PHYSIOLOGICAL AND PSYCHOLOGICAL SYMPTOMS ASSOCIATED WITH MENOPAUSE

by

Julia A. Engram

A Master’s Research Project submitted in partial fulfillment of the requirements for the degree

Master of Arts

LIBRARY - OTTAWA UNIVERSITY
OTTAWA, KANS.

OTTAWA UNIVERSITY

February 1998
PHYSIOLOGICAL AND PSYCHOLOGICAL SYMPTOMS ASSOCIATED WITH MENOPAUSE

by

Julia A. Engram

has been approved

January 1998

APPROVED:

[Signature]

[Signature]

ACCEPTED:

[Signature]

Associate Dean for Graduate Studies
ABSTRACT

The purpose of this study was to identify the physical and psychological symptoms associated with menopause. The literature reviewed included an examination of the definitions of menopause, psychological symptoms, menopause and depression, and cross-cultural implications of menopause.

In this study, 51 women responded to a forty-one item questionnaire designed to measure physiological and psychological symptoms of menopause along with barriers and side effects of menopause and hormone replacement therapy. The findings indicated that the most frequently reported psychological symptoms related to menopause were irritability, anxiety and depression. The majority of the women also agreed that HRT improved the quality of their life.
ACKNOWLEDGMENTS

I would like to express my love and appreciation to my family for their encouragement during the development of the study. I especially want to thank Sam Sr., Kim and Toni for their tolerance, patience, assistance and for believing in me. My special thanks to Germaine. A special thanks to Tom Roche for his patience.
TABLE OF FIGURES

Figure 1 - Survey Data .................................................. 40
Figure 2 - Frequency of HRT Responses ......................... 41
CHAPTER 1

THE PROBLEM

Introduction

Women of all cultures and ethnic backgrounds experience menopause; the symptoms may vary but the end result is the same when the life cycle of a woman begins to change. As the life cycle changes, the estrogen level diminishes and hormonal changes occur. Some women develop symptoms in their late thirties, while the norm is approximately forty-five. This phase can last for as long as 15 years. Per Teaff and Wiley (1995), the typical length is six years.

The onset of menopause is a significant time in a woman’s life, because it often correlates with life changing patterns. It forces women to notice the changes in her body image, behavior and attitudes. This is often called mid-life crisis, and for many women it is a crisis. The end of this phase is menopause. Clark Gillespie, M.D. (1989) indicates that menstruation may cease when a woman is anywhere between forty-five and fifty-one years of age. Women get very emotional during this time of life and have psychological symptoms like depression, anxiety, mood swings and irritability.

Depression is one of the most significant symptoms of menopause and could possibly be at the root of the misconception that menopause and mental illness are synonymous terms. Scientist and medical experts have tried to determine if there is a correlation between menopause and depression. Teaff and Wiley (1995) report that many women experience mood swings and sixty-five percent of the women attending
menopause clinics report feelings of mild depression. Menopause and depression are synonymous symptoms for millions of women, and therefore termed menopausal depression.

Menopausal depression produces physiological effects like anxiety, fatigue, irritability, headaches, tension and lack of concentration. While most women in their fifties no longer wish to bear children, the knowledge that she is no longer capable of reproduction may be painful. In addition to grieving for the loss of her fertility, a woman may also feel that she is losing her sexual attractiveness.

According to Sheehy (1991, p.35), doctors are still in the dark ages on the subject of menopause. Lamentably, few doctors are well informed. Many assume that the vaguely described symptoms are psychological in nature. In the past, women’s wisdom was ignored, not only by doctor’s, but overall. Women’s knowledge of their body is dismissed as “neurotic, hypochondriacal, hysterical.” However, the old perspective is changing because of advances in medical and scientific knowledge. Women are also more informed and are asking questions.

Vliet (1995) surmised that women suffer in silence, along with their fears: “Am I crazy?” I know something is different with my body, but the doctors keep telling me there is nothing wrong. Women doctors are not necessarily more understanding just because they are women. They have been taught the same negative stereotypes of female patients as male doctors. All physicians have been taught the same flawed system of education, that does not hear women’s voices, do not adequately address women’s body differences, or value women’s insights and experiences.
Greer (1991) states that, many women have given up complaining because of the prevailing response, which infers that they really should get on with it and stop feeling sorry for themselves. Scientist and physicians, male and female who have studied menopause as a career cannot agree upon the psychological content and its effects on the emotions of women. Whether or not depression may be associated with menopause has been the subject of intense debate. This may be due to the looseness of the terminology and perhaps the subjective fears on the part of some researchers. Menopause and depression, for millions of women, go hand in hand.

Is menopausal depression a fact or myth? The problem of menopausal depression and other psychological symptoms like anxiety, fatigue, irritability, headaches, tension and lack of concentration have been a source of mystery to millions of women. Survival during menopause is difficult for some women because of the ongoing problems that accompany this event in a woman’s life. Doctors sometimes feel frustrated when there is no rational explanation for the migraine headaches or the unexplained fatigue of a 38 year-old woman. They do not always have an answer and do not conceive that the symptoms could be pre-menopausal. Sheehy (1991, p.70) noted that The Massachusetts Women’s Health Study reported in a 1986 Harvard Medical School Publication that “depression” in middle-age woman is mainly associated with events and circumstances unrelated to hormonal changes that occur during menopause. The children grow-up and move out or go off to college, divorce, career changes and often the care of elderly parents can be traumatic for women. These all have a significant impact on the emotions of women and the onset of menopause and biological changes compound the problem.
Development of the Problem

Clinical depression is twice as common in women as in men. This is probably the root of the myth that menopause and depression are synonymous (Teaff and Wiley, 1995). Depression and mood swings can be related to a woman’s expectations about aging and the fact that American society focuses on youth and body image. There are women who equate their self-worth with physical attractiveness. Many women believe that forty is over the hill and the onset of menopause is devastating. It is possible that the depression and mood swings can be tied to a woman’s expectation about aging. Is it hormonal, or could the depression and mood swings be related to changes in hormone levels or the menopause? Cooper (1995) states that menopause often produces troubling problems for women, such as depression, mood swings, hot flashes, night sweats, headaches, dry skin, insomnia, excessive vaginal dryness, shrinkage of genital tissue, and urinary incontinence. It also increases a women’s risk of heart disease, osteoporosis and diminishes the sex drive.

According to the Diagnostic Statistical Manuel, DSM IV (American Psychiatric Association, 1994) the emotional symptoms like depression can be described as an affective disorder. The first type is characterized by alternating periods of mania and depression; a condition called bipolar affective disorder. There are two major types of affective disorder. The first is characterized by alternating periods of mania and depression; a condition called bipolar affective disorder. This disorder effects men and women in approximately equal numbers.

Episodes of mania can last a few days or a few months, they usually take a few weeks to run their course. The episodes of depression that follows generally last three
times as long as the mania. The second is called unipolar depression or depression without mania. This depression may be continuous and unremitting or more typically come in episodes.

Unipolar depression strikes women two to three times more often then it does men and is common in menopausal women. Approximately sixty to eighty percent of women experience mild to moderate emotional symptoms during their thirties and forties. How serious are such symptoms? They are usually not serious enough to cause significant disruption in home, work and social relationships and functions. Another fifteen to twenty percent of women, however experience marked luteal phase symptoms, which are severe enough to disrupt optimal functioning at home and work, and is a significant source of distress for the individual woman (Vliet, 1995, p.129).

Several recent studies have shown that these brain-mediated symptoms are actually more numerous during the perimenopause (ages’ forty to Forty-nine years) than after menopause (Vliet, 1995, p 129). When articles say “there is no evidence that women become more depressed at menopause,” they are missing the important time frame in which to look for these mood changes, as well as to look for major depression. Considering the existing studies that have asked this question, and included women in their late thirties and early forties, such distressing symptoms are extremely common and do appear to correlate both with declining hormone levels and with widely fluctuating hormone levels. Many women know or suspect this connection (Vliet, 1995).

Need for the Study

It has been observed in world wide studies that both depressive syndromes and anxiety disorders are two to three times more common in women than in men. The cause
of mood changes that occur during the onset of menopause has been debated in journals and in the media for years. Does the onset of menopause effect the emotional problems experienced by women when their bodies are under going biological changes? There is evidence of a link between hormonal changes and psychological problems like mood swings, depression and other emotional problems? Each woman with depression experiences it a little differently. Clinicians must look at each case differently because of the woman’s age, cultural, psychological background and socioeconomic background. It is important for counselors to understand that female clients experiencing depression or anxiety could possibly be having hormonal changes due to menopause or the onset of menopause. Families should have some education on the subject, so they can better understand why a spouse, mother or another female family member is suddenly different. Persons need to understand what women or the woman in their life is experiencing during the onset of menopause.

Depression is a psychosis and should be taken seriously. Depressed people are always at risk for suicide. Because depression is more common in women, the implication is that a hormonal factor, which has not been addressed is an important connection with a women’s health. If there is a link between the onset of menopause and depression, clinicians need to be knowledgeable. There are many unanswered questions, is it the hormones or a combination of life stresses? Women often fear what these changes in their bodies mean, and need to understand the effects of menopause and the impact hormonal changes may have on their bodies. It is therefore extremely important that persons be
cognizant about menopause so that proper health decisions can be made to assure an optimum quality of life in later years.

**Purpose of the Study**

The purpose of the study was to identify the physical and psychological symptoms associated with menopause.

**Research Question**

What are the psychological and physical symptoms associated with menopause?

**Definition of Terms**

**Climacteric**: This term includes all the emotional and physical changes that take place as ovarian function diminishes but does not necessarily include the physical cessation of menstrual periods. Thus, the climacteric embraces such symptoms as flushes, night sweats, insomnia, emotional instability, depression, fatigue, forgetfulness, palpitations (Gillespie, 1989, p. 3).

**Depression**: Depression is a whole body illness, involving changes in body chemistry that cause a variety of symptoms. Depression effects not just your emotions, but also your physical health and the way you think and behave. One of the reasons that depression so often goes undiagnosed is that some people remain unaware that their problems could be related to a mood disorder.

Psychoneurotic or psychotic disorder marked by sadness, inactivity, difficulty in thinking and concentration, and feelings of dejection (Ferber and Le Vert, 1997, p. 9).

**Estradiol**: The primary and most potent estrogen produced by the ovaries before menopause. It is the biologically active estrogen receptors and is involved in over 400 functions of the body (Vliet, 1995, p. 474).

**Estrogen**: Three types of female sex hormone secreted by the ovaries during the reproductive years and are responsible for the female characteristics of breasts, feminine curves and menstruation (Vliet, 1995, p. 474).
Hormone: Chemicals produced by various glands that are transported around the body to exert multiple metabolic effects (Vliet, 1995, p. 474).

HRT: (Hormone replacement therapy): Technically, the administration of any hormonal preparations (natural or synthetic) to replace the loss of natural hormones produced by various glands (thyroid, ovary, testes, etc.). HRT in common usage now refers to estrogen and progestin after menopause (Vliet, 1995, p. 474).


Menstruation: Monthly bleeding from the vagina in women from puberty until menopause, caused by shedding of the lining of the womb if there is no fertilization of an egg (Vliet, 1995, p. 477).

Osteoporosis: A condition characterized by the decreased by in bone mass that results in frailty of the bones. When calcium leaves bone for whatever reason, the bone becomes weakened and osteoporosis exists. There are many causes of osteoporosis, simple aging being one of them. The loss of estrogen at the menopause, is by far the commonest and most serious cause of osteoporosis. Without estrogen calcium leaves the bone at a very rapid rate (Gillespie, 1989, p. 191).

Perimenopause: The several rears subsequent to menopause when the menstrual periods and continuing through menopause to the first few years just after periods stop. It has a variable age of onset and is commonly accomplished by bone loss, cholesterol changes, sleep changes, hot flashes, and other phenomena (Vliet, 1995, p. 479).

Postmenopausal: The years following the end of menstruation and decline in production of ovarian female hormones (Vliet, 1995, p. 480).
CHAPTER 2

LITERATURE REVIEW

Introduction

The literature reviewed in this chapter includes an examination of the definitions of menopause, psychological symptoms, menopause and depression, cross cultural implications of menopause and the use of hormone replacement therapy to treat menopausal symptoms.

Menopause Defined

"For a long time we have thought of menopause as a very sudden event, it really is not," say Dr. Trudy Bush, epidemiologist and associate professor of Obstetrics and gynecology at Johns Hopkins Medical School. The ovaries start producing less estrogen probably in the mid-thirties. There is a gradual loss of estrogen production and other hormones until the ovaries stop putting out very much estrogen at all. It is not uncommon to see symptoms in the very early forties as a sign of gradual estrogen withdrawal (Sheehy, 1991, p.17).

Going, through menopause is like hitting the big time. All of a sudden you feel as you are in the major leagues. You are finally an adult and no one mistakes you for an over grown 20-year old. Although you may not be able to see the light at the end of the tunnel, you certainly know what is there. By middle age, you and the world no who you are, your previous accomplishments, friendships, family relationships, all speak for you. Now that you have arrived, you may find yourself in a strange state of limbo wondering just where you are: "If this is middle age, how do I fit in" (Cone, 1930, p.343)?
Menopause is a milestone marking a woman’s last menstrual period and the transition from the reproductive to the non-reproductive time of life. For some women it is a smooth transition; for others it creates both physiological and psychological discomforts (Utian and Jacobowitz, 1990, p. 22).

Climacteric is completely unrelated to any form of sexual arousal, this word describes the entire rite of passage beginning with perimenopause and including post menopause. Climacteric is a term used primarily by the medical community to refer succinctly to the complete menopause time span and the accompanying endocrine, somatic (body), and psychic changes (Cone, 1993, p.23).

The general public did not begin to discuss the climacteric until after it had been captured by the medical profession and defined as a syndrome, by which time it was too late to render it respectable. The medical notion of “menopause” was the brainchild of C. P. L. de Gardanne, who described a syndrome he called “la Menopause” in Avis aux femmes qui entrent dans l’age critique, published in 1816. “Menopause” was not defined until 1899, in an article on “Epochal Insanity’s” contributed by Dr. Clouston to A System of Medicine by Many Writers, edited by Professor T. C. Allbutt, under the heading “Climacteric Insanity.” By describing a set of symptoms, and identifying it as a syndrome with a dramatic name, the medical establishment was empowered to treat the “critical phase,” de Gardanne’s “age critique,” as a complaint in which their intervention was to be sought, rather than as an important process in female development with which women themselves would have to deal (Greer, 1991 p.23). To be precise, the word “menopause” applies to a non-event, the menstrual period that does not happen. It is the invisible
Rubicon that a woman cannot know she is crossing until she has crossed it. Insistence on an inappropriate idea of a kind of invisible leap leads to some utterly mystifying data on “age at menopause.” Women are asked, some many years later, when they “went through menopause.” It would make more sense to ask them when they had their last bleed, which might with reason be dated to a month and a year (Greer, 1991, p. 23).

According to E. Bonner in the American Cyclopaedia of Obstetrics and Gynecology, 1887, stated that the climacteric, or so called change of life in women, presents, without question, one of the most interesting subjects offered to the physician, and especially to the gynecologists, in the practice of his profession. The phenomena of this period are so various and changeable, he must certainly have had wide experience who has observed and learned to estimate them all. So ill-defined are the boundaries between the physiological and the pathological in this field of study, that it is highly desirable in the interests of our patients of the other sex, that the greatest possible light should be thrown upon this question (Greer, 1991, p. 244).

Menopause is arbitrarily defined as “the final cessation of menstruation,” as if it were a single point in time when the switch is turned off on those fabulous egg ripening machines, the ovaries (Sheehy, 1991, p.8).

Menopause, few people can agree upon what it actually is. MPX is a medical abbreviation for “menopause.” The word was coined by a Frenchman from Greek words meaning, roughly, end of monthlies. In modern usage it has become synonymous with all the events that take place as the ovaries cease to function (Gilliespie, 1989, p. 3).
Emotional and Psychological Symptoms of Menopause

Here is a list of the most common emotional symptoms found in the menopause: depression, irritability, anxiety, insomnia, tension, antisocial behavior, headaches, inability to concentrate, loss of sex drive, nervousness, aggressiveness (Gillespie, 1989, p. 42).

It is important to set the record straight right from the start. Menopause does not cause depression. Nor does it turn you into a crazy person. Studies show that women who have recently gone through menopause did not have higher levels of depression, anxiety, or stress than persons of the same age who were still menstruating. We have come a long way from the days when menopause was believed to cause insanity (Cone, 1993, p. 64).

Nevertheless, menopause does bring on definite chemical changes in a woman’s body. Some may result in a more heightened premenstrual syndrome, for a week or so each month. Mood swings that occur subsequently are not a fabrication, and it is difficult for many women to control them. Furthermore, menopause happens at about the same time women experience a myriad of other changes mentioned earlier. If you combine all these factors, you are bound to see a deviation from a woman’s normal emotional profile (Cone, 1993).

Scientists and physicians, both male and female, who have studied menopause professionally, cannot agree upon the psychological content of the menopause and, in many cases, simply state their own convictions. Gynecologists have just now begrudgingly added emotional problems to their lexicon of menopausal symptoms (Gillespie, 1989, p. 41).
Although menopause that occurs at the average age of fifty-one does not cause depression in most women, it does set up certain vulnerabilities, both biological and psychological. The signs of aging are now more certain. The truth, for most of us is the transition between young and old can occur in the blink of an eye. It can happen when your last parent dies and you realize you are head of the family or your child having a child marks the turning point. Whenever it happens, it may set off a chain reaction of fear, anxiety and depression (Ferber and LeVert, 1997, p. 97).

Women are two to three times more likely than men to develop major depression, dysthymia and seasonal affective disorder. According to the Diagnostic and statistical Manual of Mental Disorders (DSM-IV), the manual of the American Psychiatric Association, a woman’s lifetime risk for major depression ranges from 10 to 25 percent, compared with 5 to 12 percent for men (Ferber and LeVert, 1997, p. 17).

There may be many signs and symptoms associated with menopause, but in well balanced, educated, contented woman who finds her family, sexual and professional life fulfilling, there may be no symptoms whatever so ever (Greer, 1991, p. 17).

In 1880 A. Arnold, Professor of Clinical Medicine and of the Disease of the Nervous System in the College of Physicians and surgeons in Baltimore, contend that all the recent studies of menopause reported no pathology associated with it. In 1897, Andrew Currier called the negative view of menopause a “hoary” tradition with no basis in fact. In 1900, Dr. Mary Dixon Jones writing in the Medical Record angrily called the notion of menopause as a “dangerous period” a libel on the natural formation of one half of the human race. In 1902, writing in the Transactions of the Tennessee State Medical
Association, M. C. McGannon wrote with regard to menopause that “it is in no sense a critical period” (Greer, 1991, p. 70).

The psychological symptoms would be better described as behavioral symptoms. Irritability, nervousness, feeling blue or depressed, forgetfulness, excitability, insomnia, inability to concentrate, tearfulness, feelings of suffocation, concern about health, panic attacks, mental imbalance, fear of nervous breakdown or insanity have all been reported by women complaining of climacteric distress (Greer, 1991, p. 95).

According to Evans, (cited in Greer, 1991), the menopause does not appear to give rise to a specific pattern of psychological symptoms. In relation to the general increase with age of psychiatric illness in women, the fact of the menopause is relatively small, in spite of some conflicting reports. Admissions to mental hospitals increase with age in both sexes, but more steeply in women, with a peak in the climacteric age group. However, there is no evidence that the menopause induces psychiatric illness or psychological changes apart from adding to the stress upon a woman already predisposed to anxiety and depression.

Dr, Sarrel of Yale said in 1989 that, “estrogen addition over a six-month period appeared to relieve sleep disturbance most significantly, and resulted in a marked improvement in all categories of menopausal symptoms in 40 percent of women.” He went on to say that it was “of concern that women don’t realize how much their quality of life may be improved with proper estrogen therapy and that only 15 percent of all menopausal women received hormone therapy at all. Many women simply do not seek
medical help, even though hormonal therapy may be a benefit to them” (Vliet, 1995, p. 79).

Ovarian hormones also have been found to have effects on several other mood-altering neuropeptides: endorphins (“morphine within” pain reducing chemicals), oxytocin, vasopressin, and prolactin, which are involved in modulating memory, motor coordination, and a variety of behaviors. Recent studies have demonstrated a decrease in some serotonin measures (either plasma-free tryptophan or platelet serotonin) in the menopausal and perimenopausal years that correlates with the age of peak suicide rate for women (a comparable peak has not been seen in men). Recent studies have found that brain levels of 5-hydroxyindoleacetic acid (5-HIAA), a serotonin breakdown product, are lower among patients who have attempted or completed suicide. If 5-HIAA is low, it indicates that brain serotonin levels are also low (Vliet, 1995, p.16).

The much publicized Massachusetts Women’s Health Study reported that in a 1986 Harvard Medical School publication that “depression in middle-aged women is associated mainly with events and circumstances unrelated to the hormonal changes that occur at menopause” (Sheehy, 1991, p. 70).

A majority of men, married to women in the transition, focused on the emotional impact on their spouses, saying they manifested anxiety, irritability and mood swings. Fewer than half the men took any notice of physical problems that underlay these emotional reactions, despite the fact that the overwhelming majority of the women in menopause reported struggling with hot flashes, night sweats, and difficulty sleeping (Sheehy, 1991, p. 91).
Up to 80 percent of menopausal women in a self-report study described feeling nervous and irritability. In fact, estrogen does improve mood and the sense of psychological well-being even in well-adjusted women who have no distressing menopausal symptoms, according to a brand new study done by Dr. Edward Ditkoff at the University of Southern California School of Medicine (Sheehy, 1991, p. 72).

Dr. Susan Ballinger in Australia found a greater incidence of psychological symptoms in women aged 45 to 49, when estrogen is decreasing most rapidly, compared with both younger and older women. While the changes are occurring, some women tell me they feel as they are on a roller coaster emotional ride. Most of us do not like to feel so out of control and unable to explain what is happening to us (Vliet, 1995, p. 81).

The withdrawal of endorphins produces effects similar to withdrawal from morphine: irritability, tearfulness, anxiety, stomach upset, diarrhea, and sweating. I think it is reasonable to think that declining levels and thereby play a contributing, if not a causative, role in the onset of the anxiety, depressive and pain symptoms described by women in these phases (Vliet, 1995, p. 82).

This reduction in the amount of active testosterone at the brain has the result of further decreasing sexual interest (libido), particularly if estrogen levels are also low. In addition, both estradiol and testosterone have mood-elevating effects, so when progesterone diminishes the binding of estradiol and testosterone at brain receptors, it’s not surprising that you may notice your mood is grumpy, irritable, tearful, and depressed (Vliet, 1995, p. 88).
At the North American Menopause Society meeting, Susan Ballinger, Ph.D., of Sydney, Australia, reported on their study addressing connections between women’s perception of the presence of life stress and levels of their ovarian estrogen’s. Ballinger’s study assessed life events, clinical depression, and anxiety, together with measurements of urinary and plasma estrogens. This study demonstrated that a high level of urinary estrogens correlated with higher psychosocial stress scores. Her conclusion was that “psychosocial stress, emotional vulnerability, and coping skills may all contribute to estrogen deficiency in post menopause (Vliet, 1995, p. 149).

Although vasomotor and atrophic symptoms are widely recognized as being true symptoms of the menopause Utian (1972), considerable controversy has surrounded the etiology of other accompanying complaints. Opinions have varied widely and are seen as reflecting the discipline of the investigator. Thus, while gynecologists have concentrated on determining which symptoms can truly be attributed to an estrogen-deficient state amenable to hormone replacement therapy, social scientists have maintained that the symptomatology of mid-life is affected more by the expectations of a particular sociocultural tradition or by other factors such as life stress. More recently, a common interdisciplinary meeting ground seems to have been found, with the recognition of the interactive effects of endocrine changes with sociocultural and psychological factors. (Morse and Dennerstein, 1989, p.179)

Population studies of women have been conducted to examine the relationship of psychological symptoms to chronological age and menopausal status. A number of studies have reported evidence that many psychological changes (e.g., nervousness,
irritability, headache, depression, and decreased social adaptation) occur with greater frequency in women whose menstrual cycles has recently changed (Dennerstein and Burrows, 1978). More recent studies have confirmed these results. Bungay, et al. (1980), using a questionnaire mailer, studied a representative sample of the population of Oxford, England. In this study, the menopausal status of the subjects was not hormonally assessed. The authors assumed a mean age at menopause. Symptoms of reduced self-confidence, difficulty in making decisions, anxiety, forgetfulness, difficulty in concentration, feelings of unworthiness, tiredness, dizzy spells, low backache, and aching breasts all increased in the fifth decade and peaked in the years just prior to age 50. These symptoms had a high prevalence from the ages of 30 through 50 and then began to decline (Morse and Dennerstein, 1989, p.80-81)

Various theories have been proposed to explain the psychological symptoms occurring during the climacteric. The biologic perspective on these symptoms ascribes them to declining ovarian function. The symptoms may reflect changes in the brain—and in particular, in hypothalamic function—with changing steroidal levels. The endocrine changes responsible for the symptoms may arise from reduced levels of estrogen’s, progesterone, or both, or increased levels of follicle stimulation hormone (FSH) and luteinizing hormone (LH). An alternative view is that the symptoms may reflect an imbalance elsewhere in the hypothalamic-pituitary-gonadal axis. There is growing evidence that amine metabolism may be effected by levels of endogenous and exogenous steroid hormones. Thus, altered amine metabolism may be responsible for the affective changes experienced during the climacteric. Psychological symptoms occurring during
this period are sometimes claimed to be secondary manifestations of disabling vasomotor symptoms (hot flushes and sweating) and, under these circumstances, are explained by a "domino theory." Thus, if the flushes cause the victim to stay awake, and the night sweats disturb her sleep by forcing her to change the bed linens or to shower, she will report insomnia and fatigue, which may result in irritability and nervousness (Van Keep, 1983; Morse and Dennerstein, 1989, p.182).

A Swedish study by Collins and et al. (1983) explored the relationship between personality variables and psychological symptoms at menopause. They found significant correlations with anxiety proneness, external locus of control, and feminine interest but neither vasomotor nor sleep changes were associated with personality characteristics. Van Keep and Prill (1975) proposed that previous coping styles, in conjunction with underlying personality factors, may determine individual reactions to the cessation of menses and to hormonal changes during the menopause. This means that certain women can be regarded "psychologically vulnerable" and may be predisposed to respond adversely to a variety of typical hormonal fluctuations. There are many similarities in the symptom occurring during the monthly menstrual period, postpartum, and in the climacteric. Longitudinal research studies of these women would reveal whether consistent vulnerability plays an enduring and central role in these symptoms (Morse and Dennerstein, 1989, p.188).

In addition to case histories of mood and behavioral symptoms occurring during the menopause, observers also identified a distinctive mood syndrome in association with menopause. In a review of the cases of climacteric related mental illness at Bethlehem Hospital between 1888 and 1893, Savage (1893-1894) argued that the plethora of
menopausal symptoms, including emotional symptoms, could be sufficiently exaggerated so as to become abnormal. Observers reported a particular form of melancholia as: “profound with vague delusions of an extreme character, that the world is in flames, that it is turned upside down, that everything is changed, or that some very dreadful but undefined calamity has happened or is about to happen. In some cases transient paroxysms of excitement break the melancholic gloom” (Schmidt and Rubinow, 1989, p. 194).

Despite similar point prevalence rates and similar clinical presentations of depression during the menopause and at other times of life, one cannot conclude that these syndromes share identical etiologies. Brown and colleagues (1984) reported involutional onset depression to be associated with a lower family history of depression than early onset depression. Further, in the earlier mentioned 1979 study by Weissman, 47% of the menopausal and 65% of the postmenopausal (as defined by age) depressed women had no subsequent history of depression. Thus, although menopausal depressions cannot be distinguished on the basis of clinical presentation, they may well differ from earlier onset depressions with respect to family history and age of index depressive episode. It is not unusual in medicine for phenomenologically similar disorders to have different precipitants or causes; for example, meningitis in both the neonate and infant may present with fever, vomiting, and drowsiness, yet different pathogenic organisms are typically involved with each age group. Further, Rosenthal (cited in Schmidt and Rubinow, 1989, p. 195-196) has suggested that our inability to detect a menopausal mood syndrome may represent the combination of a low frequency of occurrence with an imprecise syndromal definition.
There is the old myth that menopause was the cause of mental illness in women. Today, in different studies, it has been determined that hormonal changes and the lack of estrogen, is the cause of the emotional upsets that occur in some women during the menopause. Hot flashes, irritability, mood swings, night sweats, and depression continue have some women asking the question, “why me.” It happens to every woman when she reaches that turning point in life. “Women are going to menopause clinics four or five years younger than in the past,” says Phyliss Kernoff Mansfield, a veteran researcher (Sheehy, 1991, p. 9).

**Cross Cultural Implications of Menopause**

People are living a lot longer and more women all over the world will have the experience. The subject of menopause has been taboo in this culture because of a lack of knowledge on the subject, the old myths and fear of aging. Today it continues to be a source of controversy.

Dr. Allison Galloway, an anthropologist at the University of California at Santa Cruz, stated that “menopause happens because through technology, we have extended our lives to the point where we run out of egg follicles, because persons are living longer.” That is a theory that will probably be debated by other scientists and physicians.

The change of life is experienced differently depending on the individuals cultural thoughts on aging and the role of older women in their particular society. In some societies the role of women is elevated, she has more say and her opinions are valued.

There have been a number of cross cultural studies that have examined the different menopausal experiences of women in non-industrialized societies. Flint (1979) studied the wealthy, well-nourished Indian women of the Rajput caste. These women
experienced limited symptoms and did not complain of depression or psychological symptoms of menopause. They anticipated the menopause because they were freed from veiled invisibility and at last are able to sit and joke with the men, reports' anthropologist Marcha Flint (cited in Sheehy, 1991, p.13)

Arabian women who similarly perceived the menopause positively like-wise reported few or no menopausal symptoms (Moaz, 173). The prospect of role loss due to the involution of reproductive capabilities is also handled well by Zulu women (Wilbush, 1982), who substitute “social” children for biological ones through surrogate “wombs.” In addition, they enjoy freedom from contamination of menstrual blood and liberation from being separated in menstrual huts. African women were sent to what is called the menstrual hut, because their culture believes the blood was dirty and would contaminate others. Once menopause occurred the women were no longer subjected to the hut. They also assume powerful roles as advisers and influence their husbands in the choice of younger wives. A study by A. Davis in 1982 of women in a Newfoundland fishing village showed that although many maintained a high status through mid-life, reports of hot flushes, tension headaches, anxiety, and fatigue were common (Urban and Schwarzenburg, 1988, p.186).

African-American women in general are more likely than white women to pass through menopause with no psychological problems. One possible reason is the dominance of grandmother in maintaining the extended black family; it is often granny who assumes a primary care role for offspring of her unmarried children (Sheehy, 1991, p.61).
Anthropologist Margaret Kock reports that 65 percent of Japanese women consider menopause uneventful. The Japanese language does not even have a word for hot flashes. (A report in The Lancet, however, describes “sinking spells” among Japanese women, rather like the swooning of Victorian women.) In China, where age is venerated, menopausal symptoms are rarely reported (Sheehy, 1991, p.59).

In America, youth and desirability go hand in hand, and the role for the older woman is uncertain at best. So although menopause in the United States is defined primarily in hormonal terms, cultural attitudes cast the signs and symptoms in a negative light (Sheehy, 1991, p.59). There is a stigma that a menopausal woman is old, and it is the attitudes of others that reinforces the stereotype about menopausal females. Gail Sheehy states that of the scanty research on menopause, almost none has reached beyond well-educated white women who live near academic centers or who have the means to consult doctors about health maintenance at this time of life. Shame, fear, misinformation and most of all, the stigma of aging in a youth-obsessed society-are the vague demons that have kept us silent about a passage that could not be more universal among females. The most common fears are: I will lose my looks, I will lose my sex appeal, I will be depressed, fade into the woodwork and I will be “old.” The word old is a stigma, and when menopause occurs some women feel devastated.

The median age at which women in Western countries stop ovulating altogether is 50.8. But today there are no clear age cues to when the long transition begins or when it ends. “For a long time we have thought of menopause as a very sudden event—it really is not,” say Dr. Trudy Bush, epidemiologist and associate professor of obstetrics and
gynecology at Johns Hopkins Medical School. "The ovaries start producing less estrogen probably in the mid thirties. There's a gradual loss of estrogen production and other hormones until the ovaries finally stop putting out very much estrogen at all. It's not uncommon to see symptoms in the early forties as a sign of gradual estrogen withdrawal" (Sheehy, 1991, p.9).

Increasingly, say veteran practitioners, the American women turning up in menopause clinics are younger by four or five years that in the recent past. Researchers now admit they have underestimated the number of younger women who experience all the symptoms of menopause even though they still have periods. "We know now there are women who start experiencing changes in their menstrual cycle in their late thirties," says Phyllis Kernoff Mansfield, a veteran researcher of female cycles at Penn State (Sheehy, 1991, p. 9).

So often women say, "I am waiting for my doctor to tell me what to do." Lamentably, few doctors are well informed about menopause, and many assume that the vaguely described symptoms are psychological in nature. Since physicians are temperamentally disposed to helping people, they, too, feel frustrated at the state of scientific ignorance about women's health in the middle years. "You do not need to know about that yet," is one standard answer women are given. The doctor pats her on the head, and out the door she goes with her migraine headaches, ill-defined blues, or unexplained fatigue-what could it be? More commonly, she will not even bring up menopause, and her gynecologist will not either. Some women spend the next three or
five years making the rounds of internists, neurologists, even psychiatrists, with no resolution, because they all ignore the obvious (Sheehy, 1991, p.71).

Menopause is not specific to certain women, it happens to professors, engineers, doctors, lawyers and house-wives. Women who are mentally prepared and secure have an easier time with the transition. They have different attitudes and views on menopause, and culturally there are differences. Dr. Trudy Bush, an epidemiologist, says “menopause is not a disease,” but a major life transition. The transition carries with it a different internal hormonal milieu (Sheehy, 1991 p. 23). Greer (1991) quoted the official view of the International Menopause Society in The Change. It states that menopause is a social construct, that illness is not the only response, that women need to know what a normal menopause is, whether their own is abnormal, and what doctors can do about alleviating their symptoms and that the approach to menopause is polarized between dismissing the menopausal woman and telling her to get on with it, and treating menopause itself as a deficiency disease, and finally that “new life-styles” that stress youth, fitness and active sexuality are leading to a new consciousness of the aging body.

Cross cultural studies of women and menopause reveals that change of life is experienced differently depending on one’s cultural assumptions about aging, femininity, and the societal role of older women (Sheehy, 1991, p.58).

The hot flash is an amazing and perplexing experience for the majority of menopausal women. The upper body heats up and breaks into a sweat, and the individuals pulse rate accelerates. It starts at the chest and goes up the body, and lasts for a few minutes. When the first one occurs, it is a total surprise.
Sociologist Pauline Bart studied anthropological accounts of the status of women in a large number of cultures. She found that the feminine role assumed by a woman in her fertile years was reversed in all cultures after menopause (Sheehy, 1991, p. 58).

Menopause and Depression

Defining depression is not easy, because depression effects people in different ways. It is a whole body illness, involving changes in body chemistry that cause a variety of symptoms. It remains a growing concern for women and men. Depressive illness is becoming more and more common. Social and economic changes over the past twenty years have left people more vulnerable to mood disorders like depression (Fieve, 1989). The disintegration of the family structure, the mores of the church, schools and government has changed.

Based on my research and clinical experience, more women become depressed than men due to a woman’s physiology and hormonal changes. Depression effects the emotions and the physical condition. Depression sometimes goes undiagnosed because people do not relate the symptoms to a mood disorder. There are three types of depression: major depression, dysthymia, and bipolar disorder (Fieve, 1989, p 18).

Major depression significantly changes behavior and health. It affects a person’s day to day living skills. Major depression can often result in a psychiatric hospitalization. The hospitalizations can be long term if the condition is severe.

Dysthymia can have milder symptoms but can be longer lasting and chronic.

Bipolar disorder involves periods of mania followed by periods of depression. Individuals experiencing mania have a lot of energy, go on shopping sprees, often become hypersexual and cycle in their mental illness, resulting in recurring psychiatric
hospitalizations. Bipolar disorder is the most serious of the depressive disorders (Fieve, 1989, p. 18).

Depressed people may sleep a lot, isolate themselves, have somatic symptoms and often experience a lack of energy (Fieve, 1989, p.19). Depressed women complain of crying for no reason, irritability, anxiety, change of eating habits, sadness and fatigue. Depression interferes with the person’s inability to think clearly. Depressed women complain of the ability to concentrate (Fieve, 1989).

It is true that clinical depression subsides in women over fifty, and irritability and depression in middle-age women do have many other sources. Mood changes are frequently mentioned by women in the perimenopause phase, and they are often told there is no hormonal basis for feeling depressed? (Sheehy, 1991, p. 17). It is factual that estrogen does improve moods and the sense of psychological well-being in well-adjusted women who had no distressing menopausal symptoms, according to a brand new study done by Dr. Edward Ditkoff at the University of Southern California School of Medicine.

The most experienced researchers say that when estrogen levels in the blood are very low, a woman might start to feel a bit sad or blue or notice irritability or mood swings, but not of a clinical magnitude (Greer, 1991). Women who experienced a long perimenopausal period, more than a two-year transition, had a “moderately increased, but transitory, risk of depression,” reports the 1992 follow-up on a previous Massachusetts study. And this depression was prompted not by unfortunate social circumstances; it was due to menopausal symptoms (Greer, 1991). Even Pauline Bart, writing in a feminist
collection entitled Women in Sexist Society, blames the middle-aged woman for her own depression:

"Women who have overprotective or over involved relationships with their children are more likely to suffer depression in their post-parental period....Housewives have a greater rate of depression than working women....Middle-class housewives have a higher rate of depression than working-class housewives....The patterns of black female role behavior rarely result in depression in middle age. Often the 'granny' or 'auntie' lives with the family and cares for the children while the children's mother works; thus the older woman suffers no maternal role loss. Second, since black women traditionally work, the vicarious living through their children that is characteristic of Jewish mothers does not occur. (Greer, 1991, p. 19)

This could all have been put quite differently, so that it did not appear that depressed. Women had gotten it wrong, had over-invested in their children and therefore suffered inevitable refection. The black woman who continues to fulfill a female role is not dealing better with her empty nest, because her nest is not empty. Her children are probably still living with her not because of tradition so much as poverty. Black women do not do the work they do because of tradition, but because of necessity. (Greer, 1991 p. 116).

It is only to be expected that allopathic medicine would place all the emphasis on the biochemical basis for depression in fifty-year old women. Though we find, as Aylward found, that menopausal women are low in indoleamines, and in particular tryptophan, we ought to perhaps consider the possibility that these substances are not secreted in sufficient quantity because patients are depressed. Low levels of tryptophan are as likely to be a symptom as a cause. It seems equally possible that the display of genuine interest in the middle-aged women and the expression of concern for her state of mind and health will raise her spirits, and the objective sign of raised spirits will be higher levels of tryptophan. It would seem from the marked placebo effect noticed in studies of menopause that a very little help and support go a long way with menopausal women.
According to Dr. Barbara Evans: The menopause does not appear to give rise to a specific pattern of psychological symptoms. In relation to the general increase with age of psychiatric illness in women, the effect of the menopause is relatively small, in spite of some conflicting reports. Admissions to mental hospitals increase with age in both sexes, but more steeply in women, with a peak in the climacteric age group, but there is no evidence that the menopause induces psychiatric illness or psychological changes apart from adding to the stress upon a woman already predisposed to anxiety and depression (Greer, 1991). The changes that effect both the body and mind at and after the menopause is immensely complicated. Not only are there hormonal changes, but also emotional, social and family changes, and no one really knows why in fact some women, albeit the minority, pass through their fifties and sixties with little physical or emotional disturbance (Greer, 1991, p.72).

The death of the womb straddles Freud’s two categories of physical pain and mourning, and bears all the narcissistic weight that physical pain does, with the same propensity for “emptying the ego.” The mourner can ignore her condition only at her peril; somehow or other the loss must be acted out. The form that the acting out takes will depend not only on the personality of the mourner but upon her circumstances. Many of the older descriptions of climacteric syndrome noticed that it involved a desire for solitude, a desire that solicitous persons felt obliged to deny. Even when mourning was considered proper and carried out in public, people who assumed that women’s emotions exist in order to provoke responses in other people could see no value in a woman’s unwitnessed tears (Greer, 1991, p. 271).
The incidence of depression is increasing worldwide. No one knows why, but it is a fact. Here are some important facts one may want to know about depression:

- A major episode of depression in a woman born in the 1930s will most likely occur as she nears fifty. However, if depression occurs in a woman born in the 1950s, it will most likely happen when she is about thirty.

- Although experts have long pooh-poohed the notion that estrogen and testosterone have any value in the management of depression, it has recently been established that such is the case. These steroid sex hormones play a distinctive role in the control of related depressive problems.

- An interesting study, initiated by the National Institute of Mental Health, provided three separate categories of treatment at various institutions for depressed patients. The first two groups were exposed to two different types of psychotherapy, the third to antidepressant drug therapy or an inert placebo. The drug therapy worked more rapidly and more effectively than psychotherapy. The placebo failed, but not completely. While the three groups each eventually had about a 60 percent cure rate, the placebo helped almost 30 percent of those who took it. (Gillespie, 1989, p.170)

Estrogen deprivation can trigger a bad mood or sap your energy, but it does not bring on full-scale clinical depression. Clinical depression is twice as common in women
as in men, which is possible the root of the misconception that menopause and mental illness are synonymous terms. But separate studies in the United States, England, and Sweden have all shown that women are no more prone to have their first bout of depression during menopause than at any other time. Involutional melancholia, once a catchall phrase that implied any mental problems found in women over the age of 40 were hormonal, has been removed as a diagnostic classification in the psychiatric manual (Teaff and Wiley, 1995).

Hormonal depression usually involves feelings of lethargy, a lack of concentration, less interest in sex, and perhaps less desire to socialize. Hormone replacement therapy helps the vast majority of the women troubled with hormonal depression, both because it relieves the underlying symptoms and because estrogen has a mood-altering effect on the brain. Specific receptors for estrogen are located in the limbic forebrain, the area that is responsible for our emotions. Estrogen increases the levels of serotonin, a chemical associated with good moods. In fact, by counteracting the chemicals that limit serotonin production, estrogen acts similarly to the antidepressant Prozac (Teaff and Wiley, 1995). It is true that clinical depression subsides in women over fifty, and irritability and depression in middle-aged women do have many other sources. But mood changes are so commonly mentioned by women in the perimenopause phase, why should women be told there is no hormonal basis for feeling depressed cited in (Sheehy, 1991, p.71).

Recent research on emotional responses to menopause reveals that the social factors play a large role in depression that occurs during the menopause. Women who have invested heavily in their roles as mothers are more likely to be depressed. There is a
natural corollary: women with interest, education, or professionals are less apt to become upset after menopause. Research indicates that the reason for this is that they have more options in their lives (Ransohoff, 1987 p. 64)

“That’s looking at major depression as a disease,” stresses Dr. Howard Fillit, a gerontologist at Mount Sinai Hospital in New York City. “A woman comes into a doctor’s office at age fifty-one with the menopause and says, ‘Doctor, I can’t function very well in the office. I think I have memory loss, I can’t pay attention to my work, and I feel really depressed.’ If the doctor reads the literature, he knows that there is no major association of depression with the menopause, so he says, “C’mon, you’re crazy.” If the doctor was aware that these complaints and symptoms are real, although they may not qualify as a disease, this problem could be dealt with in a constructive manner (Sheehy, 1991 p.71)

**Hormonal Replacement Therapy**

I believe that no matter how much research is done, there will probably never be a universal, comprehensive, “clear right or wrong approach to hormone replacement. “Each woman is unique and presents the challenge of being her own long-term research study. In a review of menopausal hormone therapy in the 1992 inaugural issue of the Journal of Women’s Health, summarized:” The scientific evidence to date supports the concept of hormonal therapy for use by most postmenopausal women to maintain an active and full life.” Journal of women’s health , no.1 (1992): 1-4

It is estimated that twenty percent of the female population do not experience menopause symptoms. Sixty percent report minor discomfort, another twenty percent
experience symptoms severe enough to seek medical attention and 20% start HRT and stop because of side effects (Gillespie, 1989 p.46).

In keeping with the hypothesis that estrogen exposure is important to the regulation of mood are the findings that estrogen may have antidepressant effects (Halbreich and Endicott, 1985; Klaiber et al., 1979) while estrogen antagonists, such as clomiphene citrate in high dosages, may precipitate hot flashes, irritability, and depression (Voda, Dinnerstein, and O’Donnel, 1986).

According to the medical literature, exogenously administered estrogen has a salutary effect on the dysphoria of the menopause. It is well known that women who seek care for symptoms occurring during this period of biologic change frequently complain of irritability, anxiety and depression, and it is well-established (Worely, 1987) that estrogen relieves somatic symptoms of the menopause such as hot flashes and dyspareunia secondary to atropic vaginitis (Good, 1989, p.173).

Sherwin and Gelfand have reported a well-designed, double blind crossover study, with biologic correlates, in which the effect of estrogen, androgen, or a combined preparation of the two agents given parentally, and who had undergone bilateral oophorectomy, had lower depression scores during treatment with the active agents than did a group receiving a placebo (Voda, Dinnersten, and O’Donnel, 1982).

Both of the two largest double-blind, placebo-controlled, crossover studies that have been published report improvement with estrogen therapy as opposed to placebo for a variety of psychological and sexual symptoms of the menopause. Campbell and Whitehead (1977) compared 2 months of daily therapy of 1.25 mg of conjugated
estrogens with placebo in a short-term crossover study involving 64 patients with severe symptoms. Estrogen was significantly more effective than placebo in alleviating 12 symptoms (hot flashes, insomnia, vaginal dryness irritability, poor memory, anxiety, worry about age, headaches, worry about self, urinary frequency, pessimism, and low spirits) and produced increased coital satisfaction. How these symptoms were measured, however, was unclear (Morse and Dennerstein, 1989, p.183).

Much less literature exists on the therapeutic effect of estrogen on psychological symptoms of the menopause, as substantiated by a review of recent issues of respected medical journals and standard texts. For example, during the years 1983 through 1986, the journal “Obstetrics and Gynecology” (volumes 61-68), published by the American College of Obstetricians and Gynecologists, included no original articles dealing with either the psychological aspects of the climacteric, the effect of estrogen on psychological symptoms of the menopause, or the relationship of estrogen to mood during this period (Good, 1989 p.173)

The second reference to the menopause in this text, in the chapter entitled “Psychiatry and Psychology of the Middle Aged” (Butler, 1985), is a brief paragraph stating that “women usually experience the menopause between forty and fifty years of age,” and that “the role of estrogen deficiency and hormonal imbalance is clear. The autonomic nervous system is affected; there is vasomotor instability. Since the author makes a definitive statement about the effects of estrogen deficiency but does not include its psychological effects, the reader might well assume that there is no relationship between estrogen deficiency and mood ( Good, 1989, p. 174)
The third reference to the menopause in the Comprehensive Textbook of Psychiatry is from the chapter entitled "Endocrine Disorders" (Reiser and Reiser, 1985). Here the author, in the subsection entitled "Menopausal Distress," states:

Effects of estrogen on mood may be indirectly moderated through its influence on androgen production. In any case, a significant role for changing hormonal levels is evidenced by the severe physical and psychological symptoms that follow abrupt (surgical) depletion of ovarian hormones (p. 174).

Later in this subsection, however, the author states that "psychological distress should be evaluated and treated primarily by appropriate psychotherapeutic and sociotherapeutic measures," again suggesting no indication for estrogen in the treatment of menopausal psychological distress (Good, 1989, pp. 174-175)

Sherwin and Gelfand (1985) have reported a well-designed, double-blind crossover study with biologic correlates, in which the effect of estrogen, androgen, or both on mood during the menopause was investigated prospectively. Women who received estrogen or androgen, or a combined preparation of these two agents given parenterally, and who had undergone bilateral oophorectomy, had lower depression scores during treatment with the active agents than did a group receiving placebo. This coincided with higher plasma estrogen and testosterone levels in the treated group. When the steroid treatment was stopped, the depression scores of all of the menopausal subjects rose significantly over those of a control group of women with intact ovaries who had undergone hysterectomy. The authors concluded that these data suggest a correlation between circulating levels of estrogen or testosterone and effect in healthy women. The question is whether these findings, in persons whose ovaries have been surgically removed, can be generalized to
women whose menses have ceased as an integral part of the aging process (Good, 1989, p.175)

Summary

In summary, many researchers believe that biological changes that occur during the onset of menopause and not the menopause itself that cause the psychological changes the effect the emotions of women. It is defined as a significant life change that is experienced by females of all cultures. It is clearly defined that some women experience emotional changes that impact their day to day living. There are the opinions of the experts who have studied menopause and the psychological symptoms experienced by women during this period of life. The chapter has a clear definition of depression, and the various types of depression.

Cultural differences are discussed in this chapter and how the roles of women may change after menopause in a particular culture because of attitudes and tradition. No one can agree that ethnicity is a factor in how the menopause affects women because of the different customs and attitudes in the various cultures.

There is also information on Hormone Replacement Therapy and the role it plays in the treatment menopausal symptoms. Experts agree that HRT does improve the quality of life for women, diminishes the emotional roller coaster experienced by some women and slows down the aging process.
CHAPTER 3

METHODOLOGY

Introduction

This chapter describes the methodology used in this study of the psychological and physical symptoms of women experiencing menopause. It covers the research design, the sample and population of the participants, the instrumentation and procedure used in the study. Assumptions and limitations of the study are defined, as well as the method of analysis.

Research Design

A descriptive research design was chosen for this study. The purpose of a descriptive research design is to describe systematically the facts and characteristics of a given population. This description includes a collection of facts that describe existing phenomena. Here, the investigator attempts to explain phenomena that already has taken place. It will not predict events in the future, rather, seek results indicating the relationships that may point to cause. The approach taken is a cross-sectional design, where data is sampled at a single point in time. (Merriman and Simpson, 1984)

The most common technique used for gathering data in descriptive research is the survey. This method will allow the researcher to study relationships or events as they happen in human life situations (Merriman and Simpson, 1984, p.57-66).
Sample and Population

The participants for this study were individuals known to the researcher through contacts at work, school, church, and the community in general. The sample included 51 females between 38 and 60 years of age from White, Asian, Hispanic, and Black ethnic groups.

Instrumentation

Forty-one questions were used to identify the physical and psychological symptoms associated with menopause. The questions were derived from the literature that described menopausal symptoms. The instrument was assessed for face validity by graduate faculty.

Procedure

The instruments were mailed or hand delivered with a cover letter and self addressed, stamped return envelope over a two week time period. Prior to mailing the instrument, each individual was consulted on taking the survey.

Assumptions and Limitations

It is assumed that the participants in the study responded honestly and to the best of their ability to the items on the questionnaire. The size of the sample and the non-random way in which the sample was selected limits the ability to generalize the findings of this study to a larger population of menopausal women.
CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Demographic Description

Of the 51 women participating in the study, 53% were within the 38-45 age bracket, 47% fell in the 46-60 age bracket. Thirty one percent of the participants were White, 6% were Asian, 22% were Hispanic, and 41% were Black.

Findings

According to figure 1, 94% of the women surveyed reported experiencing menopausal symptoms. These women reported experiencing both physiological and psychological symptoms. The most frequently reported physiological symptoms were hot flashes (86%) and night sweats (94%).

The most frequently reported psychological symptoms were irritability (92%), anxiety (86%) and depression (67%). Other psychological symptoms that were reported by a majority of the respondents were mood swings, difficulty concentrating and insomnia.
<table>
<thead>
<tr>
<th>Symptom</th>
<th>White</th>
<th>Asian</th>
<th>Hispanic</th>
<th>Black</th>
<th>Nat. Am.</th>
<th>Total</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 38 - 45</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>9</td>
<td>0</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Age 46 - 60</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>0</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Cultural Barriers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Menopausal Symptoms</td>
<td>16</td>
<td>3</td>
<td>9</td>
<td>20</td>
<td>0</td>
<td>48</td>
<td>94%</td>
</tr>
<tr>
<td>Light-Headed/Dizziness</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>17</td>
<td>33%</td>
</tr>
<tr>
<td>Crawly Skin</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>18</td>
<td>35%</td>
</tr>
<tr>
<td>Vaginal Itching</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>0</td>
<td>24</td>
<td>47%</td>
</tr>
<tr>
<td>Perimenopause/Menopause</td>
<td>14</td>
<td>3</td>
<td>9</td>
<td>20</td>
<td>0</td>
<td>46</td>
<td>90%</td>
</tr>
<tr>
<td>Hair Loss</td>
<td>9</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>0</td>
<td>22</td>
<td>43%</td>
</tr>
<tr>
<td>Vaginal Dryness</td>
<td>12</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>0</td>
<td>35</td>
<td>69%</td>
</tr>
<tr>
<td>Heart Palpitations</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>0</td>
<td>22</td>
<td>43%</td>
</tr>
<tr>
<td>Change in Cycle</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>19</td>
<td>0</td>
<td>34</td>
<td>67%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>13</td>
<td>3</td>
<td>3</td>
<td>15</td>
<td>0</td>
<td>34</td>
<td>67%</td>
</tr>
<tr>
<td>Irregular Menses</td>
<td>14</td>
<td>3</td>
<td>8</td>
<td>16</td>
<td>0</td>
<td>41</td>
<td>80%</td>
</tr>
<tr>
<td>Depression</td>
<td>13</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>0</td>
<td>34</td>
<td>67%</td>
</tr>
<tr>
<td>Night Sweats</td>
<td>13</td>
<td>3</td>
<td>9</td>
<td>18</td>
<td>0</td>
<td>43</td>
<td>84%</td>
</tr>
<tr>
<td>Hot Flashes</td>
<td>15</td>
<td>2</td>
<td>9</td>
<td>18</td>
<td>0</td>
<td>44</td>
<td>86%</td>
</tr>
<tr>
<td>Cry For No Reason</td>
<td>11</td>
<td>2</td>
<td>6</td>
<td>9</td>
<td>0</td>
<td>28</td>
<td>55%</td>
</tr>
<tr>
<td>Menstrual Spotting</td>
<td>14</td>
<td>3</td>
<td>7</td>
<td>13</td>
<td>0</td>
<td>37</td>
<td>73%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>15</td>
<td>3</td>
<td>10</td>
<td>16</td>
<td>0</td>
<td>44</td>
<td>86%</td>
</tr>
<tr>
<td>Irritability</td>
<td>16</td>
<td>2</td>
<td>10</td>
<td>19</td>
<td>0</td>
<td>47</td>
<td>92%</td>
</tr>
<tr>
<td>Appetite</td>
<td>7</td>
<td>1</td>
<td>8</td>
<td>11</td>
<td>0</td>
<td>27</td>
<td>53%</td>
</tr>
<tr>
<td>Difficulty Concentrating</td>
<td>10</td>
<td>1</td>
<td>8</td>
<td>11</td>
<td>0</td>
<td>30</td>
<td>59%</td>
</tr>
<tr>
<td>Change in Sleep Pattern</td>
<td>11</td>
<td>3</td>
<td>5</td>
<td>16</td>
<td>0</td>
<td>35</td>
<td>69%</td>
</tr>
<tr>
<td>Diminished Sex Drive</td>
<td>9</td>
<td>1</td>
<td>9</td>
<td>8</td>
<td>0</td>
<td>27</td>
<td>53%</td>
</tr>
<tr>
<td>Mood Swings</td>
<td>10</td>
<td>1</td>
<td>7</td>
<td>14</td>
<td>0</td>
<td>32</td>
<td>63%</td>
</tr>
<tr>
<td>Unexplained Fatigue</td>
<td>13</td>
<td>1</td>
<td>9</td>
<td>15</td>
<td>0</td>
<td>38</td>
<td>75%</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>10</td>
<td>1</td>
<td>6</td>
<td>15</td>
<td>0</td>
<td>32</td>
<td>63%</td>
</tr>
<tr>
<td>Excessive Vaginal Bleeding</td>
<td>12</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>0</td>
<td>32</td>
<td>63%</td>
</tr>
<tr>
<td>Headaches</td>
<td>11</td>
<td>1</td>
<td>7</td>
<td>9</td>
<td>0</td>
<td>28</td>
<td>55%</td>
</tr>
<tr>
<td>Dry Skin</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>11</td>
<td>0</td>
<td>21</td>
<td>41%</td>
</tr>
<tr>
<td>Genital Tissue Shrinkage</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>0</td>
<td>18</td>
<td>35%</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>0</td>
<td>21</td>
<td>41%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td>33%</td>
</tr>
<tr>
<td>Restlessness</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>17</td>
<td>0</td>
<td>37</td>
<td>73%</td>
</tr>
<tr>
<td>Current Use of HRT</td>
<td>13</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>0</td>
<td>33</td>
<td>65%</td>
</tr>
<tr>
<td>Relief with HRT</td>
<td>13</td>
<td>2</td>
<td>7</td>
<td>12</td>
<td>0</td>
<td>34</td>
<td>67%</td>
</tr>
<tr>
<td>Neg-Side Effects of HRT</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>10</td>
<td>20%</td>
</tr>
<tr>
<td>HRT + Quality of Life</td>
<td>13</td>
<td>3</td>
<td>9</td>
<td>12</td>
<td>0</td>
<td>37</td>
<td>73%</td>
</tr>
</tbody>
</table>
Figure 2, below, reports the findings on the respondents' perceptions on effects of hormone replacement therapy (HRT) for the symptoms of menopause.

![Frequency of HRT Responses](image)

Thirty-three (65%) of the respondents reported current use of HRT. Thirty-four (67%) of the respondents have experienced relief with HRT, ten (20%) experienced negative side effects of HRT. Seventy-three (73%) of the respondents believe that HRT improves the quality of life overall. There were no significant differences in the responses to the items on the questionnaire based on the ethnic group of the respondents.
CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary
The purpose of this study was to identify the physical and psychological symptoms associated with menopause. The literature reviewed included an examination of the definitions of menopause, psychological symptoms, menopause and depression, and cross cultural implications of menopause.

In this study, 51 women responded to a forty-one item questionnaire designed to measure physiological and psychological symptoms of menopause along with barriers and side effects of menopause and hormone replacement therapy. The findings indicated that the most frequently reported psychological symptoms related to menopause were irritability, anxiety and depression. The majority of the women also agreed that HRT improved the quality of their life.

Conclusions
According to the literature reviewed in this study, there is both clinical and experimental evidence that suggests that estrogen affects systems involved in regulating mood. In some studies, women who had diminished estrogen levels experienced depression or some other type of mood disorder. Women who received estrogen had lower depression. A major difficulty in the study of menopause has been the inadequate description and definition of the endocrine system of women. Studies from the feminist view are biased and other studies examined the relationship of psychological symptoms to chronological age and menopausal status. Psychological symptoms occurring during this
period are sometimes claimed to be secondary manifestations of a disabling vasomotor system, that is hot flashes, night sweats and sweating. The findings of this study seem to concur with others that there is considerable evidence of an increase in psychological complaints during this phase of a woman’s life. The researcher also concluded that although women experience significant psychological changes during the onset of menopause (biological and hormonal changes that occur during this phase), attitudes, cultural influences and bias can effect the way women feel about themselves at this life transition.

The researcher determined from the literature review that most medical researchers agree that women can benefit from hormone replacement therapy and that the pros outweigh the cons. The risk factor is greater for women who have medical problems and predisposed to cancer. Menopause itself is not the cause of the depression, but the hormonal changes that are experienced when the biological changes occur as the female body clock winds down. The shame, fear, misinformation and the stigma of the change itself, are social factors that affect the way a woman feels about herself during menopause. The deprivation of estrogen can trigger a bad mood or sap one’s energy, but it does not bring on full scale depression.
Recommendations

The researcher learned from the literature reviewed in the study, that women need to follow-up with their doctor when starting HRT, because it takes several months to find the right dosage of hormones for each individual. Hormone replacement therapy has been like an elixir of life for millions of women, and for others it is a health risk. Women need to be cognizant about HRT and the risks and benefits when taking hormones.

When these changes in a woman’s body occur, it is important to know exactly what is going on. Estrogen levels need to be checked. If there is heavy or irregular bleeding, does it come from menopause. See a doctor to get a professional opinion of these changes. There are several diagnostic tests available to determine if a woman is menopausal (Sheehy, 1991).

It is the researchers recommendation that this topic is further researched using a larger population that include some control methods. Though research using the small sample population indicates the relationship between psychological symptoms and menopause, other variables could effect the outcome of this research.
REFERENCES


## APPENDIX A

### QUESTIONNAIRE

Menopause Symptoms and Side Effects

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you between the age of 38-45?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are you between the age of 45-60?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you have cultural barriers that prevent the use of HRT?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What is your ethnicity? White Hispanic Native American Black Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you experienced any menopausal symptoms?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you experienced dizziness or swimming in the head?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you sometimes have “crawly skin”, the sensation of ants or other insects creeping over your skin?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has there been vaginal burning or itching?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Are you menopausal or experiencing premenopause?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you experience any hair loss?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you experience any vaginal dryness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you experience heart palpitations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you experience a change in your menstrual cycle?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Do you experience insomnia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you experience irregular menses?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you experience depression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Do you experience night sweats?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you experience hot flashes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you cry for no reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Do you experience menstrual spotting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Do you experience anxiety?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Do you experience irritability?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you experience increased appetite?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do you have difficulty concentrating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you experience change in sleep pattern?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Do you have diminished sex drive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Do you experience mood swings?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Do you experience unexplained fatigue?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Do you experience weight gain?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Do you experience excessive vaginal bleeding?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Do you experience headaches?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Do you experience dry skin?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|---|---
| 33. Do you experience shrinkage of genital tissues? |   
| 34. Do you experience urinary incontinence? |   
| 35. Do you experience heart disease? |   
| 36. Do you experience osteoporosis? |   
| 37. Do you experience restlessness? |   
| 38. Are you currently using HRT? |   
| 39. Do you experience relief from the above symptoms when receiving HRT? |   
| 40. Do you experience negative side effects from taking hormones? |   
| 41. Do you believe that HRT enhances a woman’s quality of life? |   

8  38924 OTTAWA: TH
18 MIS  02/23/98  5213-