a treatment regimen prescribed to menopausal women on the assumption that the hormones in their bodies—present in smaller quantities than before menopause—need to be provided from exogenous sources, either to alleviate various symptoms or to prevent a variety of chronic diseases or even death. Initially estrogen alone was prescribed to treat short-term symptoms. Currently progestin is also included for several days a month to help prevent the development of abnormal endometrial cells in women with a uterus (American College of Obstetrics and Gynecology (ACOG) #247 1998b; Whitehead, Hillard, & Crook 1990). HRT is available in a variety of forms including pills and patches, intramuscular injections, vaginal creams, and other creams to be applied to certain areas of the body (Utian and Jacobowitz
1990:69-72). Estrogen is typically contraindicated for women with a history of breast and endometrial cancer, undiagnosed vaginal bleeding, suspected breast or endometrial cancer, prior gall bladder disease, thrombophlebitis, and hypertriglyceridemia (Greendale and Judd 1993; Lucero and McCloskey 1997).

There are both risks and benefits that result from taking hormone replacement therapy. Steroidal estrogens, like those used in HRT, are potentially harmful chemicals and are under consideration for inclusion in the list of substances “known to be a human carcinogen” in the National Institutes of Health's 10th Report on Carcinogens (NIH 2002). In terms of their benefits, estrogen has been shown to have positive effects on cholesterol levels, can minimize and possibly prevent the effects of osteoporosis, and may help prevent Alzheimer’s disease. However, a recent report questions the long-held wisdom of using HRT for heart disease and osteoporosis prevention based on a review of recent and past studies of these drugs. The report states that existing drugs used specifically for lowering cholesterol or blood pressure or preventing fractures work better and with fewer known risks than HRT (Grady, New York Times, April 18, 2002).

Estrogen use is also associated with increased risks of several types of hormone-dependent cancers—endometrial (Hill, Weiss, Beresford, Voigt, Daling, Stanford & Self 2000), cervical, breast, and ovarian.

Long-term use of HRT, usually beyond ten years, is associated with a greater risk of breast cancer and ovarian cancer (Jacobs 2000; Panidis et al. 2001; Rodriguez, Patel, Calle, Jacob & Thun 2001). At the same time, a woman’s risk for breast or ovarian cancer appears to decrease 15 (breast) to 29 (ovarian) years after quitting HRT. Women who take a combined estrogen-progestin form of HRT have an increased risk of breast
cancer greater than women who take estrogen only (Schairer, Lubin, Troisi, Sturgeon, Brinton & Hoover 2000).

There is general agreement that estrogen and HRT are effective in treating so-called short-term symptoms such as hot flashes, sweats, and urogenital and skin changes (ACOG #247 1998b; Genazzani, Spinetti, Gallo & Bernardi 1999; Kenemans, van Unnik, Mijatovic & van der Mooren 2001; Lucero and McCloskey 1997; Wills, Ödegaard, Persson, Hedbrant, Mellström & Hammar 2001). Hot flash frequency, duration, and severity are reduced by HRT. Both systemic and local use of estrogen can reverse atrophy and dryness in vaginal and genital tissue. Despite these positive effects, many women quit taking HRT (often after their symptoms subside) because of negative effects like the return of menstrual-like bleeding, fear of breast cancer, weight gain, irritability or fluid retention (Boraz, Simkin-Silverman, Wing, Meilahn & Kuller 2001; Kenemans et al. 2001).

**Cardiovascular disease**

Heart disease is the number one cause of death in women in the United States (Minino and Smith 2001). Rates of heart disease increase among women after menopause, probably because decreased estrogen levels after menopause result in an increase of LDLs (low density lipoproteins) and total cholesterol and a decrease of HDLs (high density lipoproteins) (Greendale and Judd 1993:430). Estrogen replacement helps adjust lipoprotein levels, decreasing the LDLs and raising HDLs. Progestins added to protect the endometrium may reduce some of the positive effects of estrogen on the lipoprotein levels (Contreras and Parra 2000). Women who use HRT for at least five years can experience lasting positive effects on their risk for CVD (Kopera and van Keep 1991).
However, HRT is not an effective tool in preventing or treating recurring cardiac events among those with existing heart disease (Barbour 2000; Grodenstein, Manson & Stampfer 2001). In this situation, longer duration of HRT use did reduce the risk for a second heart event (e.g., heart attack), but at the same time, women experienced a significantly increased risk of thromboembolic disease. It is much more effective to address these women’s heart disease risk factors—blood pressure, lifestyle, diet, smoking, lipids—through screening and other types of medications (Bittner 2000; Rexrode and Manson 2002).

**Osteoporosis**

Osteoporosis is probably the most popular issue today regarding the protection offered by HRT. For example, loss of height and bone density are a main focus of the Premarin/HRT advertisements on TV starring actress Lauren Hutton and singer Patti LaBelle. An estimated 25 million Americans have osteoporosis, three-fourths of whom are women (ACOG #246 1998a; Scheiber 1999). Whites are more likely than African Americans to experience fractures from osteoporosis. Most deaths attributed to osteoporosis follow from embolisms and chest infections brought on by the immobility resulting from hip fractures (Varma 1992).

Osteoporosis is also an extremely costly condition, an estimated $10 to $15 billion spent treating osteoporotic fractures (National Institutes of Health 2000). Risk factors for osteoporosis include female sex, northern European heritage (alternately white ‘race’ in most epidemiological studies) or Asian ancestry, thin build (either due to petite build or as a result of dieting), physical inactivity, smoking, chronic illness, long-term use of many medications, family history of osteoporosis, and premature menopause (Haddock 1990; Rudy 1990). Peak bone density, which most women reach in their mid-
thirties, and rate of bone loss are other very important factors in the development of

Steroids like estrogen can decrease the initial bone loss which occurs in the first
five to eight years after menopause (Scheiber and Rebar 1999). However, bone loss will
resume after a woman stops taking HRT (Vestergaard, Hermann, Gram, Jensen, Kolthoff,
Abrahamsen, Brot & Eiken 1997). Preventive treatments for osteoporosis either act by
inhibiting bone resorption or stimulating bone formation. Calcium and vitamin D are
critical components of bone growth. They help in attaining bone mass and treating bone
loss, but are not effective in preventing loss (Netelenbos 1998; NIH 2000). Instead, a
number of steroidal and other medications are useful for preventing loss. Estrogen helps
prevent loss as does the synthetic steroid, tibolone. A new group of substances called
SERMs (selective estrogen receptor modulators), including Raloxifene, are proving to be
effective in reducing fracture risks but without stimulating uterine tissue the way estrogen
does (NIH 2000; Termine and Wong 1998). However, SERMs do not effect hot flashes
or lipoproteins (Netelenbos 1998). Only weight bearing exercise stimulates increased
bone growth, but other types of exercise remain important for their effect on bones by
increasing muscle strength and improving balance and agility, two keys to minimizing
falls that may lead to fractures (Burkhardt 1992; NIH 2000).

Dementia

There is growing evidence that estrogen can prevent Alzheimer's Disease (Panidis
et al. 2001; Solerte, Fioravanti, Racchi, Trabucchi, Zanetti & Govoni 1999). Researchers
and estrogen are related because estrogen aids in synapse formation, improves cerebral
blood flow, and reduces heart disease risks (Geerlings, Ruitenberg, Witteman, van
Swieten, Hofman, van Duijn, Breteler & Launer 2001). Estrogen can help improve
several measures of cognitive function. Women with mild to moderate dementia who took a high dose of estrogen for eight weeks showed improved attention and verbal and visual memory (Asthana, Baker, Craft, Stanczyk, Veith, Raskind & Plymate 2001). As with the effect of estrogen on heart disease and osteoporosis, the longer women take estrogen, the greater the decrease in their risk of Alzheimer's disease (Geerlings et al. 2001; van Duijn 1999).

Despite the numerous favorable effects of estrogen on the skeletal and cardiovascular systems, as well as for hot flash relief, HRT should not be seen as a cure-all for postmenopausal women's health problems. Recent research by Hlatky, Boothroyd, Vittinghoff, Sharp & Whooley (2002) indicates that women who have vasomotor symptoms benefit more from HRT in its effect on their quality of life in terms of physical function and energy levels than do women who have no vasomotor symptoms. Thus, Rexrode and Manson argue that Hlatky's research should "challenge the widely held belief that hormone therapy helps women remain more youthful, active, or vibrant" (2002:642).

Alternatives

There is a growing number of non-hormonal alternative treatments which have the potential to relieve short-term menopause symptoms and which may prove to have longer term benefits. The most common alternative remedies associated with menopause include vitamin/mineral supplements (e.g., Vitamin D, Calcium), phytoestrogens (particularly soy), exercise, attention to diet, and numerous herbal compounds (e.g., black cohosh, Dong Quai). One of the most common caveats regarding the use of herbal compounds and phytoestrogens, most of which have not received FDA approval, is that...
the actual amount of the active substance(s) is highly variable and its effects not completely known (Israel and Youngkin 1997; Seidl and Stewart 1998b).

Phytoestrogens are substances that occur naturally in many foods and are chemically very similar to estrogen (Knight and Eden 1995:168). Foods such as cereals, flaxseed oil, and legumes contain phytoestrogens. With regards to menopause, phytoestrogens may have positive effects—hot flash relief, lowering cholesterol levels—similar to taking estrogen supplements (Knight and Eden 1995). Soy supplements are the most common form of phytoestrogen marketed, usually in the form of pills (e.g., Caltrate 600+Soy or Monistat Healthy Woman Soy Menopause Supplement), soy milk, or soy flour. Daily doses of soy protein have been shown to reduce hot flashes by 45% (compared to 83% by estrogen), though with little effect on anxiety, headaches, or insomnia (Albertazzi, Pansini, Bonaccorsi, Zanotti, Forini & De Aloysio 1998). In addition, soy can help decrease hot flash frequency, on a level equivalent to a placebo (Murkies, Lombard, Strauss, Wilcox, Burger & Morton 1995). There is also evidence that soy can decrease levels of LDL cholesterol (Washburn, Burke, Morgan & Anthony 1999). Thus soy may provide an adequate alternative for women who cannot or do not want to take estrogen.

There are many medicinal herbs associated with women’s menstruation and menopause, including some with a long history of use (e.g., black cohosh). Herbs are gaining and maintaining popularity in the search for “natural” treatments for menopausal symptoms (Notelovitz 1994; Seidl and Stewart 1998a). Several herbs are associated with menopausal and menstrual complaints, including Dong Quai, black cohosh, ginseng, kola, licorice, sarsaparilla, angelica, chastetree, and fenugreek, though none have been
approved for this use by the FDA. Black cohosh, for example, has long been used for menstrual complaints. Several studies have shown that black cohosh can produce a euphoric effect similar to other hormones and can improve somatic complaints (Israel and Youngkin 1997; Lieberman 1998).

Behavioral techniques or lifestyle changes are also thought to ease menopause symptoms (Cornell 1997; Lucero and McCloskey 1997; Notelovitz 1994; Seidl and Stewart 1998b; Utian and Jacobowitz 1990). These interventions typically recommend avoidance of spicy food, alcohol, and caffeine and wearing clothing made of natural fibers and wearing them in layers to alleviate hot flashes (Miller 1992), aerobic exercise to prevent heart disease and osteoporosis, and dietary changes in terms of monitoring fat, cholesterol, and total caloric intake to prevent heart disease (Notelovitz 1994; Seidl and Stewart 1998b).

Why Use Hormone Replacement?

I asked the women a series of questions to learn the ways they chose to deal with and/or treat the physical signs they attributed to menopause. I wanted to know if they were familiar with “hormone replacement therapy,” took any hormones for menopause, and if their doctors had given them a choice about taking hormones. I also asked if they had ever tried anything other than hormones for menopause, including home remedies or natural products, and where they had learned about the treatments. I also asked women if they were familiar with any side effects of taking hormones (namely specific risks of the treatment). There was a series of questions specifically for women who responded that they were taking hormones: for which symptom(s) they were taking the hormones, whether hormones were beneficial for osteoporosis, heart disease, or emotional/psychological problems, and whether they thought the hormones helped. I
asked hormone users how long they had been taking the medication, and past users why they had stopped taking the hormones.

Do the women in the study know why HRT is prescribed? Women gave a range of responses, from those who have never heard of HRT, to those who have a vague idea of replacing something that is missing, to knowing that HRT may help hot flashes or osteoporosis. Mary (43 years old, Euro) has only heard of HRT and, therefore, does not really know much about it. She could be no more specific than to state that HRT is to replace “whatever” is missing. Gina (49 years old, Euro) has a better understanding of why a woman would take HRT: “it replaces your hormones, like it leaves your body, like estrogen or somethin’ like that. Doesn’t that leave your body and you need that too, don’t you? And they give you all these pills.” Yet she gives no indication that she knows that it can help reduce symptoms or their severity let alone that it might have long-term health benefits.

Alison, on the other hand, has spoken to her physician about HRT and knows that it helps balance a woman’s hormones and minimizes the effects related to changing hormones. She does not currently take it, but thinks it might be something she needs because of a physical change familiar to many women:

“She says I don’t quite need it yet. But I hope she—all this hair I’m gettin’ under my chin, I do need to find out something!” (42 years old, Euro)

The role of HRT in the management of hot flashes is familiar to some women. For example, Athena had to think a moment before remembering what she had heard about one of the benefits of HRT:

“I’ve heard about ‘em, but I’m not sure what they do, but I heard women’s supposed to be on them when they go through their menopause. Oh, I think that I heard that it’s supposed to help them to deal, it slows down their hot
flashes. They'll still sweat, but it'll slow it down.” (45 years old, African American)

Agnes also mentions the effect of HRT on moodiness as well hot flashes: “I think it just kind of helps you maintain what you lost, so you won't probably have the sweats as bad and the swings.” (44 years old, Euro)

Diana, who trained as a nurse before coming to the US, knows that HRT is used to help hot flashes and for osteoporosis:

“It is used to help control some of the hot flashes, it also helps with the bones. Osteoporosis is one of the diseases I heard that menopause can affect so they give a lot of people hormones because you can’t just get calcium from foods or what you eat at that point. Hormone therapy may be helpful.” (43 years old, Hispanic)

Diana’s training and background make her unusual among the women in the study and gives her an inside track on understanding HRT and provides her information to share when friends ask questions about their health.

Familiarity with HRT

Some women were unfamiliar with HRT, what it is, and why a woman might take it. At least five women indicated that they really did not know anything about HRT. For example, despite having had a hysterectomy recently Eileen (39 years old, Euro) had not heard of HRT, and consequently did not know why it was used. Frances (46 years old, Euro) said that she has “just heard of it, but don’t know any details” regarding the uses of HRT. Barbara (45 years old, African American) said that she has never taken HRT or other hormones. When I asked her why she hadn’t she replied “Is it supposed to help or something?” These women make up a minority of the women in the study in that they appear to be completely unfamiliar with HRT. Familiarity with HRT is not likely to be strictly an age-related phenomenon since many other 45- or 46-year-old women in the
study have at least a cursory understanding of hormone replacement. Nonetheless, it is clear that a portion of women fall outside the range of influence of pharmaceutical advertisements and probably receive minimal health care for menopause or gynecological issues.

While some women may not be very familiar with HRT, others are fairly knowledgeable about HRT and are aware of a number of potentially negative effects of HRT. For example, two women were turned off by the prospect of having their periods return if they took HRT. Some formulations of HRT, those containing both estrogen and progesterone, may cause a return of menstrual-like bleeding. While she is not completely familiar with HRT and whether it might be beneficial for her, Rhonda decided that a return of her periods was not something she was interested in exploring:

“You know what, the last doctor I had, he gave me a little bit of information and then it was like he was pushing the hormone treatments which he didn’t really explain. But then he said the bad word, is your period will probably come back. And it’s like, well, the I don’t want to deal with this, because, and then he said I’d have to take it for the rest of my life which is another thing!” (54 years old, Euro)

Barbara (45 years old, African American) also finds distasteful the prospect of having her periods return. Her doctor suggested HRT as a remedy for some of her symptoms and told her it might bring back her periods. She did not want to go through her periods again and feared that she might also be able to get pregnant again, something for which she feels she is too old.

Agnes (44 years old, Euro) is wary of the effects of HRT on her heart. However, her wariness is a result of a confused understanding of HRT which is thought to protect the heart by controlling the levels of LDL and HDL cholesterol (Stevenson 1998; Vyas and Gangar 1995). Her doctor has told her that when she gets a little farther along in
menopause, he thinks she should take HRT. He explained that HRT can “affect the heart,” something she interprets as a negative aspect of HRT. She is very worried about her heart because of problems with two of her valves and an irregular heartbeat. Agnes’ confusion regarding the relation between the heart and HRT makes her wary:

“But then he tells you about the, well it does play a part on the heart. And I’m like well, you give me stuff for {my back} and it eats the liver—I says I’m not even takin’ ‘em—and now you want to give me something else and it causes damage here {points to heart} and I already have enough problem with the PVCs and two valves. Why do you want to add to the condition? But he says that kinda helps to control—you’re lackin’ that hormone when they gotta give you back that hormone. Well you’re givin’ back that hormone, but you’re hurting another way. So you’re damned if you do, and damned if you don’t.”

Many studies indicate that menopausal women frequently cite a fear of breast cancer as a reason for not taking HRT (Magruder 1999; Walsh, Brown, Rubin, Kagawa & Grady 1997; Rabin, Cipparrone, Linn & Moen 1999). However, only one woman in the current study identified breast cancer as a reason she would not like to and did not take HRT. Marion (51 years old, Euro) said that she’s “Scared of I’ve heard they cause breast cancer and, uh, I’d just rather not take ‘em. I’d rather take as few as medications as possible.”

These examples demonstrate the varied levels of knowledge about HRT possessed by a group of women who may need to decide whether to take HRT, for both short term symptoms and long term health maintenance. Women rarely made comments regarding the role of HRT in the prevention of osteoporosis or heart disease. The focus on short-term symptom relief rather than long-term health benefits is not unique to women in the current study. A national survey by the North American Menopause Society also found that women think of HRT more in terms of providing symptom relief than disease...
prevention (Kaufert et al. 1998). The women I interviewed would benefit (following the feminist argument that women be equal partners in health care decisions) from additional information about HRT from their doctor as well as other sources before facing an important health care decision, weighing their specific needs as well as the health risks associated with hormone use.

Women’s Treatment Choices

Women Who Take Nothing

The majority of the women in the study (n=37, 92.5%) do not take any hormones to treat symptoms they associate with menopause (hot flashes, feeling blue, trouble sleeping, vaginal dryness, etc.) or for long-term benefit. Whereas nationally a large proportion of women start taking HRT and quickly discontinue the regimen, the same is not true among the women in the current study (NAMS 1998). In general, the women have not turned down an offer to take hormones; rather they are unfamiliar with HRT or have been told by their doctors that they do not need hormones.

Women gave a number of reasons explaining why they did not take hormones. Five women specifically stated that their doctors had told them they did not need to take hormones yet, despite the fact that the women might be bothered by hot flashes or other menopause symptoms. Generally, the women indicated that their doctors had done a blood test that indicated the woman was not in menopause or did not have low enough hormone levels. In these cases, the doctors are literally the gatekeepers to access to hormones, providing prescriptions as well as information and blood work to confirm or refute arrival at the menopause transition.

Two women had talked to their doctors at a previous appointment about HRT and were scheduled to undergo “tests” at their next appointment to determine if they needed
to start HRT. Janet (51 years old, African American), for example, has not spoken with her doctor specifically about whether she needs HRT, but at a recent exam her doctor ran a number of tests—blood, urine, X-rays, and that those tests will be repeated at her next visit in a few months. At that point her doctor will have a better sense whether Janet is a candidate for HRT.

A number of women also stated that their doctors had not talked to them about using HRT. For example, Linda’s periods have become very irregular in the last few years and she feels more moody (47 years old, Euro). Yet, she has not had a serious discussion about HRT with her new doctor who thinks Linda is “too young” to need them. It is difficult to know if by “too young” the doctor meant that Linda could not be going through menopause yet at the age of 47 or that the doctor prefers not to give HRT to women who are younger than a certain age. Nonetheless, she trusts her doctor to guide her care. Arlene (47 years old, Euro), was specifically not a candidate for HRT since she had recently had breast cancer, much to the chagrin of her older, postmenopausal sister. Arlene’s sister was taking HRT and worried about having to stop taking hormones in the wake of her sister’s cancer.

There are several reasons beyond the lack of a doctor’s recommendation to explain why women do not take HRT. Several women chose not to take HRT, stating that they did not think they needed hormones. For example, Judy (51 years old, Euro) said she got through menopause without ever taking hormones; she just “struggled through” the symptoms. Janet (51 years old, African American) preferred to just “go with the flow” and work through whatever symptoms she had. Debby (54 years old, African American) said that her doctor strongly recommended that she take hormones
and she has taken some sort of medication for menopause. Nonetheless, she is not interested because she does not like to take medications:

“In the hospital, the doctor suggested the standard, what you call it, those pills... Anyway, it’s for menopause and you can get it over the counter. But I don’t take it, I just suffer with it. I don’t really like medicine no way, I just suffer with it.”

Rita (50 years old, Euro) does not feel that her menopause symptoms are severe or troubling enough for her to need to take any hormones, and she may just be too young to need them:

“Well, he wanted to give me some, but I don’t think that I really need it that bad, you know, for the hot flashes. They don’t come that (often), when they do come, they’re only last a few seconds and they’re gone. You know, I can deal with the stress of you know, being down in the dumps every once in a while. I can deal with, I don’t need no medication. I’m not too severe that I think I need the medication yet. I mean, you know, maybe as I get older I might, I don’t know.”

In another instance, Delia, who had a hysterectomy 28 years ago after her last child was born has never taken any hormones. Even now, her doctor does not feel that she needs to start any form of hormone therapy:

“At first I ask my doctor, yes. I did a couple of times and they ask me what I feel, how do I feel. And they say I don’t need no medication yet. And I don’t need hormones yet.” (53 years old, Hispanic)

Particularly in the case of low income women, their financial situation dictates their ability to buy medications and receive medical care. While almost half of the women in the study lacked insurance, only one woman, Lisa (52 years old, Euro), specifically stated that because of her insurance situation (or lack thereof) she could not afford to take HRT or pay for doctor visits to seek medication. She even asked me if I knew of any resources for paying for HRT or whether there were any drug studies through which she could get some medications. While financial concerns prevent some
women from commencing HRT, they also affect the women in the study who take
hormones, as discussed below.

Gina (49 years old, Euro) was somewhat skeptical and possibly unsure about why
a woman would take hormones at menopause. Her understanding of HRT is that it
replaces hormones that a woman’s body needs that are lost at menopause. She asked if
all women take hormones (since she does not get regular medical care and her periods are
still essentially regular at age 49) and I replied that some women take them, others do not.
Similarly I explained that some doctors expect women to take hormones and others do
not. She was skeptical that there was not a more clear pattern in whether women take
HRT, particularly if the missing hormones are so essential:

“Yes, if the doctor prescribed stuff like that, I would probably take it,
yeah, if he says you need it. If he says you don’t, you’ve got plenty of it, I
don’t know. But when you go through menopause, don’t you have to, you
do lose all that stuff don’t you and you do need that to function, don’t you?
Hormones and estrogen?”

Gina’s interpretation of hormone loss and HRT, more than that of any other woman in the
study, seems to fall within the deficiency model of looking at menopause.

Several women indicated that they would be interested in taking hormones at
some point. Sandra felt that she would be an excellent candidate for the potential long-
term benefits of HRT because she has heart disease. On the other hand, she knew that
there were some potential obstacles to her taking HRT because of her family history of
uterine cancer and fibroids and she was already taking quite a few other medications for
other health problems. Kathy (51 years old, African American) would also like to
investigate the possibility of taking hormones. She is planning to go back to school and
knows that she will have trouble concentrating through her hot flashes. However, she is
not too hopeful because she too takes a number of different medications and thinks her doctor will be skeptical about prescribing HRT.

Rachel (47 years old, African American) anticipates starting HRT soon. Her doctor speaks highly of HRT and has begun preparing her to take HRT. She thinks that she will get HRT at her next appointment and she is beginning to look forward to the benefits it has to offer:

"I have no idea what it's gonna be like. They say it's gonna be good once I start takin them. That's what the doctor told me. She said I'll feel a lot better. Say I'll have a lot more energy."

Anita (47 years old, African American) is keeping her options open for the present, but may consider taking hormones in the future. She plans to wait and see how she feels in the future and will depend on her doctor to tell her if she needs HRT:

"It'll kinda depend. Like I says, I am very conscious of some of the symptoms that I'm having. And I will ask to be tested again and I guess it would depend on my physical condition. I trust my caregivers that if they recommend this for me that I will put trust and probably follow their suggestions."

Delia (53 years old, Hispanic) is the only woman in the study who indicated interest in and familiarity with HRT for its potential long-term health benefits. While her doctor recently told her she did not yet need to take hormones, she is nonetheless interested in the prospects of HRT to protect her against osteoporosis and heart disease.

**Use of Alternative & Natural Remedies**

Seven women who were not currently taking any HRT indicated that they preferred more "natural" treatments for their symptoms. Joan (43 years old, African American) must follow up with her doctor to see if she needs to take HRT and she really would prefer to take care of her symptoms in a "more natural way rather than medicine."
In the meantime, she tried an over-the-counter compound called “Estract,” that is sold as an estrogen supplement. Her discovery was accidental—she was at the drugstore looking for something else when the Estract caught her eye—but it turned out to be very beneficial: “It worked great, helped the mood swings, made the hot flashes go away.” She has also seen yam creams that are said to contain estrogen that can be absorbed through the skin but has not tried any.

Debby (54 years old, African American) occasionally turns to medicinal herbs for relief from hot flashes. She has a book on medicinal herbs which she consults to see what might help with her problems, and she buys the herbs at the health food store or grocery. For menopause she has tried goldenseal, valerian—which she drinks as teas—and green tea. At this point, she does not feel like her symptoms are severe enough for her to seek out any other type of medications:

“You know, medicinal herbs, you know, I drink from time to time. They help a little bit. Like I said, it’s really no problem, not really, to the point where I’d be concerned enough to want to run out and buy some medicines.”

Agnes (44 years old, Euro) has not tried any treatments for her menopause symptoms, but is leaning towards what she considers to be a natural alternative—getting the necessary vitamins and substances from food. While her doctor has suggested she try HRT, Agnes is wary of pills and would rather get what she needs from her diet. However, before she chooses to do anything, she plans to read and look up information to help her decision.

“The doctor said he’s willing to put me on estrogen. If I could find out how to get it naturally, going into libraries and gettin’ manuals on stuff, just like I did when I carried (my son). I took all mine naturally with the foods and that because I figure I blame that prenatal pill cause (I lost my other pregnancy while taking prenatal vitamins).”
Annie (42 years old, African American) is also a proponent of natural remedies for various ailments as well as for menopause. She takes “herbs and stuff. Like garlic, the original stuff.” She could not name a particular herb that would work specifically for menopause since everyone’s body chemistry is different. However, she drinks a tea called “healing herb” that contains green tea “to help mend my bones, they say it’s for to help menopause too”. She learned about the herbs she uses to treat herself by reading books at the library.

Harriet (46 years old, Euro) prefers to handle her menopause symptoms as naturally as she can. Most times she just lives with the hot flashes, but sometimes tries herbs when she has the money to spend:

“Right now I just deal with it natural. Sometimes if I have the extra money I might buy something over-the-counter, like an herb or something. Otherwise, I know what it is, I just take it day by day.”

Her herb of choice is black cohosh, one long known to contain phytoestrogens. Black cohosh makes her sweats, hot flashes, and moodiness more manageable:

“You know, those did help...Those did help, it didn’t actually take everything away, but it helped to where you can cope with it...You can take some of it away but not all of it. But some of that stuff it did do, it did help with some of it to where I could be out more and be around people more.”

While Delores (46 years old, African American) has not yet reached menopause, she has thought about how she wants to handle her symptoms. A friend told Delores that HRT made her sick and does not recommend the pills to other women. Other women she has spoken with say that they do not think hormones (like the little patch they put on) do anything for them. Furthermore, Delores’ approach when the time comes will reflect her interest in holistic and herbal healing. She intends to consult with her doctor, as well as her holistic practitioner, to compare notes on their respective treatment options. On the
other hand, while she has heard negative things about standard HRT, she is interested in the use of another hormone in easing menopause symptoms:

"So, I think when I, when it’s my turn, I will try to do the holistic approach to the hormone. Because I was told when I was...in India that instead of them giving us women the estrogen—is that what they give us?—they should give us the men hormone instead, and that works better. They said give us that because then it balance out our hormone and then we don’t get crazy and flashes."

The experiences of these women who prefer to treat menopause naturally show that there are many interpretations of the idea of a natural or non-hormonal treatment. Black cohosh and herbal estrogen supplements, while not strictly speaking hormonal, do contain phytoestrogens which are plant-based compounds that can be converted into or used by the human body as a hormone. However, as these women demonstrate, it is important and necessary to do research to learn about available alternatives and standard treatments, as well as to talk to a physician and other women.

**Women Who Take HRT**

Three women in the study have used HRT and another woman received, but did not fill, a prescription for hormones. Rhonda (54 years old, Euro) went through a phase where she experienced uncomfortable vaginal dryness. Her doctor gave her topical estrogen cream which she used. He also suggested that she consider taking additional hormone replacement. While she used the cream and it relieved the vaginal dryness as well as minimized her hot flashes, she is not sure she wants to take hormones long term—she does not like to take pills and does not like the prospect of taking long-term a medication that may or may not be necessary:

"And then we talked about whether I wanted to go on that too and I just don’t like it. I don’t know that much about it except that they said it’s forever. I said is it necessary and he said yes. And I said is it positively
necessary and he said it’s necessary. And I said when it gets back to positively, call me! So, he left it, you know, he says it’s necessary. I don’t know, how would he know? I tried it, they gave me something years ago. I had to take it 12 days and then you could be off of it for so long. I think I took it 2 months, and it was like, I hate pills, so I really just didn’t follow through. And then they start shoutin’ that ‘forever’ again and it was like, well, I just don’t want to be on medication.”

Clearly, Rhonda has a number of reservations about taking hormones other than the topical cream. She does not like the to take pills orally, particularly when she might have to take them for the rest of her life. Furthermore, she does not feel comfortable making a decision about a serious issue like hormone replacement that she may end up taking for many years to come based simply on reading a pamphlet from her doctor. She no longer uses the cream regularly and is not ready to take other hormones.

Cheryl and Peggy both currently take hormone replacement therapy as they have since having hysterectomies. Cheryl (47 years old, African American) had the surgery about four years ago because she had severe bleeding and anemia from fibroids. Her ovaries were also removed during the surgery. She has been taking hormones since then, trying to find just the right one—she currently takes Premarin.

When I asked her if she felt like she had a choice in whether she started taking hormones, she laughed. Her doctor explained that if she did not take hormones, she would be “a complete mess—that if I didn’t take some kind of hormone replacement that my moods would just fluctuate all over and that I need to have a balance in there.” Since Cheryl has taken Premarin, she has found that it keeps her in a more even emotional state. She also takes an antidepressant which may be partly responsible for stabilizing her emotions. Yet, she went through a period of a few weeks when she did not take the hormones because she could not afford to refill her prescription. During this period, she continued to take her antidepressant but cried more, felt low and had a lack of
energy, so she definitely notices the effects of both the hormones and antidepressants on her emotional state. However, Premarin only helps a little with her hot flashes, generally only minimizing the intensity or frequency. At the same time, she does not expect a complete reversal of menopause symptoms:

“I don’t think there is a ‘cure’ like with all of the different medicines that they have out in terms of menopause, I don’t think anything takes it away. True it makes it less or not as often or not as intense, but it’s still there.”

Peggy (55 years old, American Indian) had a hysterectomy after a Pap test showed “signs” of uterine cancer. She too first began taking estrogen (she could not remember the specific name of the pill) after her surgery a year ago. Lately she has not taken the medication at all, however, because she lost her medical and prescription coverage through Medicaid during a recent move and can only afford to purchase some of the most critical medications—those for her blood pressure and diabetes. She hoped to get her coverage reinstated in the next few weeks. Ordinarily she found that the estrogen helped make her hot flashes less frequent, improved her vaginal dryness, and enabled her to sleep through the night. On the other hand, one side effect she notices when she does not take the estrogen is its effect on her libido:

“Just makes so I don’t have no, what do I want to say, sexual desires if I don’t take ‘em. If I don’t take ‘em I don’t have sexual desires like, you know, like a normal…”

She also feels more moody when she does not take the hormones—just like when she used to have her period. So, while Peggy does not like to take medications unless she has to, she generally prefers taking the estrogen for the relief of her symptoms.

Ruth (51 years old, Euro) received a prescription for HRT from her gynecologist but has yet to fill it. She has some trouble sleeping and hot flashes, along with a lot of
emotional ups and downs. Ruth’s gynecologist suspected depression and also prescribed an antidepressant which she wanted Ruth to try for a while before starting the HRT. The doctor feels that it is more important for Ruth to deal with her mental health problems and that they are not a direct result of menopause. Consequently, Ruth takes the antidepressants instead and will wait and see when her doctor thinks she should take HRT. She does not believe that her emotional problems are related to menopause. Rather she feels that as she has aged she has less control over her emotions than when she was younger. She refuses to use menopause as a scapegoat the way she sees other women do.

Summary

Examining how women treat their menopause symptoms is the final piece in using Kleinman’s concept of Explanatory Models (1980) to explore menopause. By examining women’s treatment options provides insight into what women think they should do about menopause and the symptoms that accompany it. Most women simply cope with their symptoms or adjust certain behaviors (e.g. layer their clothes, stand in a cold room) to minimize symptoms like hot flashes. The fact that only three of forty women take hormones would indicate that most women in the study do not consider menopause to be a medical problem or, at least one that requires regular monitoring by a health care provider. Nonetheless, there were some women who spoke of wanting to learn about ways, including hormones, to treat their hot flashes or vaginal dryness.

There are a number of potential barriers which may hinder the women in the study from receiving HRT, related largely to socioeconomic status and ethnicity. Previous studies of HRT use have shown that the women most likely to start using HRT and to continue using it are ‘white’ and educated (Appling, Allen, van Zandt, Olsen, Brager & Hallerdin 2000; Brett and Madans 1997; Finley, Gregg, Solomon & Gay 2001).

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Furthermore, rates of HRT use are substantially lower among African American women than among white women (Appling et al. 2000). Other research reports that women who begin taking HRT often quit within the first year because of negative side effects, e.g., bleeding, cramping; fear of cancer, and lack of understanding the benefits of HRT (Dören and Schneider 1996; Kaufert et al. 1998; Magruder 1999; Reynolds, Obermeyer, Walker & Guilbert 2001; Vihtamaki, Savilahti & Tuimala 1999). It is not possible to use results of the current study to make a statement to support or refute previous research because so few women actually use HRT. Failure to continue taking HRT is not an issue for the women in the current study since the two women taking HRT continue to take the medication as long as they can financially afford to buy their prescriptions.

Lack of medical care and insurance undoubtedly limit some of the women in the study from pursuing care and hormone treatment for menopause concerns. Socioeconomic status is a significant predictor of HRT use and information. Low-income and less-educated women are less likely to receive counseling regarding HRT from their health care providers or to use HRT (Brett & Madans 1997; Ettinger, Woods, Barrett-Connor & Pressman 2000). The impact of these socioeconomic indicators, in fact, may reduce differences in HRT use along ethnic lines, particularly differences between African American and European American women. In addition to income level, lack of insurance or a regular primary care provider are barriers to both adequate medical care (Salganicoff and Wyn 1999) and access to use of and information about HRT (Ettinger et al. 2000).

More insurance plans are starting to cover prescriptions for HRT, increasing the likelihood that women of various economic levels will be able to pay for these
medications if they need them. As recently as the late 1980s, women on Medicaid were less likely than women with private insurance to be using HRT (Stafford, Saglam, Causino & Blumenthal, 1998). By the mid-1990s, changes were instituted in terms of the government paying for preventive services for Medicaid recipients that were not previously covered, including HRT. In the current study, almost half of the women had no medical insurance to cover such care. One woman who took HRT spoke specifically of her fluctuating ability to pay for the medication depending on how far her monthly income would stretch.

The gender of a woman's physician may be another element that may affect the information women receive about hormone therapy. Specifically, are women more likely to receive information and counseling about HRT from a doctor of one gender or another? Several studies have looked at this issue but arrived at different conclusions. Huston, Sleath & Rubin (2001) found that male doctors were more likely to discuss HRT with their patients. By comparison, Seto, Taira, Davis, Safran & Phillips (1996) found that female doctors were more likely than their male counterparts to initiate HRT treatment with their patients. The reason for this difference is not clear. Seto et al. (1996) point out that it remains to be seen whether these seeming gender differences are due more to differences in physicians' knowledge about HRT or to gender differences in how physicians discuss the topic of HRT.

Another potential obstacle to taking HRT for women with multiple health problems occurs if they already take a number of other medications on a regular basis. Adding HRT to a laundry list of other medications may cause unwanted interactions. Two women spoke directly to this issue. They were interested in taking hormones for
menopause, yet believed they were already taking too many medications. They believed their doctor would not be likely to recommend yet another medication.

A small number of women in the study were interested in learning more about HRT and there were also several women who currently knew very little about the medication. The responsibility falls to health care providers to adequately inform their patients about HRT and help evaluate their patients' individual needs, risks, and benefits. Much research supports the necessity of patient education by their doctors as well as support and recommendation to encourage continued use of HRT (Finley et al. 2001; Motheral and Fairman 1998).

Of course, overall, it is most telling that only a small number of women in the study were disturbed enough by symptoms like hot flashes, sweating, and sleep difficulties, to be curious about treatment options. Of the women currently taking HRT, only one did so specifically because of troublesome symptoms.

Again, these findings suggest that Biomedicine does not strictly define menopause ‘treatment’ or provide a blueprint for what women should do regarding seeking symptom relief or preventing risk of future disease. In this sense, the system of social control that Biomedicine is said to be appears not to be working. Furthermore, the lack of Biomedical control relates to a lack of authority of medicine and medical knowledge.
CHAPTER 7
CONCLUSION

Summary of Findings

The current study is an examination of the issues of the experience and knowledge of menopause among a sample of low-income women in Cleveland, Ohio. Specifically, I focused on learning about women's experiences as well as several ways to look at what women know about menopause and their health. In this concluding chapter I will review the findings of the study, discuss some of the limitations of the study, and make some suggestions for future menopause research.

The study involved hour-long, semi-structured interviews with forty women from the West side of Cleveland. The sample consisted of women of European American (n=19, 47.5%), African American (n=14, 35%), Hispanic (n=6, 15%), and American Indian (n=1, 2.5%) descent. The women were between 39 and 55 years old, with an average age of 47. Just over half of the women were currently employed (55%), and the rest were unemployed. Likewise, half of the women had medical insurance (57%) and the rest had none.

The women fit four categories of menopause status. Seven (17.5%) were premenopausal, meaning they were still menstruating regularly. Fourteen were perimenopausal (35%), that is, experiencing menstrual irregularities but without reaching the end of menstruation. Thirteen women were postmenopausal (32.5%) since they had gone for more than 12 months without menstruating. Six women (15%) had hysterectomies.
Menopause Knowledge and Information

In order to investigate women's knowledge about menopause, I asked them at what age menopause typically occurs, what makes it happen, and what are some common signs of menopause. Most women think that menopause happens from the mid-40s to age 50, which is fairly close to the average age of menopause among women in industrialized countries, 51 years old. However, women were unsure about why menopause occurs.

The majority stated that they did not know why their periods would eventually stop, just that it happens. One-fourth of the women linked the end of their periods to hormone changes. The four most common signs that women recognized as being related to menopause are hot flashes, changes in menstrual patterns, emotional changes and sleep problems. They both noticed these changes in their own bodies and had heard about them from other women.

Research shows that women receive information about menopause and health from a variety of different sources. Among the women in this study, many had not thought of menopause prior to when it happened to them, therefore, few had information about the particulars of menopause before it occurred. When it did, many of them began to seek out information about the changes that occur, investigated whether their experiences were “normal,” determined how long signs like hot flashes would be likely to last, learned if their symptoms were related to menopause or some other health problem, and found of if there were any long-term consequences to menopause.

The women most often consulted reading materials like magazines or books to learn about menopause. Informing oneself by reading or asking questions was the best way to avoid negative stereotypes of or misinformation about menopause. They also
spoke to health care providers among whom they often preferred women doctors or nurses. Occasionally they talked to other women, including their sisters or mothers and friends. From these other women, they could learn about what some symptoms of menopause are like. However, they remarked that other women had the tendency to dramatize the changes at menopause.

Likewise, women who had been going through the menopause transition thought that younger women would appreciate information about menopause, information that they often did not have. If the women in the study had to tell another woman about menopause, they would stress that menopause is different for all women, that there are certain symptoms or signs that are part of menopause, and that it is a normal part of life. Some women also explained that it is a good idea to go to the doctor for a checkup to make sure that a woman is healthy or to seek treatment for bothersome symptoms, but not for expected or usual indicators.

**Signs and Symptoms of Menopause**

Using a symptom checklist containing items used in menopause research as well as more general symptoms, I asked women to tell me what symptoms they had experienced during the two weeks prior to the interview. The two-week period is standard window for studying menopause symptoms while avoiding the passage of too much time to skew recollection. From a list of twenty-seven items, women reported an average of 15 symptoms. They more often reported general symptoms (60%) than ones associated with menopause (40%). Among all the women, aches and pains was the most common symptom category noted. Other common symptoms women reported include feeling tired, back pain, feeling blue, pins and needles in their hands or feet, shortness of breath, hot flashes, and trouble sleeping. Perimenopausal women reported the greatest
number of symptoms. African American and European American women reported similar symptoms, both general and menopause-related.

I also asked women what they thought caused the symptoms they had. The symptoms they attributed to menopause included hot flashes, sweats, vaginal dryness, menstrual problems and irregular periods. While many lists of menopause symptoms also include fatigue, sleep problems, depression, irritability, and dizziness, the women in the study did not consider these to be related to menopause.

Finally, I allowed women’s narratives to give voice to their experiences of specific symptoms. In these narratives, women described the sensations of certain symptoms, their processes for identifying specific physical or emotional changes with menopause, and how they coped with their symptoms.

Beliefs and Attitudes about Menopause

Using a series of statements describing different perceptions of menopause, I examined women’s attitudes toward menopause. The statements positioned menopause in relation to menstruation, reproduction, aging, physical changes, and whether it is a medical problem. The women in the study believe that menopause is a time of hormone and bodily changes, and can be an emotional time for a woman. To a lesser extent, women also indicated that menopause brings the end of their periods and ability to reproduce. However, they do not consider menopause to be a disease or a condition for which a woman must see a doctor.

There is no consensus among women regarding whether menopause is a positive or negative life experience. The largest group of women (35%) indicated that menopause was a negative time because of the physical and emotional changes they experienced. Hot flashes, sweats, and problems sleeping, coupled with unexpected moodiness made
them feel unlike themselves and sometimes hampered their daily activities. On the other hand, one-fourth of the women felt that menopause was positive because it is a natural change and they were glad not to have periods anymore.

Women did not really equate reaching menopause with getting older. Rather, many of them considered their perceived physical decline and poor health to be signs of aging. They worried about whether they would be able to care for themselves and their families in the coming years. Other women considered menopause to be a natural change. These women often indicated that they did not feel old and kept a youthful outlook on life.

For some of them, aging was actually a positive change because they felt that as they aged they gained wisdom. Similarly, there was no consensus regarding whether women thought a younger or older age had more benefits. For example, most women felt that neither age was better because each woman makes of her life what she can given the opportunities she receives at a particular point in time. On the other hand, some women felt that youth had advantages, particularly since younger women usually have better health and older women face age discrimination in the job market.

Thus women do not associate menopause itself directly with either aging or consider it negatively because of being a sign of increased age. Rather, physical and emotional changes at menopause make it merely an unpleasant experience. Poor health and a poor physical condition worry women and are a more indicative sign of aging.

**Treating Menopause Symptoms**

While the idea of using hormone replacement therapy to relieve menopause symptoms and prevent osteoporosis fills the medical and popular media, it is not at the forefront of the minds of the women in the current study. Only three of the women have
ever used any type of hormone replacement. Two take hormones since having a hysterectomy and one began using it for relief of menopause-related vaginal dryness. Some women indicated that they were interested in learning more about hormone replacement for symptom relief. A small number of women have tried herbal remedies to treat the hot flashes or mood swings they associate with menopause. Thus, the group as a whole does not see menopause as a medical event requiring folk or professional intervention.

Within the sample, there is a wide range of practices, attitudes, and knowledge about HRT. Some women know that hormones can relieve hot flashes, whereas many were not familiar with the idea of hormone replacement. Additionally very few women were aware of the posited benefits of long-term use of hormones for disease prevention. Perhaps the fact that almost half of the women have no insurance plays a part in both their knowledge about HRT and their patterns of use. Low-income women generally have less access to regular medical care and counseling, and, lacking insurance, have difficulty paying for medications (Ettinger et al. 1998).

Finally, there is little sense from women's descriptions that their menopause signs and symptoms are unbearable to the point of needing medications. Neither is there a sense that menopause itself is a medical condition requiring medicinal intervention. Consequently, the idea that hot flashes or sweats require intervention beyond fanning or wearing layers of clothes was not part of the mindset of the women in the study.

**Explanatory Models of Menopause**

The women in the study have specific ways of understanding menopause and Kleinman's concept of Explanatory Models provides a way to highlight them. While each woman has her own EM about menopause, for the purpose of the study I chose to
describe these models in broad strokes, looking at knowledge and beliefs across all of the
women. It is important to understand what women know and think about menopause
because this information contributes to their expectations, shapes the reality of their
experiences, and influences their attitudes to this life change. EMs are explored through
looking at the etiology, time/mode of symptom onset, pathophysiology, course, and
treatment of menopause.

Women's understanding of the etiology of menopause, the first part of an EM,
shows that nearly half the women did not have a clear conception of why menopause
occurs. One-fourth knew that the end of menstruation is related to hormone changes, and
the remaining women associated the end of the periods with the end of reproduction or
aging.

Half of the women indicated that menopause typically begins in a woman's late
forties or age 50, indicative of the time of onset, another EM component. Other women
cited a range of ages, such as from the thirties to sixties or 45 to 60. There is even a
group of women who do not know when menopause usually occurs. If a woman knows
at what age to expect menopause to occur, she may be less likely to be alarmed if she
notices changes in her menstrual cycle around that age.

Women identified several signs that are markers of the mode of onset of
menopause, another part of their EMs. To them, the start of hot flashes, sweats, changes
to their menstrual cycles, and sleep problems were the first signs that might indicate the
start of menopause. Oftentimes, these signs appear gradually and last only a short time.
Similarly many of these signs or symptoms are associated with the course of the
menopause transition which can last for a number of years.
The course of menopause, another area investigated in an EM, is marked by many of the same indicators as is the start of the transition. For example, women know to expect hot flashes, sweating, problems sleeping, fatigue, vaginal dryness, depression, dizziness, a low sex drive, and even weight gain as they move toward menopause.

Interestingly, these signs of menopause are the kinds of details which women share with each other as they discuss information about menopause. These signs are also the type of information women wished they had before their own time of menopause.

Women did not have a great deal of information about the pathophysiology of menopause, the fourth area explored in an EM. Specifically, much medical research currently points to the increased risk for osteoporosis and heart disease among postmenopausal women. Likewise, advertisements for HRT that appear in magazines and on the television try to emphasize this message. For example, actress and model Lauren Hutton warns women of the inevitability of their loss of height (due to bone loss) unless they take Premarin. Several women in the study were being treated for heart disease, but they did not make any link between their heart disease and their menopausal status. Likewise, while many women had heard of osteoporosis and knew that it was something they, as women, should be aware of, few considered it something directly relevant to themselves at the present time.

Women's treatment decisions at menopause are guided by their views regarding the other questions the Explanatory Model concept poses. Most women cope with the signs and symptoms of menopause without taking hormone replacement therapy. Three women take hormones. One of them sought relief from vaginal dryness, while the other two began taking hormones following hysterectomies on the recommendation of their
doctors. If women found their hot flashes too much to bear, they would wear layers of clothing that they could remove as necessary, go to a cold room, or sleep with the windows open, even in winter. A small group of women tried natural and alternative remedies, including herb teas, over-the-counter estrogen supplements, or holistic medicine. Such women prefer to use a natural, rather than pharmaceutical, approach to symptom relief.

Thus, the concept of Explanatory Models is a useful tool for examining many aspects of menopause. This information can then be used to help understand women’s views of menopause, for example, whether it is a positive or negative part of their lives. It also provides insight into the types of sources women on which women rely for additional information. Women’s EMs of menopause are useful to understand when examining the issue of whether menopause is a medicalized condition for this group of women from Cleveland, Ohio.

**Medicalization of Menopause**

There are several levels at which to examine the role of medicalization in the lives of the women from this study. Looking at women’s responses to statements about menopause shows that most do not consider menopause to be a medical problem for which they are required to seek confirmation from a health care provider. One woman indicated that a woman starting menopause should be checked by a doctor to make sure that everything is normal. Another woman indicated that only if one has a difficult time with severe or numerous symptoms or has questions should she see a doctor. For many of the women in the study, biomedicine does not hold authoritative knowledge about menopause as demonstrated by the fact that they do not require intervention by a doctor to know that they are going through the menopause transition. Likewise, a number of
women felt that they were going through menopause but their doctors did not, leaving the women to question their doctors’ knowledge about menopause.

An examination of women’s responses to the statements about menopause, it is clear that they do not consider menopause to be a disease. To them it is a natural part of life, just like the start of menstruation. This sentiment is echoed in their views of menopause as a positive or negative change. Regardless of how they perceived menopause, many believed that it was inevitable, natural, and something that happens to all women.

Treatment seeking at menopause is another area in which the women in the study reveal that they are not influenced by a medicalized view of menopause. There are few compelling forces, whether their health care providers, friends, or pharmaceutical advertisements pushing these women to seek hormone replacement once they reach menopause. As a result, few women use any remedies for symptom relief, whether hormone replacement or alternative therapies. Consequently, the fears of feminist HRT opponents are to unfounded in the current sample of women among whom HRT use is very low.

Thus, if using as a measure of medicalization Zola’s notion of social control (1972), menopause in the lives of the women in the study does not fall under the category of “medicalized.” These women do not automatically assume they need to seek confirmation of menopause from their doctors, nor is hormone therapy necessary to provide protection against health risks or to act as a fountain of youth.

**Role of Economic Status**

There are a number of ways in which economic status may affect women in the menopause transition. As research shows, low income women are less likely to have
access to medical care and health insurance (Coulton et al. 2001), are more likely to be in poor health (Coulton et al. 2001; McGrath et al. 1990), and have greater stressful life events. In addition, they may have less education and greater unemployment than middle class women.

Among the women in the study, just under half are unemployed or have health insurance. Nearly forty percent of the women receive public assistance. Thus it is likely, based strictly on economic factors, that these women do not receive adequate health care. In fact, approximately half of them have regular mammograms or Pap tests. Similarly, half consider themselves to be in poor health.

Lack of medical care among these women can translate into a lack of both information about their health and access to hormone replacement therapy. If women are not able to afford to have regular physical and gynecological exams, they may be unaware of health problems they might have. Furthermore, if they have questions about menopause or health issues, they will not have a health care provider from whom to seek the information. Similarly, research indicates that low-income women are less likely to receive information about HRT and, thus, are less likely to use it than other women (Brett and Madans 1997; Ettinger et al. 2000). As a few women in the study indicated, financial issues prevented or disrupted their use of HRT for relief of menopause symptoms.

Given the list of potential risks and barriers regarding the health and health care of low-income individuals, the current study of menopause among a sample of low-income women in Cleveland, Ohio, provides much needed information from a neglected population.
Issues of Gender

This study of menopause highlights several areas where gender comes into play. Many women find their early adult lives wrapped up in the role associated with motherhood. Menopause, and the end of reproduction, require a change in this role as women lose their ability to bear children. Likewise, as a woman’s children grow up and move out of the family home, her role as mother may diminish. For some women, these changes may result in a sadness or sense of loss referred to as ‘empty-nest’ syndrome (Adelmann et al. 1989). Few women in the study expressed a sense of regret associated with the end of their ability to reproduce. Many of them were glad to be freed from the responsibilities and stresses of raising children. Other women direct their energies toward a new role, that of grandmother. As grandmothers, these women can both continue their nurturing role and engage in activities and a lifestyle of their choice.

Gender issues also appear in the interactions of women and their health care providers. On one front, many women in the study expressed a preference for a female doctor with whom to discuss issues surrounding menopause and for receiving gynecological care. These women explained that they would feel more comfortable discussing these issues with a woman doctor. They also felt that female doctors would be more understanding and could speak from the experience of being a woman. Other research has demonstrated that male and female physicians exhibit different communication styles, with females being more attentive to psychosocial issues important to their patients (e.g., Hall and Roter 1998).

Some women in the study also expressed a preference with interacting with nurses (most of whom are female) instead of physicians. Women felt that nurses were willing to spend more time discussing their problems, answering questions, or explaining treatment.
procedures. Women were put off by physicians who limited the number of questions they could ask or who noticeably avoided physical contact with a patient. Similarly women did not like feeling like they had only a brief and limited amount of time to meet with a doctor. Some of these complaints and concerns are likely to be gender-related as well as reflecting differences in communication styles between physicians and nurses (e.g., Campbell et al. 1990).

Contributions

The study contributes to the understanding of menopause among low-income women by providing information about the symptoms these women experience, both in terms of those related to menopause and those related to other health conditions. It also shows how they think them; technically, not as symptoms at all. Many of the women in the group consider themselves to be in poor health, a situation that is not helped by the fact that many of them do not receive adequate medical care, either by choice or by financial circumstances. The fact that women do not identify many menopause-related symptoms nor do they attribute many of the symptoms they do have to menopause leads to the conclusion that menopause is not a significant problem in their lives. This finding is comparable to other research which finds that menopause does not constitute a significant problem in women's lives (Avis and McKinlay 1991; Neugarten et al. 1963; Cate and Corbin 1992; Formanek 1990; Sommer et al. 1999) despite the negative coverage menopause receives in the popular media. Furthermore, the finding that women associate depression with menopause in their general notion of this time of life yet do not report increased depression in their own experience adds to the discussion both of menopause symptoms and to the cultural construction of menopause stereotypes.
Much like a number of other menopause studies, this study found that women rely on a number of different sources for information about menopause and health. As other studies show (Kaufert et al. 1998; Padonu et al. 1996; Clinkingbeard et al. 1999), women are most likely to seek reading materials that cover menopause, with health care providers being secondary. Other women are another common source, but mothers are unlikely to want to talk about menopause, probably because it remains a taboo topic (Dickson 1999; Mansfield and Boyer 1991).

The study also provides a glimpse at the Explanatory Models of menopause held by a sample of low-income women. I sought specifically to examine what women thinks makes menopause happen, what the timing of the end of menstruation is, and how they know that a woman is going through menopause. This information helps researchers see how women conceptualize menopause and to see that many women think of it as a natural change and one that leads to the end of menstruation, but is not a problematic, medical situation.

Menopause presents few problems for women regarding the end of their ability to reproduce. Most of the women in the study accept the fact that they are unable to have children after menopause. Few found themselves in an empty-nest situation since many continue to care for grandchildren and some women still have young children.

Contrary to the media portrayal of menopausal women as having bad hot flashes that need treatment or worrying about shrinking due to osteoporosis, few women subscribe to this image of menopause. Furthermore, the women in the study do not think of menopause as having a causal relationship to heart disease or osteoporosis, despite the campaign by health educators to inform women (cf. Clinkingbeard et al. 1999; Appling et
al. 2000; Ferguson et al. 1989). Thus, either women have very limited or inadequate information sources, whether they learn from health care providers or the popular media. The fact that women do not consider menopause to be a medical problem probably contributes to the fact that most of them do not take hormones, a piece of information important to those who study HRT decision making.

The current study also brings to light an interesting phenomenon which I call “phantom periods.” Women described experiencing some indicators of their periods without actually having periods anymore, including bloating, breast tenderness, cramps, getting some pimples, and feeling nervous or anxious. Women who described the phantom symptoms of their periods were usually not distressed, but rather confused about whether their periods would actually return. This phenomenon of phantom periods is nearly absent from literature describing women’s menopause experiences, though Leidy (1997) refers to “phantom PMS” among postmenopausal women. Clearly this phenomenon warrants additional exploration to learn more about how women experience the transition to menopause.

Limitations

The study contains a number of methodological and conceptual shortcomings. A number of issues are related to the small sample size. Financial constraints involved in conducting the research prevented me from interviewing more than 40 women. Due to the small sample size, it is impossible to generalize the findings of the study to populations beyond those women in the study. Additionally, I would have preferred to have greater ethnic variability among the women in the study, particularly in terms of having more Hispanic participants. Cleveland’s West Side has a substantial Puerto Rican population, so it should have been possible to recruit more Hispanic women. However, I
do not speak Spanish, which prevented me from recruiting more Hispanic women at the
d Locations from which I worked. I was lucky to work with a Spanish translator who had
experience in the medical field, she was not always available to help translate when I was
recruiting participants or planning interviews. Above all, Hispanic women are highly
underrepresented in menopause research. One of the only in-depth studies from a social
science perspective that I was able to locate was Bell’s research (1995) on Mexican-
American women’s attitudes toward menopause.

Another artifact of the sample size is an inability to make comparisons among
ethnic groups or menopause status groups. For example, there are not enough women in
each menopause status group to detect any patterns in symptoms at various stages during
the menopause transition. Similarly, while other studies have shown differences between
the types and severity of symptoms among African American and European American
women, the same is not possible in the current study.

I did not devote enough attention to social issues including women’s support
networks, family relations, and life stressors, all of which can contribute to the quality of
a woman’s life and experience of menopause. Research indicates that women’s social
relations, particularly with spouses and children, impact on their experience of
menopause (cf. Adelmann et al. 1989; Vanwesenbeeck et al. 2001). Examination of the
impact of financial strain and employment also can affect women’s well-being and ability
to deal with possible changes in physical and emotional health at menopause.

Another issue involves my inclusion of women with hysterectomies in the sample.
I should not have included women with surgical menopause (hysterectomy) along with
women with natural menopause. Research indicates that women with hysterectomies
have more severe menopause symptoms and are more likely to be depressed or report poorer health that women going through menopause naturally (e.g. Kaufert 1990). I did not specifically screen women for hysterectomy to exclude them, though when I was recruiting, some women excused themselves from participation on the grounds that they had had the surgery. Nonetheless, the inclusion of women with hysterectomies is not a major flaw since the goal of the study was to provide a descriptive examination of menopause.

Finally, use of a symptom checklist may be problematic. In order to learn what symptoms women experience during the menopause transition, the accepted strategy is to ask women to provide the symptoms directly. While in the past use of symptom checklists was both popular and accepted, there is a trend among social scientists to move away from dependence on checklists (Kaufert 1990). Allowing women to generate the signs or symptoms themselves minimizes appearance of the researcher’s bias and construction of menopause. However, the fact that the list I used contained both symptoms typically associated with menopause as well as ones of a more general nature minimizes the issue to some extent since there was no implication that any or all of the symptoms are related to menopause.

Opportunities for Future Research

Continued research about menopause among low-income women is particularly critical in the current climate of insecurity in the nation’s health care system. Researchers should continue studies involving low-income women to learn more about the impact of economic and social issues on their health and menopause. Even if women do not consider menopause itself to be a health concern, women are at risk for a number of health concerns as they age, particularly gynecologic cancers. Additionally, since low-income
women are likely to be in poorer health and have an increased risk for mental illness than women of higher economic levels, systematic study of the relations between menopause changes and other health problems is important. Finally, researchers should also seek out ethnically diverse samples of women in order to gain a broader, fuller appreciation of the meanings and experiences of the women of the world.

Another interesting possibility for future research of women’s beliefs and knowledge about menopause includes the use of multiple methods of data collection. As Lock discovered in asking Japanese women about konenki and depression, the two seem to be related only in their expectations of menopause and not in their actual experience. Both Lock and Kaufert are proponents of multiple research methods in order to compare personal experiences with sociocultural perceptions of menopause.

Another direction for the study of menopause is to learn about menopause from health care providers who serve low-income patients. A number of women in the current study complained about problems they had getting their physicians to acknowledge that they were going through the menopause transition. In addition, women often expressed their dissatisfaction with other aspects of interaction with their physicians, particularly regarding the amount of time allowed for an appointment or limitations placed on the number of questions they could ask. It would be enlightening to examine the biomedical perception of menopause from the perspective of low-income women’s health care providers, comparing, for example, similarities or differences between the views of menopause by gynecologists versus general physicians. As Lock (1985) demonstrated, medical professionals’ knowledge and practice regarding menopause vary and are culturally constructed.
Appendix

Menopause Interview Questions

Basic Demographic

1. How old are you?
2. What is your marital status? (married, single/divorced, single/widowed, single/never married, cohabiting, etc.)
3. What do you do for a living?
4. What does your significant other do?
5. How would you describe your ethnic background (Euro, AfAm, Hispanic, Asian, Nat Am, ...)?
6. What is the highest education level you have completed?
   High school, College, etc.
7. What range comes closest to your total family income? (indicate range)
8. How many people are in your household?
9. Do you have health insurance? What does it cover—yearly exams, prescriptions?

Reproductive History

10. How many times have you been pregnant?
11. How many children do you have?
12. How old are they? What sex?
13. Do any of them still live at home?
14. Have you ever had a miscarriage?
15. Do you now or have you ever used contraceptives? What did you use? For how long?
16. How old were you when you got your first period?
17. Are you still having periods? How often? Still the same as they have always been (freq, duration, quality)
18. If you’re no longer having periods, when did they stop? What age?
19. Have you had a hysterectomy, when?
20. So, do you think you have been through menopause yet? Why, why not?
21. How did you first know that you were at menopause? When was that?
22. Do you use any specific word besides “menopause” to refer to the time when your periods stop?
23. What age do you think most women have menopause?
24. What do you think makes your periods stop at menopause?
25. I’m going to read a list of some things you may have experienced in the last couple of weeks. Tell me if you’ve experienced: (Leidy 1997)

Dizziness Persistent cough
Lack of energy Feeling blue/depressed
Diarrhea/constipation Backaches

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<td>Upset stomach</td>
<td>Difficulty concentrating</td>
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<td>Headaches</td>
<td>Nervous tension</td>
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<tr>
<td>Cold sweats</td>
<td>Rapid heartbeat</td>
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<td>Aches/stiff joints</td>
<td>Vaginal dryness</td>
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<td>Shortness of breath</td>
<td>Urinary tract/bladder infection</td>
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<td>Hot flashes/flushes</td>
<td>Memory loss</td>
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<td>Sore throat</td>
<td>Pins &amp; needles in hands/feet</td>
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<td>Trouble sleeping</td>
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<td>Loss of appetite</td>
<td>Breast Tenderness</td>
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<td>Menstrual problems</td>
<td>Irregular Periods</td>
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<td>Fluid/water retention</td>
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26. Just now you said you had experienced _____. Do you think it might be related to menopause? How do you think it is related to menopause?

27. In general, is menopause a positive or negative experience for you?

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**General Questions**

28. Thinking back to when you were growing up, did anyone (mother, sister, friend, aunt, etc.) tell you about getting your periods/menstruation to prepare you for it?

29. Did you/would you discuss this with your own daughter? How old was she then?

30. Briefly describe your typical experience of menstruation – how many days long, cramps, "PMS", did you know when it was coming or did it sneak up on you, etc.

31. Has it always been the same or did it change after you had a baby, or maybe it was one way in your teens and another way in your 30s, for example?

32. How about the time when your periods stop. Did anyone tell you what to expect about it?

33. What did you know about menopause from your mother or her friends, other female relatives, or your own friends?

34. If a younger woman asked you about menopause, how would you explain it to her? Did you/would you discuss this with your own daughter?

35. Do you and other women ever talk about sex or your periods or menopause? What types of things do you talk about?

36. Has your menopause impacted your relationship with your husband/companion? How (changed expectations, femininity, less/more enjoyment of sex, )?

37. In general, are you happy with your family's size and the number of children you have?
   If you have reached menopause do you wish you could still have children?

38. How do you feel about getting older? Do you have particular concerns or wishes?

39. Is life easier for young women or older women? Why?

40. What sources do you turn to for menopause and other health related issues? (friend, doctor, reading materials, WWW, TV, mother/sister)
   Do you read any health related magazines or women’s magazines? Which ones?
   Have you read any books about menopause or women’s health?
41. I’m going to read some statements about menopause. Tell me how much you agree or disagree with each one on a scale of 1 to 10. 1 is for “strongly disagree” and 10 means you “strongly agree”. (Woods & Mitchell 1999)

1 strongly disagree

Menopause is the end of having periods

2 Menopause marks the end of reproduction

3 Menopause is a medical problem

4 Menopause is a time of hormonal change

5 neither

Menopause brings positive changes to a woman’s life
Menopause is a very emotional time for women

6/ agree/disagree Menopause is a disease that you need to see a doctor for

7 Menopause leads to a lot of changes in my body

8 Menopause is a sign of aging

9 After menopause a woman has an increased risk for disease

10 strongly agree

About medicines, health practices

42. How would you rate your overall health today? Poor, fair, good, very good, excellent

43. Do you currently have any health problems?

44. Do you go to the doctor for yearly gynecological exams? Yearly physicals?

If you have gyno exams are they done by a gynecologist, an internist, a nurse (practitioner)?
Is doctor/provider male or female?

45. Do you talk to a doctor or other health care provider about health topics? Like what? (menopause, healthy eating/diet, exercise, heart disease, mental health, etc.)

46. Do you feel like you could ask the same questions to a male and female health care provider?

So, if you were given a choice would you prefer to discuss menopause and female problems with a female nurse, a male nurse, a male doctor, or female doctor? How come?

47. Do you take any hormones (Hormone replacement therapy, estrogen, etc.) for menopause?

48. Did your doc give you any choice about taking HRT?

49. Are you satisfied with your doctor’s explanation of the risks/benefits of HRT?

50. What other types of medications do you take and why? (including prescription—Pill, heart meds, etc.—OTC, vitamins—Calcium, D—alternatives, etc.)

51. Have you used something other than a prescription drug for menopause (e.g., OTC drugs, home remedies, natural products: yam, soy, menopause/older woman vitamin formulas)?

52. Do you take part in any activities to improve your health?

- Exercise (how often, what)?
- Take vitamins
- Watch what you eat?
- Have you ever smoked? Quit smoking?
- How much alcohol do you drink per week?
- Pap test (frequency)?
- Mammogram (frequency)?

53. HRT knowledge: Do you know of any side effects connected with HRT use?
54. As far as you know, does HRT help with: osteoporosis, CVD, emotions/psychol?
55. What menopause symptoms do you take medicine for? What symptom, what medicine?
56. If you take HRT, do you notice any changes in how you feel today? – physical, emotional, etc.
57. Do you have any worries about using HRT?
58. (For past or current HRT user) how long have (did) you taken it? If you stopped, why?

Healh Knowledge

59. I’m going to name several diseases. Tell me which ones, if any, women your age are more likely to get than younger women.

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<thead>
<tr>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
</tr>
<tr>
<td>Lung cancer</td>
</tr>
<tr>
<td>Heart disease</td>
</tr>
<tr>
<td>Broken bones</td>
</tr>
<tr>
<td>Cancer of the uterus/womb</td>
</tr>
<tr>
<td>High blood pressure</td>
</tr>
<tr>
<td>Cervical cancer</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>Arthritis</td>
</tr>
<tr>
<td>Acne</td>
</tr>
<tr>
<td>Bladder problems</td>
</tr>
<tr>
<td>Heart attack</td>
</tr>
<tr>
<td>Osteoporosis</td>
</tr>
</tbody>
</table>

60. Does your doctor/health care provider talk to you about heart disease and have you watch your cholesterol and fat?
61. Do other members of your family have cholesterol or heart problems?
62. Does doc talk to you about osteoporosis? How about exercise, calcium?
63. Do you and your doctor talk about cancer risks (breast esp.) as you get older?
64. I’m going to read a list of things and I want you to tell me if you think they are related to menopause. (Clinkingbeard 1999)

<table>
<thead>
<tr>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
</tr>
<tr>
<td>Fatigue/tiredness</td>
</tr>
<tr>
<td>Blood clots</td>
</tr>
<tr>
<td>Head aches</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Back ache</td>
</tr>
<tr>
<td>Vaginal dryness</td>
</tr>
<tr>
<td>Dry skin</td>
</tr>
<tr>
<td>Urinary problems</td>
</tr>
<tr>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Problems seeing</td>
</tr>
<tr>
<td>Low sex drive</td>
</tr>
<tr>
<td>Memory loss</td>
</tr>
<tr>
<td>Breast cancer</td>
</tr>
<tr>
<td>Tingling skin</td>
</tr>
<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Joint pain</td>
</tr>
<tr>
<td>Common Symptom</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Hot flashes</td>
</tr>
<tr>
<td>Heart disease</td>
</tr>
<tr>
<td>Strokes</td>
</tr>
<tr>
<td>Night sweats</td>
</tr>
<tr>
<td>Wrinkled skin</td>
</tr>
</tbody>
</table>

65. In general, what do you think of when you hear the word “menopause?” How does this compare to your own experience with it?

66. What word or phrase would you use to describe your menopause?

67. Do you wish you had more information about menopause—what to expect, how to treat symptoms—before it happened?
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