COURSE #93504 — 5 CONTACT HOURS/CREDITS RELEASE DATE: 11/01/22 EXPIRATION DATE: 10/31/25

Meanings of Menopause: Cultural Considerations

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, psychologists, therapists, mental health counselors, nurses, physicians, and other members of the interdisciplinary team who work with women.

Accreditations & Approvals

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A complete Works Cited list begins on page 28.

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NetCE designates this continuing education activity for 5 ANCC contact hours.

This activity was planned by and for the healthcare team, and learners will receive 5 Interprofessional Continuing Education (IPCE) credits for learning and change.

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AACN Synergy CERP Category B.

Social workers completing this intermediate-to-advanced course receive 5 Cultural Competency continuing education credits.

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This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Disclosure Statement

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Course Objective

The purpose of this course is to provide social workers, counselors, and healthcare providers with an understanding of the multifaceted attitudes toward aging, sexuality, and gender roles so they may provide culturally competent and sensitive interventions targeted to the unique psychosocial issues confronted by menopausal women.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define terms related to the psychosocial construction of meanings of menopause.
2. Discuss the historical evolution of how menopause has been constructed and defined.
3. Identify societal beliefs about women and aging, life transitions, menopause, social and cultural roles, body image, and sexuality and reproduction.
4. Analyze different models of explaining and defining menopause.
5. Discuss the role of culture, race, and ethnicity in women's experiences with and attitudes toward menopause.
6. Identify clinical and practice implications in working with women who are going through menopause.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

According to the North American Menopause Society, menopause is defined as a natural event whereby a woman has missed her menstrual period for 12 consecutive months (not explained by other medical factors) [1]. In general, menopause occurs around the age of 51 years [1]. Of course, there are variations across different countries, but in general, the mean age ranges between 45 and 55 years [1].

According to the U.S. Census Bureau, there were nearly 164.8 million women in the United States in 2022 or slightly more than half (50.7%) of the total population [3]. Women 45 to 54 years of age compose 13.4% of the total population [4]. If the average age of menopause is around 50 years of age, approximately 10% of the female population at any time will be going through menopause. According to the American Congress of Obstetricians and Gynecologists, approximately 6,000 women in the United States reach menopause daily [100]. Every year, approximately 1.3 million women reach menopause in the United States [22]. Worldwide, the World Health Organization estimates there will be 1.2 billion postmenopausal women by 2030 [146]. Given the increase in longevity, it is anticipated that women will spend more than one-third to one-half of their lives beyond the menopausal transition [180].

Contrary to popular myths, not all of these women will have a negative experience of menopause. Depending upon the perspective that one holds about this "change of life," it can be viewed as either negative or positive. Western medical establishments tend to describe menopause as a "deficiency disorder," resulting in a failure to produce "normal" levels of estrogen [126]. Consequently, this perspective views menopause as a medical disorder and a negative event, one for which estrogen replacement therapy is needed [5]. For other women, it can be either a positive or a neutral experience. Some view menopause as a natural developmental transition, symbolizing a new era characterized by more freedom. If this view is taken, then menopause is viewed

as a positive event. For other women, menopause is simply a neutral experience with minimal significance attached [5].

Whether the experience of menopause is positive or negative, it is influenced by many factors. Many of the meanings attached to menopause are influenced by cultural and social norms. Cultural meaning systems are cognitive structures that influence how individuals in society perceive or view social phenomena [6]. Ultimately, health phenomena are impacted by an intricate network of meanings derived from a host of factors, including life circumstances, fears, expectations, the help-seeking experience, and social reactions of friends, family members, and authority figures [7]. Health attitudes and belief systems can influence actual symptomology. For example, studies have shown that women who have positive attitudes toward menopause ultimately experience menopause in a more positive manner [147].

The purpose of this course is to increase the knowledge base of physicians, social workers, counselors, nurses, and other healthcare practitioners about how the experience of menopause has been socially constructed and how societal and cultural norms and belief systems shape its social construction. The emphasis of this course is on the sociocultural and historical context of menopause. Despite this emphasis, in no way should the biologic and physiologic dimensions and processes of menopause be dismissed. As Atwood, McElgun, Celin, and McGrath argue, it is important to look at menopause from an integrative approach, taking into consideration the interaction of the current and past sociocultural contexts, the biology, the psychology, and the social and family environments in which women experience menopause [8]. Social and cultural norms that define how menopausal women "should" act and react will ultimately influence symptoms and behaviors, which in turn will impact how others respond [8]. As a result of completing this course, practitioners will gain increased awareness about how culture, race, and ethnicity influence women's experiences and attitudes toward menopause. This awareness will then help practitioners to deliver more culturally competent and relevant services and interventions to women from diverse groups.

Please note that persons experiencing menopause are referred to as women throughout this course. While most persons who experience menopause are cisgender women, it is important to acknowledge that persons of many gender identities may cease menstruation and experience menopause. It is important that patients be questioned regarding their preferred pronouns and titles and that this information be respected. This is an essential aspect of patient-centered care and will improve rapport and patient outcomes.

ROLE OF CULTURE AND GENDER IN HEALTH BEHAVIORS

Culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [9; 10]. Culture involves attitudes and beliefs that are passed from generation to generation within a group. These patterns include language, religious beliefs, institutions, artistic expressions, ways of thinking, and social and interpersonal relations [11]. Culture can also represent worldviews, encompassing assumptions and perceptions about the world and how it works [12]. An understanding of a specific culture helps to elucidate why groups of people act as they do and respond to the environment as they do. Culture is not static; it is not merely inherited nor are groups of people passive recipients of culture. Rather, "culture and people negotiate and interact, thus transforming and developing each other. It is a process of continuous modification" [14].

Culture is woven into how individuals experience emotions, distress, and problems and how they report symptoms. Lee, Fawcett, Yang, and Hann liken individuals' experiences of health and illness to a journey that is socially influenced by community, culture, social supports, and organizational

processes [103]. While Western definitions of health and illness often prevail in healthcare systems, racial and ethnic minority individuals' views of health are frequently influenced by Eastern holistic paradigms [127]. In other words, experiences of illness should be understood alongside with cultural beliefs, value systems, and language and terminologies used to express (or not express) symptoms [15]. In some cultures, menopause is synonymous with aging, which has negative connotations. Some women going through menopause may then experience distress because they equate aging with loss of function and roles [148]. It is important to explore the extent to which attitudes, which are shaped by cultural norms, influence the menopausal experience. In Mayan culture in Mexico, there was no word for "hot flashes," and Mayan women did not complain about such symptoms [16]. Does this mean then that women in this culture did not experience hot flashes, or does it mean that the social expectations around menopause shaped the experience and ultimately what was or was not discussed?

When exploring women's health experiences, gender is yet another central variable that must be taken into account. First, it is important to differentiate between sex and gender. Sex is the biologic classification based on reproductive organs and chromosomes (i.e., male and female), while gender is a social construct influenced by societal, institutional, historical, and cultural norms [17]. Gender affects patterns of societal, community, familial, and individual expectations; processes of daily life; intrapsychic processes; and social interactions [18]. Gender is also defined by existing institutions and ideologies and is imbued with views about power differentials. Therefore, when attempting to understand the experience of menopause, some scholars emphasize the impact of meanings attached to reproduction, fertility, sexuality, aging, and social and gender roles [149]. These dimensions are contingent upon the attitudes and belief systems perpetuated and reinforced by social and cultural structures and institutions [19]. It is also important for healthcare and mental health professionals to examine their own biases about women within the context of health, reproduction, and psychological well-being. In general, helping professionals have a proclivity to focus on the negative aspects of women's lives, referred to as the "women-as-problem bias" [104].

DEFINITIONS OF TERMS

An understanding of the following terms will allow for better comprehension of the key points of this course [1; 8; 20; 180]:

- Perimenopause: The transition between the initial symptoms of menopause and the actual cessation of menses. This period generally begins between 30 and 45 years of age. During this time, menstruation may be sporadic.
- Menopause: The cessation of menstruation due to the failure of ovarian follicular functioning. This results in decreased levels of estrogen and progesterone. Technically, menopause has occurred after a woman has had no menstrual bleeding for one year. At this time, the levels of estrogen and progesterone decrease. Menopause typically occurs at 50 years of age, but it can occur earlier or later.
- Postmenopause: The stage when menopause is complete and the menstrual cycle has completely stopped.
- Vasomotor: The dilation or constriction of blood vessels. In relation to menopause, this type of response will cause many women to experience hot flashes.
- Hormone replacement therapy (HRT): The process of replacing lost hormones in women during the phases of menopause.

SOCIAL CONSTRUCTION OF MENOPAUSE: A WESTERN HISTORICAL CONTEXT

In this section, the social construction of menopause will be traced, with a focus on how Western society, particularly the United States, has defined, constructed, and portrayed menopause. As discussed, the evolution of the definitions of menopause and the perspectives surrounding its etiology and remedies are socially constructed and politically charged [21]. This is not necessarily unique to menopause, but is also true of other disorders, social problems, and/or illnesses.

Throughout history, menopause has had negative connotations. Hippocrates described a climacteric syndrome, which was attributed to a weak uterus causing women to lose power [150]. In 1701, a physician argued that women 45 to 50 years of age develop a condition known as "hysterick fits" [8]. As the label implies, the underlying premise was that menopause affects women on a psychological level. Others believed that menstruation was a biologic way for the female body to eliminate poisonous chemicals, and lack of menstruation resulted in toxic accumulation. This has been the historical case throughout different cultures and religions [181]. Menstruation was a social mechanism for restricting and controlling women's sexuality, social identities, and movements.

The term "menopause" first surfaced in a paper written by C.P.L. de Gardanne in 1821 [151]. It was used to differentiate the end of menstruation during the late midlife stage for women. Prior to the use of the term menopause, the term climacteric was used for the general midlife transition for both men and women [182].

In 1839, the first book about menopause was published, and it said that menopause was the result of "the death of a womb" [8]. By 1857, an Irish physician observed that menopause had "evil" consequences, including irritability, hysteria, and low spirits [8]. This is not necessarily the first time menopause was linked to the concept of "evil," as this association can be traced back to the Victorian era (1837 to 1901) [21]. The link to sin was inextricably tied to the cultural identity of womanhood during that time. Women's social roles in the Victorian era, for example, were generally confined to childbearing and domestic roles [23]. The perceived virtues of women at the time (e.g., passivity, nurturance, docility) were explained by medical and biologic processes [23].

Over time, the notion of menopause being closely linked to insanity became more prevalent. In a medical textbook published in 1887, the authors note [8]:

The ovaries, after long years of service, have not the ability of retiring in graceful old age, but become irritated, transmit these irritations to the abdominal ganglia, which in turn transmit the irritation to the brain, producing disturbances in the cerebral tissue exhibiting themselves in extreme nervousness or in an outburst of actual insanity.

Edward Tilt, a gynecologist and founder of the London Obstetric Society, argued that this type of madness could only be resolved by removal the uterus, as this was where the madness was believed to reside [151]. If hysterectomy was not prescribed, sedatives, opium, or vaginal injections of lead or pulverized cow's ovary were advocated [151].

During this same time, the French scientist Regis de Bordeaux invented an ovarian extract injection to treat menopausal insanity [21]. By the 1890s, the increased medical attention to menopause continued due to the rise of two medical fields: surgical gynecology and endocrinology [128].

By the early 20th century, psychoanalytic theory had gained prominence. Sigmund Freud and his psychoanalytic followers argued that menopause was a neurosis [21]. One Freudian analyst asserted that women during their menopausal years were unproductive and useless members of society because they had lost their reproductive ability [8; 23; 24]. In 1925, Helen Deutsch, another psychoanalyst, wrote *Psychoanalysis of the Sexual Functions of Women*. Although she proposed that menopause was a normal part of the psychosexual developmental stages, she also posited that menopause was traumatic to all women [24]. Deutsch had a fatalistic view of

menopausal women because she, like many people of the time, believed that menopausal women's social roles and purpose in life diminished to almost non-existence [24]. Overall, many of the psychoanalytic works on menopause appear to center around the issue of loss—loss of generativity, youth, self-esteem, and fertility. Menopausal symptoms were seen as a physical response to the issues of loss [24].

The years between 1918 and 1941 witnessed an explosion of interest in the study of sex hormones. Scientists discovered that hormones like estrogen could be isolated and synthesized [23]. The manufacturing of hormones was equated with the discovery of the "fountain of youth" [23]. However, estrogen replacement therapy for menopause did not become the accepted medical solution advocated by the healthcare community until 1966.

In the late 1960s, an era of defining menopause as a disease or deficiency began, which is first evidenced by the publication of *Feminine Forever*, a book by Robert Wilson, an American gynecologist [25]. Wilson maintained that menopause, as an estrogen deficiency, symbolized the end of femininity for women [25]. In essence, menopausal women were a form of living decay [21]. He argued that the effects were not only physiologic (i.e., the shriveling or deadening of ovaries) but also psychological (i.e., resulted in adverse consequences on women's character). His book suggested to women that the only way to deal with the negative effects of menopause was estrogen replacement therapy [26]. The concept of menopause being caused by a reduction of endogenous estrogen led to the use of replacement therapy, which continued into the 1980s [150; 183].

Furthermore, during this time, menopause was believed to be an instigator of other illnesses, and consequently, estrogen replacement therapy was viewed as a preventive intervention for other diseases that might follow [25]. Estrogen replacement therapy was also sold to women as a way to maintain their youth [27]. By 1975, 28 million prescriptions for estrogen replacement were reported [129]. Interestingly, the use of estrogen itself was not a novel intervention, as it was being used in a limited manner in the 1930s to treat hot flashes. However, Dr. Wilson's book popularized this medical intervention, and the pharmaceutical companies disseminated advertisements that showed all the catastrophic, negative effects of women experiencing menopause [27]. Hormone replacement therapy became a common solution in contemporary medicine [183]. With this popularization, menopause was no longer a private issue but was transformed into a medicalized process [28]. (The term "medicalization" has been coined to describe the process by which non-medical phenomena is transformed and treated as a medical problem [105].)

McCrea argues that with the medicalization of menopause, four prominent beliefs emerged and continue to be perpetuated [21]. First, women's roles, functions, and potential are biologically destined. Second, physical attractiveness and appearances are inextricably linked to women's identity. Third, if femininity is any way negatively affected, it will cause adverse social and psychological consequences. Finally, women's worth is linked to reproductive ability; in other words, as women age they are not productive or useful to society [21].

By the mid-1970s, empirical evidence began to suggest that estrogen replacement therapy was associated with an increased risk of cancer of the endometrium [29]. Two epidemiologic studies in 1975 found an association between postmenopausal estrogen therapy and increased risk of endometrial cancer [21]. During this time, estrogen therapy prescriptions declined a bit, but for the most part, estrogen replacement therapy remained the acceptable treatment for menopausal women [21]. In the 1980s and 1990s, there was another increase in hormone replacement prescriptions, with the lay public and the medical establishment alike largely positive on the treatment [129].

The two epidemiologic studies also spurred consumer groups to pressure the U.S. Food and Drug Administration (FDA) to place a warning label on estrogen replacement therapy regarding potential negative repercussions. Eventually the warning was added to estrogen replacement labels, but not before many suits were filed by pharmaceutical companies [21; 23].

The Women's Health Initiative, consisting of a series of randomized clinical trials with more than 161,000 postmenopausal women, was started in 1991 and was one of the largest studies examining the long-term effects of hormone replacement therapy. By the time the studies were halted in the 2000s, several studies had found that women who took combination estrogen and progestin had an increased risk for blood clots, myocardial infarction, and stroke compared with the placebo group [130; 184]. These findings triggered more awareness among women about the effects of estrogen replacement therapy, but it also resulted in the stigmatization of hormone therapy following menopause.

In the 1980s, premenstrual syndrome (PMS) was introduced as a disorder. Although this course focuses on menopause, it is impossible to not briefly discuss the medicalization of PMS, as the two concepts are interrelated. Late luteal phase dysphoric disorder (LLPDD) was introduced in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1987 in the Unspecified Mental Disorder section as a topic for further research. LLPDD was not necessarily meant to replace PMS but was considered a more severe disorder with recurring episodes of dysphoria during the menstrual cycle [30]. In 1994, LLPDD was replaced by premenstrual dysphoria disorder (PMDD) in the DSM-IV and was also placed in the section in the DSM that warranted further research. The DSM descriptions of the two disorders were not very different. Basically, the DSM-IV reordered the listing of symptoms and added a new symptom (feeling out of control) [30]. In 2013, following decades of research, PMDD was recognized as an official depressive disorder in the DSM-5 [125]. Precise diagnostic guidelines are now available.

Similar to the construction of menopause, the media and pharmaceutical companies have played a role in medicalizing these menstrual disorders, and medications were developed to treat the associated symptoms. In a 2011 study analyzing 48 internationally known medical textbooks published in the United States, menopause was generally depicted as a system failure and "as a precursor to disease" [106]. Because the "role" of women's reproductive systems is to facilitate childbearing, menopause tended to be represented as a failure, with the associated estrogen deficiency leading to physical and psychological symptoms (and an implication that this lack of estrogen is an "abnormal" state for the female body) [106].

A 2011 analysis of text from *OBGYN*, a magazine targeted to gynecologists and obstetricians, found that menopause was depicted as a normal condition and part of the journey of life [107]. However, physicians were still presented as serving a crucial role linking medical interventions to women's menopausal symptoms.

Today, it is generally recognized that the medicalization of menopause, as with other conditions, can empower or oppress women, depending on how menopause is depicted in science and medicine [131]. Furthermore, researchers and scholars are beginning to recognize that current recommendations are based on research conducted on menopausal women who are predominantly White and American. Consequently, it is unknown to what extent the findings from these studies can be generalized to women in other cultural, racial, and ethnic groups. Researchers and practitioners are urged to step out of "Western ways of knowing," and out of the "one-size-fits-all" model [31; 32].

SOCIAL AND CULTURAL IMPACT ON AGING, FEMININITY, GENDER ROLES, AND SEXUALITY

This section will briefly review Western ideas about midlife, aging, sexuality, body image, gender roles, and reproduction, because definitions and experiences of menopause are embedded in a larger sociocultural context. As points of contrast, various non-Western cultural belief systems will be reviewed, but it is not possible to offer a comprehensive review of all the various cultural and racial/ethnic subgroups. It is also important to remember that there is tremendous diversity within groups, and caution should be taken to not overgeneralize.

MIDLIFE

For women and men, the midlife developmental cycle is often characterized as difficult or negative, and several key stressors (e.g., menopause, children leaving the home, a changing marital relationship) are believed to mark this transitional period [108; 152]. Children leaving the home (referred to as "empty nest syndrome") is believed to trigger feelings of emotional loss for women whose roles are inextricably tied to motherhood [108]. It is also during this period women may begin to provide caregiving to aging parents or experience the possible loss of a parent [108]. The midlife stage has been largely characterized as stressful for women [185]. Despite these negative portrayals of midlife, research shows that many women find it to be a positive time, with more time to spend on themselves and social interests and a newfound confidence [109; 110; 185].

The notion of an "empty nest" may also be culturally specific to societies (like the United States) in which children tend to leave their parental homes earlier; in some cultures, children tend to leave home much later. In the Unites States, leaving the home is an indicator of healthy, high-functioning children and good parenting [109]. However, in some countries (e.g., China, Italy), family and collectivism are paramount, and a child who leaves home early may be interpreted as an indicator of ruptures in the family system [109]. Overall, midlife is not as debilitating as it is portrayed in societal stereotypes [132]. In some cultures, midlife actually symbolizes new creativity, power, generativity, and freedoms (e.g., freedom from financial worries, parental responsibilities) [152; 153].

AGING

Krajewski asserts that menopause is a satellite taboo, or a taboo related to a larger social taboo [154]. In this case, the taboo of menopause is related to the greater issue of aging [154]. Therefore, in order to better understand attitudes about menopause, it is essential to have an appreciation for societal stereotypes regarding aging. Thornton has identified six prevalent myths about aging in Western cultures [33; 111]:

- Older people are constantly sick and experience serious physical conditions.
- Not only are elderly people physically debilitated, they lack mental acuity.
- Older people tend to be sad, lonely, and grouchy.
- The elderly are sexless, and discussion of sex among older individuals is "dirty."
- Elderly people lack vigor and vitality.
- The aged are not productive citizens and are not amenable to change.

These myths ultimately reinforce and perpetuate the notion that growing old is a social problem [33; 133]. This is augmented by the large amount of literature and discourse about the "baby boomers" and how they will be creating problems in the healthcare, social, and economic arenas. The label "baby boomers" belies the fact that this group is extremely socially, economically, and politically diverse.

It has been said that Western culture values self-sufficiency, control, uniqueness, and individuality, all characteristics associated with youth. Because older people are viewed as dependent, the process of aging is not respected [186]. In Western culture, where societal norms value youth, with aging comes invisibility [112]. This invisibility and marginalization is in contrast to traditional Asian cultural norms, in which old age signifies wisdom, status, and power in the family and the community [34; 155; 186]. Kao and Lam maintain that when Asian immigrants age in the United States, their experience of aging is very different from how they were socialized [35]. It is a more demanding task to age in a society in which contributions of the elderly are devalued, compared to a society in which elders are treated with deference. Similarly, in Native American culture, the aged are believed to be a repository of wisdom and their role is to teach the young the traditions, customs, legends, and myths of the tribe [36]. Consequently, elders are taken care of by the tribe. This is also the case in traditional African religions, as the oldest family members are believed to have special status and an ability to communicate

with God [37]. Again, these cultural values are quite divergent from Western norms about the aging process and the elderly.

SEXUALITY

Sexuality has been profoundly shaped and influenced by the media. Frequently, the media sets the standards of sexuality and beauty, and many times, these standards are not attainable by the general population. These standards impact how women experience their own sexuality [38]. The media also disseminates the message that good sex is a passionate and an erotic experience, achievable by all normally functioning individuals [39]. However, for women, there is still an underlying message that they should not be the ones to instigate sex [39].

In particular, the media plays an influential role in early sexual development. One study found that girls 11 to 15 years of age relied on portrayals in the media for information about relationship formation and management and tips about how to become sexually attractive [40]. In part this is because parents are reluctant to discuss sex with their children, and therefore, children are socialized on existing cultural sexual norms through the media.

White American cultural norms emphasize the values of individualism and self-sufficiency. With this comes emotional distancing, and as a result, the topic of sexuality is not explicitly discussed [41]. However, this lack of discussion about sexuality is not limited to White Americans. In a qualitative study using focus groups with African American women 18 to 30 years of age, the participants were divided in their experiences of having open discussion about sex and sexuality with a female caregiver [42]. About half of the women felt that their mothers had betrayed them by withholding information about sex, which ultimately led them to feel inadequate. When the topic of sex was raised, it was usually limited to the context of contraception. These women recalled fear and ignorance regarding menstruation, with euphemisms, such as "monthly visitor" or "aunt coming into town," used instead of more neutral terms. All of this ultimately resulted in ambivalence about sex [42].

In traditional and patriarchal cultures, women are expected to fulfil their duties as wives and be cooperative about sex with their husbands [134]. Their sexuality is tied to their husbands' needs [156; 157]. In these cases, women are often uncomfortable discussing the impact of menopause on their sexuality and may feel guilty and worried that their husbands will be unfaithful [134].

Interestingly, older men and women are often viewed as genderless and asexual [43; 187]. In other words, older individuals are no longer sexual beings and are perceived to be unproductive or deviant [187]. Consequently, there is a stereotype that elderly individuals no longer engage in sexual activity; when they do, they are perceived to have committed some kind of transgression [43]. Ultimately, these ageist myths become internalized, and older people have a more difficult time accepting their sexuality [44]. In a study of older women, for example, the women expressed that they no longer have to worry about sexual concerns anymore [45].

FEMININITY AND GENDER ROLES

Notions and stereotypes of femininity and gender roles are culturally laden and are constantly changing along with societal norms. This reinforces the notion that gender is constructed based on societal beliefs about how men and women should act and behave. For example, in Victorian times, the cult of domesticity created a distinct sphere of life for women: the home. A woman's primary responsibilities were to care for the home and to focus on the rearing of children. Simultaneously, it was important to possess characteristics of purity and piety, which were believed to be the mark of a "true woman." In essence, marriage was a vehicle for a woman to define and shape her identity. However, this was primarily a Eurocentric (and androcentric) construction of femininity and women's roles. Some have argued that these more traditional gender role expectations do not apply to other racial/ethnic groups. For example, it has been argued that gender roles were and are much more fluid among African Americans due to the harsh realities during the slavery era.

Consequently, the patterns of role sharing are more prevalent in African American families as a means to survive in the face of poverty and racism [46].

The socialization process of African American women is not reflective of White, middle-class norms. For example, African American women are not necessarily socialized to expect that marriage will help them achieve financial stability. Because of economic hardships, African American women have traditionally played an integral role in maintaining their families' economic well-being—the common social portrayal of the "strong Black woman" [135]. Furthermore, while motherhood is a crucial role for African American women, the concept of motherhood is not solely biologic. The extended kinship and communal system meant that multiple African American women played key roles in raising children. In a 2007 study with African American adolescents, African American women were defined as matriarchal figures, typically mothers and/or grandmothers who were economically independent and contributed to the economic vitality of the family. Being a woman also meant being emotionally strong and keeping the family together during difficult times [48].

This conceptualization of an African American woman is a departure from the depiction of Asian women. Chinese culture, for example, endorses the view that the husband is the head of the household, the caretaker of the finances, the primary breadwinner, and the decision-maker [49]. Meanwhile, a wife is expected to be devoted to her husband and her husband's family. She is also viewed as the nurturer and caregiver of the children [50]. According to Watson and Ebrey, "a daughter [is] just passing through, waiting presumably to assume her true role as wife and mother" [51]. A popular contemporary Chinese saying is, "There exist three genders in the world: man, woman, and woman who has earned a doctoral degree" [188]. This saying reflects the idea that academic or career advancement is not feminine [135]. In contemporary China, women who remain single into their 30s and who are well-educated are called "leftover women" [188].

Similarly, in Latino/Hispanic cultures, a distinct demarcation in gender roles exist. Latino/Hispanic men are expected to perform tasks and duties related to the outside world, while women perform tasks related to the family and home [52]. Traditional cultural norms also dictate Hispanic women to be submissive, pure, and chaste while their male counterparts are supposed to be independent, dominant, and virile [53]. Because there is a cultural emphasis on the family (*familismo*), childrearing is considered a crucial role for Latino/Hispanic women [52]. For Latino/Hispanic women and girls, sex is valued only within the confines of marriage, although this standard does not generally apply to men/boys [53].

As a reminder, these are overarching themes and should not be generalized or used to create overly simplistic categorizations. It is important to remember that there is tremendous diversity within groups. Other factors within cultural groups, such as acculturation, gender, age, education, and marital status, have been found to influence cultural norms about femininity and gender roles as well.

THEORETICAL PERSPECTIVES ON MENOPAUSE

BIOMEDICAL MODEL

The biomedical model generally focuses on biologic disease or illness symptoms, and the goal of this model is to identify the cause of disease symptoms [54; 149; 189]. Using this theoretical lens, menopause would be defined as an illness or endocrine deficiency that results in decreased levels of hormones [2]. Menopause has also been portrayed as a "malfunction" of an aging reproductive system [54].

According to the biomedical model, menopause is considered to be a universal biologic process, with a set course of symptoms and experiences shared by all women [2; 25; 136]. It is based on the concept that menopause is the stage when a woman's body "fails" to produce estrogen, which then results in a range of negative symptoms [113]. Typically, these menopausal symptoms can include irritability, depression,

loss of sleep, osteoporosis, myalgia, headaches, loss of skin elasticity, and vasomotor disturbances (e.g., hot flashes) [55]. Historically, proponents of the biomedical model argued that this deficiency disease led to a loss of femininity. In a study analyzing publication trends from 1984 to 1994 in major academic journals, Rostosky and Travis found that 9,018 scholarly articles were written about menopause [56]. The majority of the articles focused on medical treatment, reproductive hormones, and hormone therapy. Only 6% of the articles focused on psychosocial implications of menopause, and these articles generally examined the relationship between menopause and mood [56].

Women have been warned that menopause will also cause other diseases and affect their quality of life [25; 57]. Proponents isolate a single variable as contributing to all these symptoms––lack of estrogen [54]. Therefore, estrogen replacement therapy has often been the solution [25; 57].

There are a few downsides to the biomedical model in the case of menopause. If menopause is considered an illness, its importance as a developmental stage in life (similar to puberty) is negated [58]. All developmental stages of life are characterized by losses and gains or positive and negative outcomes. However, the biomedical perspective focuses on women's losses during and after menopause.

In Rostosky and Travis's study, they argue that much of the medical literature written between 1984 and 1994 had serious methodologic flaws, including poor baseline data, failure to take into account diversity, lack of control groups, and overgeneralizations despite small sample sizes and nondiverse study samples [56]. Furthermore, the articles were not written in an objective manner; pejorative language was often used to describe women's bodies. Examples included "atrophic genital changes," "ovarian dysfunction," "total ovarian failure," and "problem women." It is within this medical backdrop that women ultimately seek information and assistance, which can lead to distorted constructions of menopause. The biomedical model is the most common model used to explain menopause in the United States and serves as the guidepost or truth for many women [113].

FEMINIST MODEL

Generally, feminist theoretical models emphasize the need to focus on women's interests as represented by women's social realities. When it comes to the study of women's sexuality, feminist scholars reject the biomedical model because it is deterministic and not women-centered [59]. Feminists also assert that depiction of menopause as a disease reinforces social power differentials between men and women [190]. Pollis maintains that in order to adequately understand women's experiences of life events, such as menopause, it is vital to acknowledge the potent role of gender in framing these experiences, specifically how gender is constructed and reinforced through existing social institutions [60]. This requires considering how community, culture, and history contribute to women's diverse experiences. Ultimately, according to a feminist model, scientific investigations of women's experiences should yield social change.

When applied to the study of menopause, the feminist model asserts that menopause is a natural event that marks a transition for women [158]. It is a biologic process, but with distinct sociocultural factors that interact with biologic processes in a complex manner. Menopause is not considered a disease or a disorder in this model. In fact, identifying this life event as a disorder reinforces societal attitudes regarding reproduction, fertility, sexuality, aging, and social and gender roles [19; 150]. When menopause is framed as a deficiency disease, it assumes that aging women's bodies are flawed, which ultimately perpetuates gender inequality [57]. Feminists in the 1960s maintained that misogyny was woven into the fabric of the medical establishment, reinforcing social control and the oppression of women [128]. Feminist scholars argue that the proponents of the biomedical perspective have taken a normal phenomenon and medicalized it (e.g., hormone replacement therapy as first-line therapy) [61; 159].

Instead, these scholars emphasize the importance of exploring menopausal experiences within the context of race, ethnicity, culture, gender, class, and other social locations in order to better understand the complexities of the biologic and social phenomenon, particularly in light of how these social factors lead to oppression and marginalization [62]. The feminist model has taken a very critical stance on the biomedical model in explaining menopause, but it is important not to completely renounce the involvement of biologic factors [113]. Focusing exclusively on sociocultural factors does not provide a comprehensive picture. Critics of the feminist perspective argue that the approach inadvertently dichotomizes women as either victims or empowered agents [158].

PSYCHOANALYTIC MODEL

Psychoanalysis focuses on how the unconscious influences behaviors. In terms of women's sexuality, Freud maintained that a young girl's psychosexual development revolves around penis envy; that is, she realizes her genitals are not like her male counterpart's, and she concludes she has been castrated (i.e., castration anxiety). Ultimately, she desires a penis, which results in penis envy [63]. Some psychoanalytic theorists have argued menopause is a revisit of castration anxiety. In other words, a woman's castration anxiety has been dormant as she has been busy as a wife and mother, and it then resurfaces when her role as a wife and mother is no longer the dominant theme. According to this model, menopause will then trigger depression and other psychological issues revolving around loss.

SOCIOLOGIC (EMBODIMENT) MODEL

In some ways, the sociologic model attempts to integrate the biologic and feminist model as it focuses on lived experience of the body. It emphasizes the physical and emotional experiences, which are ultimately influenced by historical, cultural, and social factors [64; 136; 149]. Experiences are not completely social or physical [28]. Consequently, sociologic theorists recognize the importance of examining how medicine, culture, and gender interact to influence women's experiences with menopause [28]. Furthermore, they believe that menopausal experiences are socially constructed; each woman constructs her own reality and attaches meaning to life events. The term "local bodies" has been introduced to describe different menopausal experiences in Japan, Canada, and the United States, as local social and cultural norms of the societies and how they conceptualized menopause play a role in influencing experiences [191]. Furthermore, the metaphors used by professionals can shape women's attitudes toward menopause. For example, metaphors have historically been used in the medical community to describe menopause and are extremely value-laden, including such terms as, "ovarian decline" and "senile ovaries" [65]. Based on how others have constructed menopause, women will construct their own reality. Consequently, there is no one objective reality of menopausal experiences as is posited in the biomedical model [65].

POPULAR BELIEFS ABOUT MENOPAUSE

It is important to examine popular or general societal myths about menopause because these messages may be incorporated into women's beliefs regarding menarche and menopause and become part of their internal cognitive schemas. Language and the development of certain terms can give some insight into the underlying meanings. For example, when an adolescent girl gets her period, some refer to it as the "curse" or the "M word," and when a woman goes through menopause, she is experiencing a "change of life," or has become "of a certain age" [104; 154; 190]. What does this tell women about these biologic processes?

The notion that a menopausal woman is irritable, depressed, irrational, and emotionally unstable is prevalent in Western society. In the United States, one survey found that American women, regardless of educational level, also held negative images of menopausal women, associating menopause with weight gain, wrinkles, loss of sexual appeal, acquiring masculine characteristics as a result of hormonal changes, and becoming mean [66]. Sexually, women who are postmenopausal tend to be viewed as "frigid," "withered," or "sexually predatory" [111; 136].

Examining how the media depicts menopause can also be telling, as it provides a glimpse of cultural norms. Furthermore, the media plays a powerful role in shaping public discourse and in reinforcing myths and stereotypes. In one study, researchers analyzed articles about menopause published between 1982 and 1993 in both lay magazines (e.g., *Ladies Home Journal, Good Housekeeping, Woman's Day, Redbook*) and popular medical magazines/newsletters (e.g., *Prevention, Tufts University Diet and Nutrition Letter, Mayo Clinic Health Letter News*) [67]. A total of 85 articles were included in the study. The researchers found that many of the articles portrayed menopause as a normal transitional experience; however, there was an underlying message that menopause was a medical disorder, specifically endocrinopathy. The majority of the articles advocated the use of HRT, and many of the articles made generalized statements about menopause [67]

Shoebridge and Steed examined two major newspapers in Australia and three highly circulated women's magazines [68]. They found that the majority of the discourse revolved around menopause resulting in other complications, disorders, and psychological disturbance. The tone of the articles conveyed biologic determinism and focused on disease management rather than prevention [68].

In a 2003 analysis of popular British self-help books regarding menopause written from diverse perspectives, all of the books included in the study approached menopause as a deficiency disease, although most also contained a caveat mentioning that menopause is a natural course for women [69]. In general, the books portrayed this event as stressful for all women. A 2020 study involving six popular online women's magazines in Romania, menopause is typically depicted as a negative biological condition. Early menopause was linked to infertility, which then cast women as less useful and relevant [192].

Overall, Western societies tend not to depict menopause in a positive manner. Menopause is often the arbitrary dividing line society has established for acceptable female sexuality and attractiveness. After menopause, a woman is often dismissed as no longer sexual and youthful [137]. Alternatively, premenstrual and menstrual women are often portrayed as hormonal and temperamental [137]. These societal images and messages may be internalized by women, who then associate menopause with negative aspects of aging and loss of desirability. With this transition comes an array of negative symptoms and disorders. Many women express surprise that their experiences with menopause were not consistent with the less than positive portrayals they have seen [183].

WOMEN'S EXPERIENCES OF MENOPAUSE: CULTURAL NUANCES

Globally, the mean age of naturally occurring menopause is 48.8 years [180]. In a systematic review of studies that mentioned menopausal onset and symptoms, researchers found that the median age for menopause in North America ranged between 50.5 to 51.4 years, with a similar range (50.1 to 52.8 years) noted in Europe [114]. In Latin America, the median age ranged from 43.8 to 53 years, and in Asia, the median range was 42.1 to 51.1 years [114; 138]. Menopausal symptoms varied tremendously across countries, geographic regions, and even across ethnic groups within the same region, with presumable influence from socioeconomic factors [138]. Making definitive conclusions regarding what might attribute to these variations is challenging [114; 138].

In fact, there does not appear to be a single universal menopausal experience [115]. On one end of the continuum, there are cultural groups in which menopausal women gain social status (e.g., Mohave Indians). On the other end of the spectrum, in cultures in which having children is valued highly, women who reach menopause are devalued, especially if they do not already have children (e.g., Gisu women in East Africa) [193]. A survey and

comparison study noted that symptoms like hot flashes differed among women in different countries. United Kingdom (UK) women's experiences with hot flashes were similar to women in the United States and Canada but different than experiences of women in China and Japan [115]. While menopause is a biologic process marked by perhaps universal changes, the meanings of menopause informed by culture will shape the experience of the symptoms in different ways.

SYMPTOM REPORTING

Whether or not a clear menopausal syndrome consisting of a common set of symptoms experienced by a majority of women exists continues to be debated by clinicians and researchers. For many years, it was assumed that menopause and the associated symptoms were universally experienced by all women regardless of their cultural, racial, or ethnic group. In part, this assumption was based on conclusions from studies conducted with White, middle-class women and women who lived in Western countries. As more cross-cultural studies have been conducted, this belief has been challenged. The findings of this research are quite complex given the multifaceted issues of culture that researchers attempt to disentangle.

In 1996, one of the larger studies on menopause involving Western women from diverse racial/ethnic groups, the Study of Women's Health Across the Nation (SWAN), was conducted to examine White, African American, Hispanic, Japanese American, and Chinese American women's menopausal experiences [70]. The study found that less than 1% of the participants experienced early menopause (i.e., before 40 years of age). African American and Hispanic women were more likely to experience early menopause, and the Asian American women were less likely to go through early menopause. In addition, the SWAN study found differences in menopausal symptoms across groups. For example, after controlling for age, educational level, general health status, and economic stressors, White women were more likely to disclose symptoms of depression, irritability, forgetfulness, and headaches compared to women in the other racial/ethnic groups [71]. African American women appeared to experience more night sweats, but this varied across research sites. Finally, Chinese American and Japanese American women reported fewer menopausal symptoms overall compared to the women in the other groups [70]. These findings replicated those of a study comparing the menopausal experience of 105 Taiwanese and 450 Australian women, which reported that Taiwanese menopausal women reported less irritability, headaches, anxiety, hot flashes, depression, and mood changes compared to Australian women [72]. In a 2019 study, researchers found that Asian women experienced fewer cognitive symptoms related to menopause compared with other racial/ethnic minority groups [161]. In a study of 725 midlife Indian women, only 17.1% of the women reported experiencing hot flashes and 94% stated they welcomed menopause [116]. In India, aging women gain status and prestige and no longer have to go through self-imposed menstrual restrictions, which may contribute to women's experiences.

Hot flashes are a common symptom associated with menopause, and studies have produced mixed results about variations in experiences of hot flashes across racial and ethnic groups. Analysis of data from the SWAN study found higher prevalence rates of hot flashes in African American women (45.6%) compared with White (31.2%), Chinese American (20.5%), and Japanese American (17.6%) women [139]. In a large study of 436 African American and White women in the United States, researchers found that African American women were more likely to experience hot flashes compared to White women after a range of medical and demographic variables were taken into account [73]. Similarly, one study found that African American women were 1.5 times as likely than White women to report hot flashes, while Hispanic women experienced fewer hot flashes and night sweats [161]. It has been speculated that perhaps body mass index and level of psychological stress may play a contributing role in this trend [73].

It has been suggested that level of acculturation may also play a role in menopausal symptom variation, and there is some evidence that women who migrate from Eastern cultures to Western cultures have higher reported levels of hot flashes and night sweats [160]. Immigration is also associated with changes in lifestyle, diet, and stress, all of which might contribute to differences in symptomology. A study conducted by Gupta, Sturdee, and Hunter attempted to isolate cultural factors by examining the menopausal experiences of three groups of women [74]:

- Asian Indian women born in India but residing in the UK
- White women in the UK
- Asian Indian women residing in Delhi, India

Asian Indian women living in the UK had more commonalities in their menopausal symptoms with their White female counterparts. For example, they reported higher levels of hot flashes and night sweats than Asian Indian women living in India. The researchers postulate that diet, exercise, and lifestyle may influence the menopausal experience, as the Asian Indian women living in the UK group had resided in the country for more than 20 years and their lifestyles may be more similar to the White women's than the women living in India [74]. Asian Indian women living in the UK were more likely than the women living in India to attribute physical symptoms to menopause rather than to other health or spiritual concerns. Perhaps this is due to the greater promotion of health education and media focus on menopause in the UK compared to India. Compared to the White women, women in both Asian Indian groups had far more positive views about menopause. They saw menopause as a start of a new phase in life [74]. It is also possible that immigrant women have to negotiate dissonant meanings of menopause [183].

In a 2022 study in China, menopausal symptoms among 208 Chinese women from three ethnic groups (Mosuo, Yi, and Han) were examined [194]. Generally, Mosuo women were regarded the most highly in terms of family status; they are given more decision-making powers and inherit higher status with age. This group also experienced the least severe menopausal symptoms of the three ethnic groups. The Mosuo women also had more positive attitudes toward menopause. More positive menopausal attitudes correlated with less severe menopausal symptoms [194].

When analyzing individual descriptive studies conducted with different cultural or racial/ethnic groups, it would seem that there are variations in symptoms across groups. Another way of empirically examining whether a common constellation of symptoms exists across all groups is to conduct a factor analysis to determine how menopausal symptoms group together. One study analyzed the SWAN dataset consisting of 14,906 White, African American, Chinese, Japanese, and Hispanic women [75]. Their findings indicated that there was no single syndrome experienced by most women. However, two common factors did emerge: hot flashes/night sweats and psychological and psychosomatic symptoms. These symptoms varied across ethnic groups and menopausal status. Overall, the Chinese and Japanese group reported the fewest symptoms while White women reported more psychosomatic symptoms and African American women reported more vasomotor symptoms [75]. African American women also experience longer menopausal transitions, but with less depression and sexual dysfunction compared with White women [195]. International studies have shown that vasomotor symptoms were also not predominant complaints for Han and Mosuo (Na) women in China [162]. An Ethiopian study of 226 perimenopausal and postmenopausal women found that the predominant symptoms were somatic [163].

Although more studies about menopause with diverse racial and ethnic women have been conducted in the last few decades, there is no evidence to suggest that all women experience the same menopausal symptoms. However, it is important to note that there is also no evidence to suggest that they do not. It is known that menopause is a biologic event and that the social, familial, cultural, and community contexts influence a woman's individual menopausal response [76].

AGE OF ONSET

Age of menopause onset could also be influenced by culture. A meta-analysis of research regarding menopause and aboriginal women found that menopause onset for aboriginal women ranged from 42 to 51 years, with a mean of 46.7 years [164]. In a large-scale study in China involving 17,076 postmenopausal women, the mean age of onset for natural menopause was 48.94 years [165]. In this study, experiencing menopause onset at a later age was associated with consumption of meat and higher levels of education [165]. For Indian women, the average age of menopausal onset is 46.2 years, with the age appearing to be affected by demographic variables (e.g., socioeconomic status, marital status) [166]. For Puerto Rican women, the mean age of menopausal onset is 48.75 years; for Costa Rican women, it is 47.48 years [167]. In general, these onset trends are younger than the average of age of menopause in the United States (51 years) [1]. Among 747 middle-aged African American, Chinese, Japanese, White, and Hispanic women who participated in SWAN, the average age of menopause was 52.63. Hispanic women had a slightly lower mean menopausal onset age (by about two years), but the difference was not statistically significant [196].

CONSTRUCTION OF MEANING IN THE MENOPAUSAL EXPERIENCE

Menopausal Language

The presence of language or terminology to describe menopause in various languages and cultures can also provide clues about whether menopausal experiences are universal. For example, in Western culture, the term menopause tends to be linked to a malfunction in women's bodies (e.g., deficiency, failure) [117]. In Arab cultures, women in midlife and menopausal stages are referred to as being in a "desperate age" or "age of despair" [117; 152; 197]. In Lebanon, the term used for menopause literally translates to "hopeless age" [156]. As noted earlier, in the Mayan culture there was no word for "hot flashes," and Mayan women indicated that they did not experience these symptoms [16]. In another cross-cultural study examining menopausal experiences of Hmong tribal women living in Australia, the researcher found that there was no word for menopause [77]. When asked about physical changes during menopause, the Hmong women reported lighter or no periods. When asked about emotional symptoms, the women reported none and found the concept of emotional difficulties caused by menopause amusing [77]. Similarly, a 2010 study with First Nation women in Canada found there was no single word for "menopause" in the Oji-Cree or Ojibway languages, with women referring to the phenomenon only as "that time when periods stop" [118]. In interviews with 185 racially/ethnically diverse women 45 to 55 years of age living in Hawaii, the pre-menopausal women expressed fears about becoming emotionally unstable [140]. In Japan, the term *konenki* is used, which connotes a natural transition [168]. In Iran, there is no specific word for menopause; some women simply say *bashdan dushmak*, which means "cessation of menses" [147]. Likewise, there is not a direct translation for the word menopause in China, although *juejing* means permanent cessation of menstrual periods and *gengnianqi* means losing one's temper during midlife [182].

Loss of Youth and Physical Attractiveness

Among middle-class White women, menopause often symbolizes the loss of youth. It is "the change," the transitional marker to aging. This was demonstrated in a focus group study with White and African American women. White women in the study were more likely to link menopause with fears about the physical components of aging compared to their African American counterparts. The African American women were more likely to view it as a normal phase of life [78]. This was also true in interviews conducted by Dillaway and Burton [113]. In this study, African American women were more likely to take their menopausal symptoms in stride while the White women were more negative about the experience and were also more likely to seek medical treatment for menopause. In another qualitative study involving 17 White, middle-class women, participants were asked to discuss perceived changes in physical appearance as a result of menopause [64]. The women viewed these physical changes, such as wrinkles, sagging arms, drooping breasts, and dry skin, with sadness and a sense of loss [198].

In interviews with Greek Cypriot women, the narratives were marked with talk about decline—typically in one's body or appearance [149]. This was mirrored in studies of Turkish and Vietnamese women [169; 170]. In a qualitative study with Iranian women, the participants discussed fears of the physical effects of menopause, which perceived loss of youth/vitality, accumulated toxins in the bodies, and vulnerability to illness and disease [147]. In another qualitative study with 27 Iranian women, participants discussed moving from uncertainty (e.g., fear of losing one's femininity and fertility) and toward acceptance [199]. This theme also emerged in a focus group study of menopausal Japanese and White women [79]. Researchers found that the White women from the focus groups concentrated on menopause as a loss of womanhood and youth and their conversations revolved around what is lost when one gets older (e.g., physical attractiveness, competitiveness). On the other hand, Japanese women in the focus groups related a perception of menopause as a transition from motherhood to a more whole person. Part of this stemmed from no longer feeling obligated to fulfill certain expected social roles (e.g., the duty to be a mother). These transitions were viewed as positive opportunities [79].

Psychological Loss

In one study with Italian Australian female immigrants, the women described menopause as "a time of sorrow" and a period when "life becomes heavier" [80]. They acknowledged the changes on a both physical and social level. To these women, menopause was associated not only with losses but vulnerabilities. The loss of reproduction was linked to the metaphor of "bad blood," leading to potential health difficulties associated with menopause [80]. In African cultures that highly value motherhood, women who are menopausal and without children often experience depression [141].

In an online study of 30 White women in their midlife years, women were recruited to participate in online forums for six months to discuss various topics related to menopause and the meanings these women ascribed to menopause [81]. A general theme of concern about the loss of youth emerged, which led to re-evaluation of identity. The reflection of changing sense of self and identity were also mentioned in Walter's qualitative study with primarily White postmenopausal women from diverse socioeconomic backgrounds [82]. Many of the women indicated "that they experienced some feeling of uncertainty regarding their body, which heavily influenced their emotional and cognitive reactions" [82]. These feelings were connected to a fear of loss of control, which can disrupt women's social order [149]. This inward reflection is linked with the physical changes women often experience. For some Iranian Muslim women, menopause triggered a deep reflection of the meaning of aging, mortality, and loss of future opportunities [198].

Freedoms

Some research with menopausal women has indicated that women may feel liberated in not having to experience a period and not having to plan their lives around their periods [61; 136]. In one study of 21 women in midlife, the participants reported feeling more sexually confident, being more "in tune" with their body, and experiencing this time period as a "happy window" [136]. In some cultures, aging women are venerated and elevated to a higher social order [171]. For example, Muslim and Hindu women who are menstruating are not allowed to perform certain religious functions or rituals, but this changes with menopause, opening new religious opportunities [171; 172].

African American women in six focus groups expressed happiness at being free from menses and pregnancies [83]. Iranian women in a qualitative study talked about the freedom of having the monthly management of menstruation. For some, menstruation had been heavy and painful; therefore, cessation was liberating [184].

There also appears to be a psychological freedom associated with menopause. Additional studies of White, middle-class women have identified similar themes of freedom, choice, and ability [84; 120]. In a survey study of 676 Nigerian women's attitudes toward menopause, the theme of freedom was prominent [85]. The women involved in the study were all at least two years postmenopausal. The survey results indicated that, for the majority, menopause was liberating and brought a sense of maturity, comfort, peace of mind, and fulfillment and an increased access to worship [85]. In another study, Tunisian and French women used the term tranquil [193].

A study with Chinese American and immigrant women during their midlife stages revealed that the women understood that menopause is a natural order of life, and while they would prefer youth to the aging process, they accepted menopause as inevitable [86]. Furthermore, they identified menopause as a time of liberation during which they could care for themselves and their inner needs, without being tied down to family and professional responsibilities. This was also expressed in several other studies, including a qualitative study with 65 Korean women from Seoul and a study with 42 aboriginal Mi'kmaq women from First Nation communities in Canada [87; 88]. In the former study, the Korean women did not deny initial feelings of loss and sadness, but eventually they progressed to feeling liberated. The women expressed an ability to enjoy life with more light-heartedness, free from responsibilities of husbands and children [87]. Participants in the study of aboriginal women echoed these themes of freedom—being liberated from having children and childrearing and being free to search for activities outside their roles as mothers and caregivers or even leave unhappy relationships [88; 193]. Similar themes surfaced in Dare's qualitative study with 40 Australian women in their midlife [108]. Most of the women in the study experienced symptoms in varying degrees and described them as irritating and uncomfortable, but they did not view them as debilitating or distressing. Many did view menopause as liberating. It is important to acknowledge that for those who experienced greater distress during menopause, there were also concurrent stressors in their lives that augmented their distress [108]. No longer having to live up to culturally defined ideals of femininity and beauty have also been reported as freeing by menopausal women [112]. Liberation from the responsibilities and inconveniences of infertility was likewise reported in studies of southeast Asian women [170].

Neutral Meanings

It is often automatically assumed that women will view menopause as "traumatic" or "significant," attaching considerable meaning to this event. In a quantitative study with 140 first-generation Korean American and Korean women from low-income households, one of the major themes was that they gave the menopausal experience far less attention than their current life situations, which were marked by stressors and demands related to immigration and employment [89]. Consequently, less emotional investment was focused on menopause and its associated symptoms, all of which

were viewed as a normal part of life [89]. Similarly, in a qualitative study with a total of 61 women from diverse racial/ethnic groups, women from all groups expressed frustrations with the symptoms related to the physical bodily changes [62]. However, the attitudes toward menopause itself differed. African American and Hispanic women had more positive attitudes compared to their White counterparts. For example, there was less anxiety regarding menopause as a life transition, and African American and Hispanic women expressed feeling too busy dealing with day-to-day realities to be burdened with the worries about what menopause means. Similar results were found with Taiwanese women from Taiwan and White women from Australia. In a large survey study, Taiwanese women were found to have neutral feelings about menopause and more Australian women were relieved not to have to deal with menses [72].

Normal Part of Life

Many women acknowledge that menopause is a normal developmental life event. In a survey of 200 highly educated Asian Indian women from Pakistan, the majority (87%) felt that menopause was a normal transition in life [142]. In Sri Lanka, women in a qualitative study indicated menopause was a natural stage in life and did not represent an end to life [200]. A study with Iranian women found a prevalent belief that menopause was God's will, natural, to be accepted, and a fact of life [147]. Similarly, in a study with 165 Filipina women in their mid-life, many stated that menopause is a part of life and was not considered a big issue [90]. However, this did not necessarily mean there are no negative connotations, as some of these women also said that it could be a scary experience [90]. In a quantitative study of Turkish women in midlife, those who viewed menopause as a normal part of the developmental life cycle experienced fewer menopausal symptoms compared to those who saw menopause as pathologic [121]. This finding is consistent with other studies done in India, Africa, and Thailand [116].

Celebrations of Growth and Maturity

A focus group study with White and African American menopausal women revealed that they felt they had greater sense of self-esteem and sense of worth [78]. They no longer rested their identities and sense of who they were on other people's valuation of themselves. The researchers observed a language of emancipation in these women's stories [78]. In a 2021 systematic study, researchers found that immigrant women tended to hail menopause as a time of mastery, maturity, success, and stability [201]. In the study conducted in Hawaii, participants expressed feeling wiser and that they had entered "a new womanhood" [140]. Some likened it to a rebirth, because they were able to focus energy on themselves rather than their children and families [197].

In some countries and cultures, aging women gain greater social status. For example, as Asian women age they attain greater respect and have greater authority in the household [34]. Similarly, in African countries and Palestine, postmenopausal women report finding greater equality with men as their position in the family and society are elevated and strengthened [141; 152]. Consequently, menopause represents a positive transition. However, some have questioned whether acculturation, Westernization, and modernization have affected perceptions of women's statuses as they age, even in these cultures. In a rural area of Thailand, researchers observed that women's health status was vital in maintaining the economic vitality of their households [91]. However, menopause is associated with getting old, and therefore, women in this area of Thailand still had to contribute in a productive manner, just like their younger counterparts, in the domestic spheres. As women age, they will not necessarily gain social status, but a reciprocal relationship may develop between older and younger women [91]. The Thai women in the focus groups indicated that menopause had not really affected their social status as they continued doing what they had been doing [91].

"Bad Blood"

In some cultures, there is an emphasis on the vitality of blood. Therefore when menopause occurs and blood is no longer being lost, women may believe that they are retaining "bad blood." This concept emerged in a survey study with 676 Nigerian women. Many participants expressed worry that lack of menstrual flow would lead to illness, as menstrual blood flow was believed to drain away impurities [85]. This cultural explanation is also shared among some women in Iran and in rural parts of Thailand. A qualitative study found that some Thai women did not want to go through menopause because they feared how their body would eliminate "bad blood" after menstruation ceased [91]. The drainage of this "bad blood" was linked to good health and youth. This culture-bound relationship between health and blood is consistent with beliefs regarding the importance of blood in shaping not only health but personality and emotional states [91]. Muslim Iranian women expressed the same anxiety about no longer being able to excrete "polluted" blood from their bodies [198].

In summary, there has been a considerable amount of literature that suggests that there are sociocultural variations in menopausal experience and in the significance of the life event. These sociocultural variations may result from differences in such variables as social roles, cultural and societal beliefs about femininity and aging, traditionalism/modernization, family and social networks expectations, and a host of systemic and institutional factors. Given these considerations, the utility, validity, and reliability of a clinical entity for menopause or a diagnosis of a "menopausal syndrome" is questionable [92]. Some have noted similarities between this controversy and the early debates in psychiatry regarding mental disorders [92]. In the field of psychiatry, much has been learned about the roles of culture and social definitions in diagnostic outcomes. The study of menopause can also benefit from a more precise definition and the use of larger sample sizes in research studies.

PRACTICE IMPLICATIONS

In working with diverse women, it is important to use a client-centered approach (as opposed to a disease-centered approach) to health and mental health care [6]. A client-centered approach focuses on the patient's thoughts, emotions, cultural and social environment, and cultural identity. The practitioner should listen carefully to how the patient describes the menopausal experience, particularly the vocabulary and metaphors used. This client-centered approach will ensure that practitioners do not simply categorize all women into one homogenous group. It is important for practitioners to avoid the myth that there is a sisterhood based on race/ethnicity; rather, each woman possesses unique strengths, resources, and needs.

ASSESSMENT

Huffman and Myers recommend that practitioners, in their clinical work with perimenopausal and menopausal women, ask and facilitate the following types of assessment questions in their counseling sessions [94; 173]:

- What are the patient's attitudes about aging and menopause? How have societal and cultural beliefs affected these attitudes?
- What are the patient's expectations and fears about menopause?
- What are the patient's most immediate needs and concerns? Are they biomedical, cultural, or psychosocial?
- What has the patient heard about menopause? How much of this could be considered factual?
- How healthy is the patient's lifestyle in terms of diet, exercise, smoking, alcohol intake, and use of over-the-counter medications?
- What is the patient's family medical history in terms of osteoporosis, heart disease, and cancer?

- What are the major stressors in the patient's life?
- What can be done to reduce the stress?
- How much thought and effort has the patient put into taking care of herself?
- What perimenopausal or menopausal symptoms has she noticed?
- What are her information gaps about menopause?

As noted, there is no universal menopausal experience. It is important to ask the patient directly how menopause has affected her physically, psychologically, sexually, and socially.

CLINICAL ISSUES FOR EXPLORATION

Due to the multifaceted biopsychosocial issues associated with mid-life and menopause, care of patients during this phase of life should involve the entire interdisciplinary team. Patients might express concerns about aging and fears and anxiety about the aging transition [20]. In Western society, aging for women is much more stressful than for men, as aging for women typically equates to a loss of femininity. As men age, more positive attributes related to their masculinity, such as competence and power, are attributed to them [95]. In a society that emphasizes youthful beauty and attractiveness, women may experience more fear, anxiety, and concern about their identity as they age and may feel pressured to prove themselves as productive and valuable members of society [95; 202]. Practitioners may explore what aging means to the patient, how her family and immediate social network view aging, and if anything has altered as a result of the aging process. As discussed, practitioners should keep in mind the cultural variations in patients' beliefs about aging; for many racial/ethnic minority women, sexism, classism, and racism also influence these views.

It is important to explore how intersectionality impacts women's experiences [143]. Racial and ethnic minority women live and navigate multiple types of oppression that affect their social identities and ultimately their experiences and attitudes. For some, sexism and racism may contribute to experiences of marginalization, while for others, classism, sexism, and ableism have profound influences on their identity, which may then influence views about aging and menopause. Health and social service professionals should ask open-ended questions in order to determine how patients construct meaning for concepts like race or ethnicity [143].

Women during their midlife years may perceive that their youth, attractiveness, and productivity have been lost. Other women may feel that they are losing their children as they become adults and achieve greater independence. The changing dynamics of relationships may be more pronounced during mid-life. These shifts and perceived losses may trigger great introspection about value conflicts and dissolutions of dreams and expectations [202]. Women in midlife experience uncertainties in an array of physical, social, cultural, familial, and psychological dimensions [202]. The notion of loss will inevitably emerge in the clinical encounter. Indeed, in a longitudinal study, psychosocial loss was a crucial predictor in how women experienced menopause [144].

The practitioner can ask the following questions to explore these themes [94]:

- Who are in the patient's support network? Who listens to her story and converses with her to help her make sense of her experience?
- What are other women thinking and experiencing who are at the same stage in life?
- What was her mother's experience? Experiences of older friends and relatives?
- How does she anticipate her life changing in terms of losses? Gains?
- What new beginnings would she like to see? How can she help these happen?
- How does she want to define menopause?
- How does she want to redefine herself as she moves through this transition?
- Who is in charge of her menopause?

ROLE OF FAMILY

It is important to remember that menopause is not necessarily a woman's issue; rather, the experience of menopause is the product of an interplay of current and past cultural, social, familial, environmental, and psychological factors, all of which influence how women will respond or believe they should respond. In addition, their experiences and responses will affect those around them [8].

Practitioners should examine the interaction of a woman's experience with menopause and her family. It is important to keep in mind that a woman's menopausal experience is not removed from her family's developmental life cycle; rather, it is embedded within it [97]. For example, is the woman going through menopause during a time of divorce, raising children, providing caregiving to elderly parents, widowhood, or while her husband or partner is going through a midlife issue as well [97]? Practitioners can then serve as family educators and facilitators, providing family members with information about the biopsychosocial dynamics of menopause. This is particularly important because menopause is not frequently openly discussed among family members, and it may help ease tensions that can ensue if family members perceive the menopausal woman as being irrational or irresponsible [202]. For example, a husband may not understand his wife's changing sexual responsiveness or may not understand the symptoms associated with menopause [97]. In a qualitative study examining women's discussions about menopause with their spouses, many women reported negative interactions [98]. One woman in the study related that her husband continually urged her to see her physician so she could "control" her symptoms. In an in-depth study with 12 Aboriginal women, many of the participants expressed a desire for their spouses to have a better understanding of the symptoms and physical changes (including the effect on sexuality and libido) caused by menopause [145]. In a small study of male partners of menopausal women, the men related feeling that their partners' emotional instability was due to "raging hormones" [13]. As facilitators, practitioners can serve to open the communication and dialogue process between family members about the perimenopausal and menopausal experience as well as the meanings of transition and aging. Providing husbands and partners training and information about the menopausal experience can be a crucial element in building a support system for women [203]. Peer support groups, participatory lectures, and group therapies for men with the goal of sharing information and experiences are also recommended [204]. Educating men and women about menopause has been found effective in increasing marital satisfaction and in fostering communication within a couple [174].

ROLE OF EDUCATION

Women in perimenopausal and menopausal stages have a strong need for information about menopause and what to expect physically and psychologically [99]. Women with knowledge about menopause are more likely to report a positive attitude, but many do not seek to learn more until they experience symptoms [175]. In focus groups with African American women from Louisiana, many indicated they were not provided with adequate information about menopause. They desired lifestyle management information specific to their unique medical needs. For example, although they recognized the importance of exercise, other medical issues (e.g., knee pain) can impede them from implementing exercise regimens. Accountability and social support with other menopausal women were also identified as important [195]. In the study of Aboriginal women, nearly 30% were not knowledgeable about the symptoms associated with menopause [145]. In many cases, women get much of their information from the media, which generally portrays menopause in a negative manner. Women may also seek information and advice from their physicians, but physicians often focus on a biomedical perspective, which emphasizes pathology and deficits. Social workers, counselors, nurses, and other practitioners can serve as a bridge by providing informational resources about the physiologic, psychological, and social changes that typically occur during these stages. Practitioners can also direct women to information about the risks and the benefits of

HRT, alternative medicines, and dietary practices in relation to menopause. However, it is important that behavioral health professionals not provide medical advice and direct their patients to discuss options with their physicians.

In working with racial/ethnic minority women, practitioners should keep in mind how racism and classism might affect help-seeking patterns. For example, some racial/ethnic minority women are overwhelmed by the day-to-day stressors of life due to poverty, discrimination, and oppression [99]. For example, in one study, African American couples were administered a survey about help-seeking for marital problems and then interviewed. More women (54%) than men (38%) were willing to seek professional help (e.g., counseling). Stigma and discrimination were cited as barriers, and one participant linked the stigma and fear of discrimination back to the atrocities African Americans experienced during slavery [47].

In many cultures, discussion of sexual matters is considered private and taboo. Therefore, some women may not feel comfortable in discussing menopausal matters with their physicians, particularly if the physician is male [175]. Women may also experience anxiety based on cultural beliefs related to the cessation of menstruation, as in the case of Nigerian women who believed it resulted in a build-up of impurities [85]. In a survey study with 746 Iranian women, 30% of the women disclosed the belief that sex during menopause was against their culture [93]. Nearly 35% of the women viewed sex during this time with shame, and 18% felt it was a sin. Practitioners may benefit from additional continuing education for themselves so they may remain informed about unique cultural norms that may affect an individual's beliefs about menopause and aging. Furthermore, educational resources should be provided within a forum that is culturally sensitive, accessible, and relevant. Churches, community centers, ethnic fairs, and sororities can offer such resources [99].

Having a structured education forum can be a source of needed information and also support for menopausal women. Although in many cultures privacy is paramount, particularly in regards to sexual topics, women often have many questions about menopause. Research indicates that many women obtain information about menopause from their mothers' experiences [122]. A structured educational series has been shown to improve health status (i.e., physical and psychological symptoms) and improve cognition in postmenopausal women [123]. This may be particularly important as some women may be obtaining their information about menopause from sources that are not always accurate. In a study of Chinese, Malay, and Indian women in Singapore, the participants stated they mainly obtained information about menopause through lay magazines and television [96]. Given the myths that are portrayed about menopausal women, assessment of each woman's acceptance of inaccurate stereotypes and level of knowledge is warranted. Practitioners can conduct education one-on-one with clients or in groups. Groups may be educational or psychoeducational in nature, providing both education and support [99]. Groups can be an effective way to encourage women to share their stories regarding their experiences, feelings of loss, successes, and strategies for coping; it can be a forum to explore how myths and stereotypes about menopause affect their lives [99]. These groups can serve as rites of passages for women in their midlife transitions, as there are no formal rites in Western society for menopause [20]. In one study, women receiving structured education on menopause experienced a slight decrease in depression and menopause symptoms, while those who did not receive education reported an increase in symptoms [176].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The National Institute for Health and Care Excellence recommends giving information to menopausal women and their family members or carers (as appropriate) that includes an explanation of the stages of menopause; common symptoms and diagnosis; lifestyle changes and interventions that could help general health and well-being; benefits and risks of treatments for menopausal symptoms; and long-term health implications of menopause.

(https://www.nice.org.uk/guidance/ng23. Last accessed October 27, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

SELF-CARE

Self-care is very important for perimenopausal and menopausal women [124]. In many cultures, women relegate their needs to the needs of others. However, because menopause is a process of changes and transitions, practitioners should encourage women to do more self-care, which may consist of exercise, eating properly, deep breathing exercises, yoga, walking, mindfulness, and/or relaxation techniques [177; 205]. Mindfulness practice has been shown to be effective in regulating emotions and can teach individuals mastery and control of intrusive and negative thoughts, ultimately leading to self-acceptance [205]. In addition, having women track and monitor their symptoms, what they eat, and how much they exercise can assist practitioners to identify what things might exacerbate menopausal symptoms [124]. However, at least one study found that very few women practiced yoga or other forms of exercise to cope with menopausal symptoms [96]. Work pressures, lack of motivation, and lack of social support were cited as factors.

INTERPROFESSIONAL COLLABORATION

The uptake of interprofessional collaboration and practice in menopause care has been slow [206]. Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for patients and their families to improve health, mental health, social, and/or family outcomes [207]. It involves the interaction of two or more disciplines or professions who work collaboratively with the patient on an identified issue [208]. Providers come together and view and discuss the same client problem from different lenses, which can ultimately produce more out-of-the-box solutions [209]. The patient is not excluded from the process; rather, it involves shared decision making from all party members [207]. Therefore, interprofessional collaboration in the area of menopause supports women in midlife by addressing specific, unique women's health issues to improve outcomes and quality of life [210].

CULTURALLY COMPETENT MENOPAUSAL MANAGEMENT

Several culturally competent menopausal management interventions have been identified [119]. Although originally developed for Asian immigrants, some or even many may be applied to other racial/ethnic minority groups [178; 179; 211; 212]:

- Hormone replacement therapy: White women tend to use hormone replacement therapy (and desire its use) more frequently than ethnic minority groups. The choice of whether or not to use hormone replacement should be individualized. In addition, practitioners should educate women regarding the benefits and risks of long-term hormone replacement therapy.
- Complementary and alternative medicine: Racial/ethnic minority women tend to use herbal and other complementary approaches to address menopausal symptoms (e.g., soy products, acupuncture, and other herbs in Asian cultures). There is research supporting the use of acupuncture, yoga, mindfulness techniques, and tai-chi to manage menopause symptoms. However, each woman's cultural beliefs about menopause may affect the efficacy of any approach.

- No management: Because of cultural values of persevering and remaining silent and the belief that menopause is a normal developmental transition, some racial/ethnic minority women will be less likely to employ specific management interventions for menopausal symptoms.
- Information from family and friends: Cultural minority women are more likely to rely on information from family or friends than to seek information from health, mental health, and social service agencies and clinics. Furthermore, providers have expressed feeling unconfident in their ability to discuss the topic in a culturally competent manner.
- Low health literacy: Women who have sought specific menopausal information written in their native language have few resources and limited detail.
- Counseling and self-help: Cultural values of persevering, relegating individual needs to the needs of the family, and lack of trust in the medical system, racial/ethnic minority women are less likely to seek mental healthcare.

EVIDENCE-BASED PRACTICE RECOMMENDATION

For postmenopausal women seeking relief of vasomotor symptoms of menopause with over-the-counter or complementary medicine therapies, the Endocrine Society suggests counseling regarding the lack of consistent evidence for benefit for botanicals, black cohosh, omega-3-fatty acids, red clover, vitamin E, and mind/body alternatives including anxiety control, acupuncture, paced breathing, and hypnosis.

(https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines/treatment-of-menopause. Last accessed October 27, 2022.)

Level of Evidence: 2 | ⊕⊕ (Suggestion based on low-quality evidence)

COUNTERTRANSFERENCE ISSUES

Countertransference is defined as a practitioner's reactions to a client's feelings and responses in the clinical encounter that stem from his/her past reactions (i.e., transference). In working with any group, there will be unique countertransference issues associated with the specific clinical issues relevant to that population. This remains true for practitioners working with women in their mid-life who are going through perimenopause and menopause. Three primary countertransference issues may arise when working with women in their midlife developmental stage [101]:

- Fear of aging and death
- Anxiety regarding loss of femininity and role status
- Competition with younger women

These countertransferences are the same beliefs that patients may hold. Some practitioners may avoid discussing these issues because of their own fears or anxiety of death and growing old. Consequently, it is important for practitioners to have a knowledge of how their mothers dealt with menopause and how their family-of-origin's attitudes and belief systems about aging, transition, femininity, and beauty affect their own feelings on the subject [20].

For younger practitioners working with women in their midlife stages, it is important for the practitioner to keep in mind how he/she views the patient [102]. For example, does the practitioner see the individual as the idealized or denigrated grandparent or parent? The practitioner may feel compelled to act and do rather than to be with the patient [102].

CONCLUSION

It is vital to take an integrative, holistic approach to the study and care of women experiencing menopause [28]. To take strictly a biologic approach would ignore the cultural and social contexts in which women experience this life event; it would assume that women's health and health behaviors are solely the result of biologic determinants. This would yield only deterministic notions about women's biology and ultimately perpetuate and reinforce patriarchal ideologies about women's roles and unequal power relations [28]. However, adhering solely to a feminist perspective about menopause would underplay the potent role of biology. The interplay of biology, culture, and other social factors is complex.

As the United States becomes increasingly heterogeneous, social workers, counselors, and healthcare practitioners must learn to work effectively with patients from a variety of racial, ethnic, and cultural backgrounds. This means being able to communicate, assess, and provide services that are culturally competent and culturally sensitive. Patients will bring their unique life stories and concerns related to menopause to the practitioner, and their cultural values and belief systems will inevitably shape how menopause is defined. This will ultimately influence menopausal women's effective coping, problem-solving, and communication strategies.

RESOURCES

The following are resources that practitioners may find useful or may share with patients to reinforce education.

Centers for Disease Control and Prevention Women's Health
https://www.cdc.gov/women

The North American Menopause Society
https://www.menopause.org

National Institute on Aging
https://www.nia.nih.gov

Third Age
https://thirdage.com

MedlinePlus: Menopause
https://medlineplus.gov/menopause.html

Office on Women's Health
https://www.womenshealth.gov

U.S. Preventive Services Task Force
https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/menopausal-hormone-therapy-preventive-medication

Women's Health Network
https://www.womenshealthnetwork.com

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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