

PSYCHOLOGICAL ASPECTS OF MENOPAUSE

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Historically, *menopause research* has developed mainly on the basis of endocrinological issues and research findings. The studies dealt primarily with the widespread complaints that women suffer in association with the menopause, with the intention of serving medical practice as directly as possible.

In 1870, a woman's mean remaining life expectancy by the time her youngest child left home at the age of twenty was only six years. Today, a woman and mother lives for another three decades on average once her children have left the family. Therefore, the psychological health status of this large female population is of considerable social relevance [1].

The Berlin Menopause Study presented here differs from other studies in that it did not interview patients from menopause clinics. Patient samples are subject to a considerable selective systematic sample error with regard to the overall female population. The results of major and methodologically established studies with psychosocial questions concerning the menopause have been published in the *European Menopause Journal* or in *Maturitas*, among others [2–7].

In our Berlin Menopause Study [8], women from the population of Berlin (age 45–55 years) were studied, and later a nationwide study was conducted with a representative sample of 600 women (age 47–59 years). The data collected in this later study shows major correlations with the results of

the Berlin study presented here [9, 10]. The studies on menopause complaints [11] were continued in an evaluation of the Menopause Rating Scale MRS II, with a follow-up after 18 months [12].

We studied women in Berlin (a quasi-healthy metropolitan sample) that were not necessarily receiving gynecological treatment during the study period, although they were all menopausal in all the other framework aspects. Thus we are able for the first time to report on the overall well-being spectrum of women (initially from a metropolitan area only).

Causal Attribution

We were able to observe that from the woman's perspective the symptoms experienced during the menopause were attributed mainly to the hormonal change. However, since the woman sees herself as a biographically evolved personality, she certainly will not overcome her own menopausal re-orientation without the psychosocial and individual aspects inherent to her.

In a good doctor-patient interaction, the primary endocrinological attribution of climacteric complaints by the woman should be supplemented by the offer of coping strategies for psychosocial aspects of quality of life during the menopause that go beyond mere hormonal care. Such a co-operation should increase the therapy compliance.

In addition to hot flushes, perspiration and nocturnal waking caused by

estrogen deficiency, other factors that limit the well-being and quality of life of women during the menopause have been reported. Such complaints include other sleep disturbances and weight problems.

Psychological Symptoms

When menopausal patients develop signs of depression, irritability, anxiety, moanfulness, these should be regarded as psychological and, depending on the severity, as psychopathological symptoms and syndromes. Thereby, a probable hormonal origin cannot relieve us of the duty to make a differential diagnosis and investigate other life-related contexts.

The overlapping of causal complexes that are explained clinically-psychologically and endocrinologically is manifest in the form of a perimenopausally changed sexual behavior: loss of libido, less vaginal lubrication and reduced frequency of intercourse [13, 14]. Who can say without further investigation how great the share of depressive episodes and relationships that have petered out is in view of an endocrine deficiency condition?

Women with a higher level of education often suffer less from climacteric complaints. Belonging to a lower social class means a higher probability of climacteric symptom severity.

Shifting Role

On the perception side, the "turn of life" represents a fundamental role shift in the life of a woman [15]. Depending on how the individual woman perceived her professional role, her role as housewife and mother, or often her double role, she will lose certain position features during the menopause. Expectations in her as the holder of a

position change. The end of reproductivity means a change of role in marriage and in society. The ensuing loss of the mother role robs her of important functions within the institution family. This can lead to a crisis in the image she has of herself. The loss of the **mother role** can also be experienced as painful because society sanctions motherhood positively in relation to the other self-realization chances of a woman, or because the loss of reproductivity is experienced as an insult. The departure of her children can trigger depressive reactions. After her biographic concentration on the duties of motherhood, reorientation (including the risk of failure) is difficult. If the woman has limited herself to the role of mother for a long time, the psychological risks may be increased.

"Empty Nest" Syndrome

Sometimes, a maternal impetus that continues to act without function is observed. After the subjective loss of meaning of the family structure and a newly evolving distribution of power, maternal behavior impulses may continue to act in the "empty nest" even though they no longer have any function. The mother role may be extended with positive substitution, e.g. in the form of charitable activities outside the family or caring for the children of others. Some mothers have great difficulties in releasing their own children from their role.

Family Dynamics

Marriage statistics clearly demonstrate this change: a high separation rate after the children's departure, after a long marriage the partner turns to a younger partner. Were the woman to start experimenting herself in this reorientation

phase by turning to a new relationship or new objectives in life, however, she would have to expect critical control by her peers and the younger generation.

Frequently, the sudden need to care for her own parents or parents in law is added to this critical development, so that visions have to take second place. It is often the menopausal woman who takes on the responsibility for and care of family members.

A woman's **gainful employment**, its duration and intensity obviously play a significant role in how the menopause is dealt with. Housewives are most strongly affected by the menopause; women with an intensive career may have some climacteric complaints, but they are usually less pronounced.

Psychosocial **support** may well be regarded as a positive aspect in dealing with the menopause. Menstruation, with all its hygienic nuisances and premenstrual symptoms, stops. Troublesome contraception is no longer necessary. Women with uncooperative partners feel that they have been liberated from the fear of an unwanted pregnancy. The refusal of unwanted sexual activity may be experienced as a release. The approaching end to constant caring for the offspring is a tangible relief – sometimes experienced with ambivalence.

METHODS

Pre- and postmenopausal women from the normal population of Berlin were studied using various psychological instruments. The subjects were recruited from doctors' offices, including doctors not specialized in gynecology, and other public institutions. Due to demo-

graphic differences within Berlin, only the results for Berlin (West) are presented here (n = 145). The sample was compared with the relevant overall population to verify its composition.

Instruments

In order to assess the climacteric symptoms of the subjects, we used the Menopause Rating Scale (MRS according to [11]), which evaluates the existence and severity of various physical and psychological complaints (eg, hot flushes, sleep disorders).

We also used the Freiburg Personality Inventory [16], a comprehensive questionnaire that supplies a description of individuals with regard to the strength of important personality dimensions such as aggressiveness, nervousness, depressiveness, composure, openness, emotional instability or extraversion/introversion [10].

The women's self-esteem was assessed using a validated scale ("On the whole, I'm satisfied with how I am"). As a further instrument, we used a cognitive evaluation scale for the menopause, with which we tried to determine whether and to what extent the women perceived their menopause as a phase of re-orientation, loss, threat or relief.

Qualitative Technique

The heart of our study is the projective "sentence completion technique", in which the subjects were offered 20 incomplete sentences, which they personally completed in handwriting, depending on how they experienced the menopause ("For me, the menopause means ..."). Our task was to sort the almost 2000 responses systematically in psychological categories. From the comprehensive empirical material,

it was possible to derive the individual experience, associations and attitudes towards role conflicts and crises in the menopause.

RESULTS

Attractiveness

Some authors hold that there is a connection between how the menopause is coped with and losses such as grieving for lost fertility, lost youth or insult due to loss of attractiveness. Contrary to the prevailing opinion that women experience mainly a loss of attractiveness, we were able to show that $\frac{3}{4}$ of the women did not subjectively feel any loss of attractiveness (Figure 1).

Social Attribution

Another result from the sentence completions concerns the public image of woman in the middle of life. The woman feels that she is perceived quite differently by society than by herself. More than half of the women felt that they were "less valuable" or thought to be "ready for the scrap heap" by society.

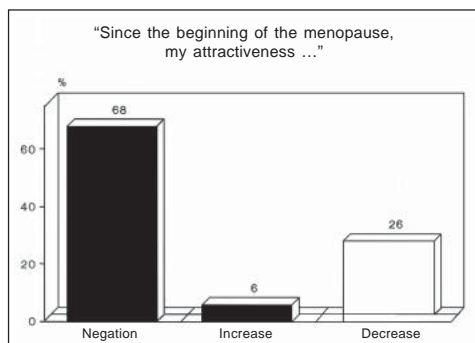


Figure 1. Personal completion of the above sentence by 138 women, allocated to psychological categories

"In society, being a menopausal woman means: "disregard", "being written off", "being relegated to the background", "not being wanted any more", "being made light of", "being beyond good or evil", "being old and useless", "suddenly being a senior citizen" (Figure 2).

Menopausal Complaints

With regard to the existence and severity of menopausal complaints (assessed by means of MRS), the picture was as follows: In terms of frequency two thirds of the women reported hot flushes, and in terms of severity 11% suffered from severe hot flushes. More than two thirds suffer from sleep disorders, and more than two thirds experience depressive episodes. On the other hand, the women in our more or less healthy sample indicated a mild to moderate severity of the symptoms, as was to be expected (Figure 3).

The severity of the manifest symptoms shows varying distribution. The subjects reported a high severity of joint and muscle symptoms and sleep disorders, followed by irritability and anxiety, reduced sexuality, depressive moods, hot flushes, and general decrease in performance and memory. The values for the symptom of decreased vaginal lubrication were lower. The 35% of the subjects that suffered from this symptom reported mainly a moderate severity. The lowest severity was reported for heart symptoms and symptoms of the urinary tract.

The Causal Attribution of Menopausal Complaints

For the gynecologist, it is important to know that 90% of the women believe their menopausal complaints to be hormonally induced. For the women, psychological and social causes are less to

the fore, they regard the hormonal change to be the main reason for their complaints. This makes the gynecologist as specialist for endocrinology the classical contact person (Figure 4).

Therefore, there is the following risk for the doctor when treating women with menopausal complaints: Patient and doctor see themselves as allies, the patient attributes her psychological problems to her hormonal change, and the doctor sees himself as the expert for physical and hormonal processes. The patient avoids dealing with her psychological problems, and the doctor is relieved because there is no need for him to discuss the psychological problems

in great detail. However, if e.g. hormone substitution therapy were not optimal, the psychological factors would have to be discussed. Both sides are behaving in a counterproductive manner by evading the psychological discussion.

Self-esteem

We found a statistically relevant connection: Women with a low self-esteem suffer more from menopausal complaints, with the exception of hot flushes. In order to help women cope with the menopause, activities that improve the self-esteem should therefore be promoted (Figure 5).

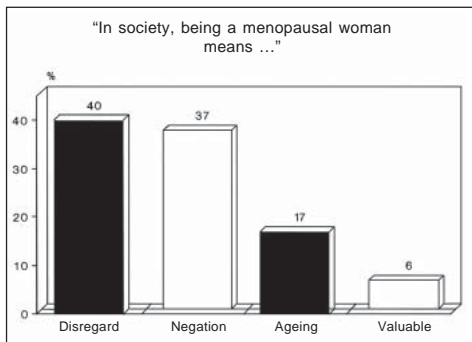


Figure 2. Personal completion of the above sentence by 131 women, allocated to psychological categories

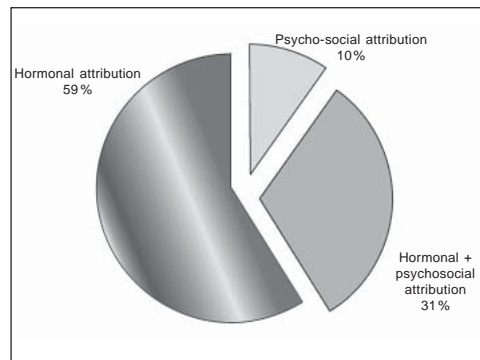


Figure 4. Causal attribution of menopausal complaints

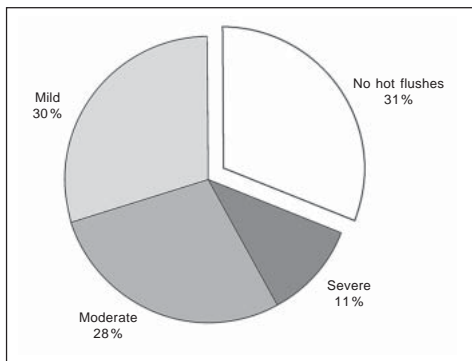


Figure 3. Hot flushes and their severity, incidence 69%, n = 126

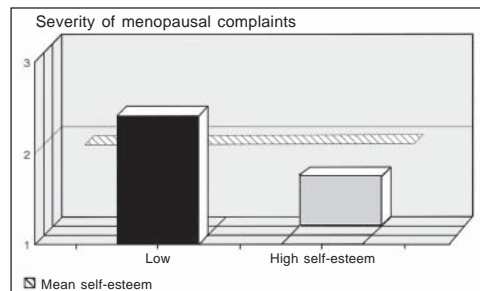


Figure 5. Self-esteem and menopausal complaints

Cognitive Evaluation

How do the women in our study rate their menopause cognitively: as a phase in life that is fraught with losses, or as a re-orientation? Contrary to the common loss hypothesis that regards the menopause largely as a tragedy or narcissistic insult due to the loss of fertility, we observed an experience of loss in only slightly more than one quarter of the women in our study. This group suffers strongly from menopausal complaints.

On the other hand, the majority of all subjects (almost 60%) experienced their menopause as a phase of reorientation in life. This perception is more likely to be associated with psychological complaints. This result can help the gynecologist to understand his patient better; if he sees the complaints less as pathological and more as the expression of an orientation crisis in a transitional phase of life, he can help her by listening to her and simply accepting her irritability and mood swings as such (Figure 6).

Cluster Analysis

An important result of this study is the fact that with regard to the menopausal complaints and individual specifics of perception of the menopause three

groups of menopausal coping can be distinguished by means of cluster analysis (Figure 7):

- the copers
- the aware
- the sufferer

The copers: More than one third of the women we interviewed experience their menopause as fairly unproblematic. For the women in this group, very little changes with regard to their quality of life, and they have very little cause for reorientation or the experience of loss. They have a high degree of self-esteem and composure. With regard to their demographic characteristics, the group of copers shows a normal distribution.

The aware: We have called this second group, again about one third of the women, "the aware". They report moderately severe complaints and experience a change in their awareness of life. This group is best characterized by an assessment of the menopause as a period of reorientation in the sense of a positive challenge, in which it manages to deal with the problems of the menopause critically and with awareness. This group has the highest level of education and almost all of these women work.

The sufferer: The third group comprises almost one third of the subjects.

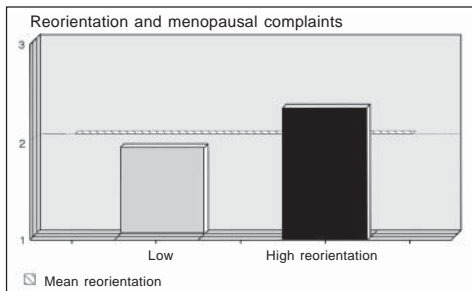


Figure 6. Reorientation and menopausal complaints

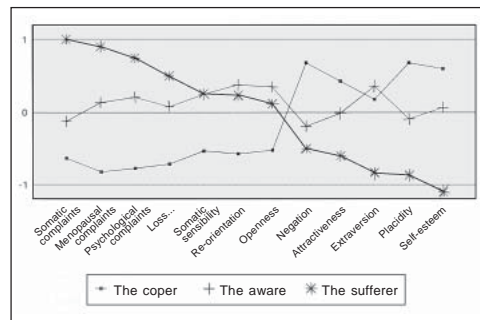


Figure 7. Perception on menopause (cluster analysis, z-standardized variable)

Compared with the total study population, these women reported the most severe menopausal complaints, which is why we have named them "the sufferers". Symptoms such as hot flashes, sleep disorders or depressive moods are particularly severe in this group. Compared with the two other groups, they have the lowest self-esteem, the highest level of loss experience and loss of attractiveness. It is conspicuous that this group most frequently includes women with a low level of education. The share of women who are divorced and live alone is particularly high. Therefore, we assume that those deficits in the quality of life that obviously exist already are reinforced by the menopause [17].

If the results of the qualitative sentence completion technique are combined with the traditional empirical data or the cluster analysis, these three groups can be described in even more detail. The distribution of social attribution of the menopause differs according to cluster: the "coper" hardly feels socially disregarded. The "aware" is the most likely to have the energy to resist the social pressure that she also feels. For the "sufferer", however, the feeling of being written off reinforces the negative self-image she already has.

The cluster analysis should not serve to typify women prematurely. The life situations of menopausal women differ far too much for this. Nonetheless, with this kind of analysis we can discover characteristics that help us to distinguish between favorable and unfavorable forms of coping with the menopause, such as the low self-esteem of the "sufferer" or the aspect of reorientation in the "aware".

SUMMARY

This study is not a combined longitudinal and lateral study. Our Berlin sample has all the demographic characteristics of a metropolitan population. For reasons of consistency of the sample, we have limited ourselves initially to the western districts of Berlin; the data for all the districts are currently being processed. Lab data, such as the hormone status, were not collected. Merely for the instrument of cognitive evaluation of the menopause there is no control sample.

Deficits in the quality of life during the menopause are reinforced in the group of suffering women. Women with a low self-esteem report more severe menopausal complaints. A connection between low level of education and stronger menopausal complaints is confirmed. The majority of the menopausal women attribute their menopausal complaints to hormonal changes.

In coping with the menopause, reorientation plays a role that must be taken into account more strongly with regard to the quality of life and in terms of a critical life event. The loss hypothesis cannot be confirmed generally for these women, with the exception of one group of complaints with high severity. A large part of the women regards the menopause as fairly uncomplicated or ignores possible burdens.

The menopausal woman perceives herself as disregarded in the public eye. This disregard is associated with psychological complaints during the menopause. The majority of the women does not experience a loss of attractiveness during the menopause, but feels that she has become less attractive for her environment.

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