Chapter 4: Sociocultural Issues in Menopause

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Cross-cultural comparisons demonstrate that reported symptoms can vary significantly among countries and among ethnic groups within countries.

Key Points[a]

1. Attitudes toward and beliefs about menopause vary historically and among cultures [C].
2. Cross-cultural comparisons demonstrate that reported symptoms can vary significantly among countries and among ethnic groups within countries in their type (e.g., vasomotor, psychological) and in the degree of distress caused [C].
3. Difficulties in integrating findings from cross-cultural studies stem from a number of limitations. Among these are differences among cultures in language used to describe symptoms; use of different methodologies in study design and in instruments used to measure symptoms; and differences in diet and other lifestyle factors that make it difficult to establish cultural versus biologic causes of symptom expression.
4. A better appreciation of cross-cultural differences in the experience of menopause may derive from an emerging interdisciplinary model in which symptoms are seen as a result of increased vulnerability due to hormonal changes in interaction with psychological and sociocultural factors.

1. The Meaning of Menopause

The sociocultural aspects of menopause have not been the focus of attention or research interest to the same extent as menopause as a physiological event. Historically and cross-culturally, perspectives on menopause have varied widely. The 19th-century Victorian image was an aging woman with a decaying body, prone to illness and insanity.[1] In contrast, the view of menopause among Asian women has focused on freedom from pregnancy and a sense of liberation.[2] Bowles emphasized that women's experience of and attitude toward menopause are influenced by beliefs and expectations inherent in the prevailing sociocultural paradigm.[3] Thus, factors such as cultural beliefs, values, and attitudes toward menopause determine the experience of individual women of that stage of life as negative and troublesome or positive and liberating.

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[a] Evidence categories are given in square brackets. A = randomized controlled trials (rich body of data); B = randomized controlled trials (limited data); C = nonrandomized trials and observational epidemiologic studies; D = Panel expert judgment. (See also table 1–1.)

Hällström wrote that the psychological significance ascribed to menopause in Western countries should be regarded as a sociocultural myth.[4] By generating expectations in women, the myth can act as a self-fulfilling negative prophecy. Reproduction and child-rearing have been the primary roles defined for women. Osofsky and Seidenberg argued that many of those writing about the psychology of menopause assumed, on the basis of their own cultural biases, that women derive greater meaning from and place greater significance on their reproductive capacity than do men.[5] Barnett and Baruch emphasized the need to revise our view of women's roles, including broadening our concept of midlife by taking into account women's roles in the workplace as well as the social contexts within which they live.[6]

Menopause research needs multidisciplinary teams to address its different aspects.

Research on menopause has long been polarized. The medical model of menopause has focused on identifying symptoms of the climacteric syndrome. Endocrinologists have defined menopause as a deficiency disease requiring treatment, with symptoms believed to be directly linked to the lack of estrogen. Social scientists, on the other hand, have emphasized the social and cultural construct of menopause, holding that whether and how climacteric symptoms are experienced is influenced by that meaning. There is evidence, for instance, that negative attitudes and beliefs before menopause may predict depressed mood or other symptoms at menopause.[7,8]

Recent trends in epidemiological research have highlighted the need to integrate these opposing views into an interactive model. Flint suggested a psycho-bio-cultural model of menopause for interdisciplinary research and for a better understanding of the different aspects of women's health.[9] It is being recognized that menopause research needs multidisciplinary teams to address its different aspects. Research from disciplines such as gynecology, endocrinology, neurology, psychiatry, psychology, and anthropology may be integrated to characterize what changes menopause entails and the individual and cultural differences that occur as a result. A central question to be addressed is whether menopause is universally associated with similar physical changes and symptoms or whether there is, indeed, cross-cultural variation. Evidence of cultural diversity in perception of symptoms lends support to the hypothesis that how menopause is experienced is not ubiquitous but distinct according to cultural groups.

It may be difficult to compare the results from different studies because of methodological problems associated with the research. (See also ch. 3, sec. 3.) Many studies have used less than ideal research designs, unvalidated rating scales that have been translated from one language to another, and small clinical samples. Obermeyer et al. in a recent review[10] pointed out shortcomings of many of the studies used for cross-cultural comparisons. She emphasized the need for studies using a longitudinal design, standardized questionnaires, and an agreed-upon definition of menopause, criteria that most of the cross-cultural comparison studies do not fulfill.

2. Cross-Cultural Comparisons

Cross-cultural comparative data can help clarify the extent to which the experience of menopause is universal, provide information about symptom variability, and identify important factors influencing symptoms. Prevalence comparisons among countries of somatic symptoms of menopause, such as hot flushes, and of psychological symptoms, such as depression and changes in sexual interest, show considerable, though not always significant, differences. Among the major findings, one of the best known is the marked contrast between the relatively high prevalence of vasomotor symptoms reported in North American and

European women and the low prevalence reported by Asian women.

Lock's classic studies of Japanese perimenopausal women[11–13] have been widely cited. She collected data on these women using a self-administered questionnaire. The study was carried out in southern Kyoto, where the women were employed in factory or other blue-collar jobs; in Nagano, a rural area where the women worked on farms; and in the suburban area of Kobe, where most of the women were homemakers. The prevalence of hot flushes was low: 3 percent of the homemakers and 10 percent of the working women reported them. The Japanese women more often reported shoulder stiffness, headache, and, to a lesser extent, lumbago, symptoms not specifically linked to the menopausal state. The most striking result was that for most of the symptoms in the symptom list about 85 percent of the women gave a negative response.

A comparison of U.S., Canadian, and Japanese women by Avis et al. showed the Japanese women to have the lowest prevalence of hot flushes and of depression as well as the lowest intake of medication.[14] Such findings may lead us to believe that Asian women do not experience the intense symptoms reported by North American, European, and African women. With regard to hot flushes, however, Lock found that the Japanese women did not have a word for the concept, which had to be explained using different words.[12]

Lock's interpretation of these findings was that Japanese women do not think the same way about menopause as, for example, women in the United States. The Japanese word for midlife transition, konenki, has a social rather than biologic connotation. According to Lock, middle age in Japan is thought of foremost as a social process; the biologic changes are generally viewed as playing only a small part. Konenki is seen as a "luxury disease" suffered only by those women who have too little to do. The strong work ethic in Japanese society coupled with a certain moralistic attitude may influence women and make them less likely to complain of any physical discomfort associated with konenki. Lock also noted that women are explicitly encouraged by the government to provide nursing care for elderly relatives, since there is a marked shortage of programs to care for the aged population. Only recently women's groups have begun to debate issues associated with konenki and have argued that middle-aged women ought to focus more on their own health. Among these activists is Albery, who challenged the belief that Japanese women do not suffer from hot flushes.[15] She also advocated a more evidence-based approach to the understanding of female aging as well as endorsement by the government for gynecologists to treat menopausal symptoms using HRT.

Thus, it may be premature to accentuate social factors in the interpretation of Lock's findings. Biologic factors may have an important role. Recent research has shed light on the role of dietary factors. In much of Asia, particularly Japan, the diet is rich in phytoestrogens. Several studies have found a decrease in the frequency of hot flushes frequency in postmenopausal women in response to soy protein supplementation.[16,17] Larger, well-controlled clinical trials are needed, however, to better address the positive and possible negative effects associated with the intake of soy protein.[18,19] (See ch. 3, sec. 6.2.)

Is it possible that Asian lifestyle could have such dramatic effects on women's health? More recent studies in Asia present a somewhat different picture of symptom reporting. Among them is a well-designed, large-scale study by Boulet et al., conducted in Hong Kong, Indonesia, Korea, Malaysia, the Philippines, Singapore, and Taiwan.[20] The climacteric syndrome was, indeed, experienced by the participants, although in a milder form than generally reported in Western countries. The prevalence of hot flushes and of sweating was lower than in Western countries but not negligible. The percentages of women reporting more psychological types of complaint were similar to those in Western

countries. Perhaps, as the authors suggested, distress related to vasomotor symptoms is translated into psychological complaints, which are more frequently considered to warrant consulting a physician.

Other studies of Asian women that compared symptom reporting include a cross-sectional study of Thai women in Bangkok.[21] The women were asked to report symptoms in the prior 2 weeks. They did experience hot flushes, although the most common complaints were dizziness, headache, joint pain, and backache. The sample was not representative, and the conclusions must be considered tentative, because the women were recruited as they accompanied family members or friends to the hospital. In a study of Thai women attending health clinics in Bangkok, 22 percent of the women with irregular menses and 7 percent of the postmenopausal women reported hot flushes, although the most common symptoms were dizziness (45 percent) and irritability (41 percent).[22]

Among perimenopausal Chinese women living in Hong Kong, 20 percent of those surveyed experienced hot flushes, and, again, psychological complaints such as anxiety and nervousness were more prevalent.[23] In another study of urban women, perimenopausal Canadian and Chinese women differed markedly in symptom prevalence: 60 percent and 18 percent, respectively, reported vasomotor symptoms, and the Chinese women ranked other symptoms as more important, including boredom, poor memory, numbness in the hands or feet, change in appearance, and change in ability to see, taste, or smell.[24] Both groups in the study reported sleep-related problems and fatigue. Ho et al. studied perimenopausal Hong Kong Chinese women and found that although 10 percent experienced hot flushes, musculoskeletal complaints were the most prevalent.[25]

Thus, the prevalence of hot flushes appears to be lower in Asian women, although some of the more recent studies have shown rates closer to western figures. Also, the types of symptoms reported and the degree of distress caused are often different. There are no good explanations for the observed differences. Hot flushes were previously thought to be linked directly only to estrogen deficiency and not modulated by other factors. Our study[26] and that of Avis et al.[27] showed that hot flushes are modulated by psychosocial factors, such as satisfaction with work role and stress at work. In an ongoing study, we found that women with high-stress jobs report the most frequent hot flushes (Collins A and Ahs A, unpublished results). Many of the assumed truths about climacteric symptoms may have to be modified. Because all symptoms are individual and modulated by cognitive processes to a certain extent,[28] they can be influenced by cultural factors. A clear, and perhaps related, example of such influences is the cultural variation in pain perception.[29]

There are probably important factors within cultures that can mediate symptom experience. They include differences in expectations and attitudes toward aging and menopause, as well as socioeconomic factors and women's roles and opportunities in society. A very important area of research that has been largely neglected until recently is the study of different ethnic groups within Western countries. Our ongoing population-based longitudinal study has shown that among perimenopausal women residing in the Stockholm area, women born outside Scandinavia report more frequent hot flushes than do Swedish-born women (Collins A and Ahs A, unpublished data). Researchers in the United States found that African-American women were significantly more likely than white women to report hot flushes.[30] The difference remained after adjustment for BMI, educational level, and menstrual and gynecologic history. The authors attributed the difference mainly to psychosocial factors and stress. Despite the high prevalence of symptoms, few African-American women had discussed menopausal management with their physicians.[30] A study[31] of women of the Indian subcontinent living in the United Kingdom showed that the

majority regarded menopause as a natural event. However, only 33 percent were happy about menopause, and 46 percent were worried about possible adverse effects, such as ill health or weight gain. Over 75 percent of the women stated that they would like to seek medical advice about management of menopause. They also stated that they would prefer a female doctor who would be able to communicate with them in their own language. Thus, the overall results suggest a great need for information and education.

The large-scale, population-based SWAN in the United States compared symptom reporting among white, African-American, Chinese-American, and Japanese-American women.[32] The Asian-American women had significantly fewer symptoms than the white women, and the African-American women had the highest prevalence of vasomotor symptoms.[32] At the same time, among premenopausal through postmenopausal women, attitudes toward menopause and aging were found to differ among the ethnic groups; African-American women were the most positive, and Chinese- or Japanese-speaking women who received their schooling outside the United States were the least positive.[33] Menopause was described as a natural transition of life by Chinese-American and Chinese women in the United States.[34] It is important to consider where women obtain their information about menopause. Study results suggest distinct differences among ethnic groups. Several U.S. studies showed that, in general, African-American women and in particular less educated African-American women have less knowledge of menopause, are less likely to discuss menopause with a physician, and have less awareness of and less knowledge about HRT,[35–38] although they are more likely to have had a hysterectomy.[39] There can be distinct biases in prescribing HRT, and African-American women are less likely than white women to use it.[40] The findings should be related to those of a recent ethnographic study by Agee of African-American and Euro-American women of menopausal age.[41] The women were interviewed in depth about the transfer of knowledge about menopause and aging from mother to daughter. The African-American women more than the white women recounted that their mothers had provided them with the knowledge and tools to negotiate difficulties associated with menopause. They relied more on their own capacity to cope with problems encountered during the menopausal transition, and they were more prone to resist a biomedical model and, thus, less willing to follow their doctors' suggestions to start hormonal treatment. Many Euro-American women stated that their mothers had not talked about their menopausal problems, and many felt that their own life experiences set them apart from their mothers. The relative lack of a role model made them more dependent on a medical approach to solving problems related to menopause.

Also, the age at natural menopause differs between white and African-American women; the African-American women reached menopause significantly earlier.[42] In trying to explain the reasons for these differences, the authors focused on marginalization and psychosocial stress as the most significant predictors of earlier menopause among African-American women.

3. Ethnographic Studies

The degree of development of a society may also be important, and we may have to look more closely at nonwestern societies that are not as developed as those of Asia. There are unique studies of populations of rural women with a low level of formal education, and living simple lives, who show no signs of distress at menopause. Data collection was adapted to the women's lifestyle and adjusted for traditional expectancies. The findings may provide us with important indications of the role of cultural norms in symptom experience and reporting.

Beyene used a systematic ethnographic approach to collect data on 107 rural Mayan women aged 33 through 57 years.[43] The women lived in southeastern Yucatán, Mexico, where the residents were subsistence farmers practicing traditional Mayan ceremonies. The onset of natural menopause was earlier than in developed Western countries. The Mayan women became menopausal at ages 41 through 45.

The women did not consider menopause a major crisis. In general, they reported looking forward to menopause and likened it to being young and free. Menopause in the rural Mayan culture was largely unrecognized except as marking the end of menstruation and childbearing. The women indicated that the only recognized symptom of menopause was menstrual irregularity followed by the final cessation of menses. None reported hot flushes or cold sweats. The premenopausal Mayan women did not seem to have cultural knowledge or expectations relating to the onset of menopause other than the cessation of menstruation. Mayan women considered menopause to be a life stage free from taboos and restrictions. They reported better sexual relationships with their husbands, because of no risk of pregnancy.

The findings were particularly valuable because of another study's analysis of the hormonal profiles of rural Mayan women.[44] It was hypothesized that their menopause would be endocrinologically distinct. Determination of FSH, estradiol, prolactin (PRL), androstenedione, and testosterone values as well as BMD of 52 postmenopausal and 26 premenopausal rural Mayan women showed the same endocrinological profile as in U.S. women. Even with specific questioning through a native interviewer, however, it was not possible to elicit familiarity with hot flushes.[44] Interestingly, some Mayans who had moved to a nearby city experienced hot flushes.

Beyene also studied rural Greek women.[43] Data were collected from women living in a village in the eastern part of the island of Evia. The villagers were farmers using traditional farming methods, including plowing with horses and mules. Like the Mayans, the Greek women experienced menopause as a life stage free from taboos and restrictions. They, too, reported better sexual relationships with their husbands. They reported that, without risk for pregnancy, they felt more relaxed about sex. However, women also associated menopause with growing old, lack of energy, and a generally downhill course. Premenopausal women reported anxiety, negative attitudes, or anticipation, with some mixed feelings. When asked about experience of menopausal symptoms, 73 percent of the menopausal and postmenopausal women reported having had hot flushes, and 30 percent reported having cold sweats. Unlike Mayans, Greek women understood the concept of hot flush, and the older women even offered the Greek word for this symptom. They were also able to give detailed accounts of the process of hot flushes and the times they most often felt the sensations and changes in their bodies. Women said they experienced more hot flushes at night and around the times they usually expected to have their menstrual periods.

These two cultures are very different from the other cultures studied, since these are rural women living in a village, where the form of life is still very traditional. In both of them, the women were farmers with physically strenuous work. Possible explanations for reduced symptomatology in the rural groups could relate to physical exercise[45] or dietary habits, although studies of such lifestyle components have yielded mixed results. (See ch. 3, sec. 5.1.) Social or socioeconomic status probably plays an important part. Not all women have access to modern medical care. In an interview study of women with spontaneous menopause in Karachi, Pakistan, 6 percent of slum dwellers sought treatment for symptoms, compared with 26 percent of middle class clinic attendees and 38 percent of the most privileged group, wives of retired military officers.[46] Only one-fifth of the slum

dwellers reported symptoms, whereas 57 percent of the middle class and 50 percent of the most privileged group reported hot flushes. In a study in India, women living in a culture in which social status increased with age experienced few symptoms.[47]

A study of menopausal Nigerian women of Yoruba descent found 30 percent to have had hot flushes.[48] Joint pain was the most frequently reported symptom. The authors suggested that the Yoruba women may not have been as aware of hot flushes as white women and that they may have wrongly attributed their sensations to environmental temperature or to fever.

In an ongoing population-based study of Arab women, Obermeyer reported on the occurrence of symptoms and on help seeking by perimenopausal women in Beirut, Lebanon.[49] The proportion of women reporting hot flushes was 45 percent, similar to figures in the United States, Canada, and Sweden. Reported depression was similar to that in Canada but lower than the U.S. figure of 36 percent. The frequency of hot flushes was higher in smokers, and women who were employed reported fewer symptoms. Thirty-nine percent had sought help for their symptoms, and 15 percent reported using HRT, figures the authors interpreted as consistent with the high educational level of Beirut women and the degree of medicalization in the country.

4. What Can Cross-Cultural Comparisons Tell Us?

Flint and Samil[50] and Obermeyer et al.[10] in reviews of the literature emphasized the need for integration of the biomedical and developmental views of menopause.

Attempts to verify menopausal symptoms in different cultures have proved difficult. (See ch. 3.) Results from different studies are hard to compare because the quality of data can differ and studies differ in design and subject representativeness. Often, the subjects were patients or volunteers. Much research has used rating scales translated from European or North American studies; concerns have been raised about the appropriateness of translations without consideration of the cultural relevance of the questionnaires' content. Many studies cited above demonstrated that symptom types and patterns vary from country to country. Vasomotor symptoms are the most frequently reported symptoms in Europe and North America, but in Asia psychological complaints appear to be more common. Yoruba women in Nigeria described joint pain most commonly. The interpretation of bodily states and, thus, symptom experience may be different in different cultures. Boulet et al. suggested that Asian women may report vasomotor symptoms less frequently because vasomotor distress is experienced more in psychological terms.[20] There is a need to know how to ask the right questions and a need for more knowledge of the cultures being studied. In addition, more reliable scales are needed, and these have to be developed in a cultural context.

Overall, there is an association between hormonal changes and climacteric symptomatology, and the association is modulated by cultural factors. There is a considerable variation in the prevalence and pattern of symptoms in different countries, a variation probably due to diversity in cultural norms and traditions as well as in diet and other lifestyle factors.

5. Access to Health Care

Kaufert developed a model of menopause in which there are important social implications of becoming menopausal that vary from one society to another.[51] The definition of menopause for any culture will be derived from the meaning and consequences of menopause and from how women's roles are defined in that society. Women are aware of these stereotypes and interpret their bodily changes in accordance with what they have learned. The experience of menopause is associated with a woman's health history as well as a wide

range of variables, such as genetic factors, diet, education, marital status, number of pregnancies, the kind of work she has carried out, social support, and access to health care.[52]

Women need education and balanced information to make personal decisions regarding whether to use HRT.

Access to health care varies widely among countries. Women's choices around menopause are said to bear consequences for their health in old age. For a long time, hot flushes and night sweats were considered to be core symptoms of menopause and the most important reason for using HRT. More recently, HRT has been widely promoted for prevention against osteoporosis, CVD, and an array of other conditions. Educated women in industrialized countries with well-developed medical care are a privileged group with access to the most recent information on HRT, whereas other groups have less access and less knowledge. On the other hand, medicalization of menopause in cultures in which menopause is not perceived as a problem is an important issue that should be debated. Some critics have questioned the role of the pharmaceutical industry in influencing health care through product promotion.[53] Developing countries with scarce resources are less likely than developed countries to allocate funds for care of menopausal women. In addition, the inequality among social groups within countries can result in very different access to information and care.

Promoting positive attitudes to aging and to menopause could be important in modifying symptoms and improving the health of women.[54] Women need education and balanced information to make personal decisions regarding whether to use HRT. An important goal for health care providers should be to educate women. Such education should lead to greater equality among women in different cultures and social levels and help women control their own health.

6. Conclusions

Menopause has long been considered a turning point in women's lives in western cultures. Although menopause as a physiologic event remains constant, attitudes toward and beliefs about menopause vary considerably historically and cross-culturally. In the past decade, there has been a heated debate among biomedical and social scientists as to whether menopause should be seen as a deficiency disease rather than a natural event. Cross-cultural comparisons fuel the debate by showing that the relation between hormones and symptoms is, indeed, complex. There are significant differences in patterns and prevalence of symptoms between countries and, interestingly, in the types of symptom reported in different ethnic groups within countries. It is difficult, however, to draw firm conclusions from available cultural and ethnographic comparison studies because of a number of limitations. Among these are differences among cultures in language used to describe symptoms and in women's inclination to report symptoms; use of different methodologies in study design and instruments used to measure symptoms; and differences in diet and other lifestyle factors that make it difficult to establish cultural versus biologic reasons for symptom expression. (See ch. 3.)

7. Future Needs

- As cross-cultural research on menopause has been hampered by methodological difficulties, better controlled, population-based studies are needed which use standardized instruments adapted to the culture studied.
- There is growing recognition that investigators in different disciplines have to work together for a better understanding of women's health at menopause; such collaboration is particularly needed for cross-cultural work.
- An interactive psycho-bio-cultural model of menopause is needed, which recognizes the interplay between the individual and her psychosocial and cultural environment. From such a perspective, symptoms can be seen as the result of increased vulnerability due to hormonal changes interacting with psychological and sociocultural factors.
- Access to health care has been shown to vary among countries and among socioeconomic groups within countries. It is important that research results be disseminated within the cultures under study so that women can make their personal decisions about possible interventions and treatment strategies.

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