# Cultural Beliefs of Menopause in the African American Woman

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Abstract

This study investigated the African American women's signs and symptoms in response to the menopausal status and their beliefs about hormone replacement therapy (HRT). The six item questionnaire was distributed to a varying socioeconomic Black female population.

A total of 44 surveys were distributed in three different locations which resulted in a 25% return rate. The study consisted of 11 respondents, all of whom worked in health care facilities.

Subjects were divided into pre-, peri-, and postmenopausal status. Statistical data were obtained from frequency tables and cross tabulations which were derived from responses to the six item questionnaire adapted from Mansfield and Voda's Midlife Women's Health Survey (MWHS).

The difficulties of sampling this particular population with this tool were discussed. This study confirms the importance for researchers to become aware of the sensitivity of the Black community towards being focused on for research.

## Introduction

In reviewing the literature on menopause, it was found that African American women have not been included significantly in research or clinical/narrative studies. Indeed, only within the last 25-30 years has menopause been considered a researchable event for women of mainstream cultural groups. One result is that menopausal studies have increased over the last 10-15 years. Today, it is less taboo to discuss the female changes that occur in a woman's lifespan.

Among primary care providers of women's health, there is a need to be able to treat women of all races based on the women's perceived health care concerns. Very little is known about the health care beliefs and health care practices of African American women, and nothing is known about their beliefs and practices surrounding menopause. As nurse practitioners deliver health care to all women, it is based on standards developed from research data gathered primarily from Caucasian women. Women appear to rely on these health care providers for reassurance about their menstrual changes despite the providers' possible misinformation or the lack of cultural relevance and misdiagnosis about the meaning of the menopausal transition.

With this research, health care providers can gain a better understanding of the African American woman's needs surrounding menopause. Therefore the research purpose was to learn what signs and symptoms African American women related to menopause and their beliefs about hormone replacement therapy (HRT). This descriptive study was done to investigate the health practices and beliefs of Black women regarding signs, symptoms and treatment of menopause. The Midlife Women's Health Survey (MWHS), was adapted by the authors from the earlier work of Mansfield and Voda (1993). However, both Mansfield and Voda worked with a predominantly white, middle class population in the East and Midwest. The current research was planned to focus on an African American midlife female population in the Northwest, specifically, Portland, Oregon.

According to 1990 census tract information, there were approximately 5,767 Black females in Portland between 35 and 74 years of age. The white female population for the same age group was 95,441 (see Appendix A, Tables 1 and Table 2 for further statistical information). Statistics showed that one third (28.2% of the population) of the African American families in Portland, Oregon live below the poverty level (Department of Commerce, Bureau of the Census,

1990). Using a sampling plan likely to access both lower and middle income Black women, the research sample was planned to cross a more diverse socioeconomic population of African American women. Throughout this research report the terms African American woman and Black woman are used interchangeably.

## Review of Literature

The literature reviewed was located in journal articles and books written about menopause. To address the topic of menopause in sufficient breadth, the initial literature search was on hormone replacement therapy, estrogen replacement therapy, menopause, and the health-related beliefs of Black women, especially those related to menopause and/or midlife. In the Medline and CINAHL data base searches, these general terms were examined: "Black women", " health care practices", " menopause", "estrogen replacement therapy" and "hormone replacement therapy" (see Appendix B, Tables 3 and 4). Only one article was found related to Black women and menopause. It contained only information about the link between osteoporosis and bone density (Luckey, et al, 1989) and was published in the Journal of Clinical Endocrinology

and Metabolism. No literature on "estrogen replacement therapy" or "hormone replacement therapy" for Black women was located in the search. Neither was there literature cited about "menopause" combined with "Black women". An abundance of articles reported on menopause, the latest in hormone treatment, and midlife women's health care practices, reflecting the more recent treatment views that both hormone replacement therapy (HRT) and fitness regimens have health benefits for women's bone density and cardiovascular well being, as well as for menopausal symptoms. However, these focused on the white middle class woman. Minimal discussion of these topics was found in nursing journals, constituting only ten articles. Most studies and articles originated within medicine, public health administration, or in the community by lay persons, authors who themselves were experiencing "the change".

Mansfield and Voda in 1990 began to research the perceptions of menopause in healthy midlife women. Their research had some startling results, that women have very negative feelings about menopause. It was found that some women considered menopause a disease while others felt it was just a sign of aging and an end to life. Mansfield and Voda (1993) state "the meaning of menopause for any woman depends in large

part on the information available to her" (p.89). In their study, they found that many women get their information about menopause from their friends (Mansfield and Voda, 1993). These studies, as stated earlier, reported on Eastern and Midwestern American women who were primarily white and middle class.

This report on the review of literature consists of four sections. The first section will begin with menopause (see Appendix C, Table 5). In this section, definitions, attitudes and research on menopause will be reviewed to clarify the different individualistic meanings that are given to the menopausal status. The next section will focus on women's health care practices (see Appendix C, Table 6) and emphasize some of the holistic approaches for women looking for natural sources. The section on Black women's health care beliefs and practices (see Appendix C, Table 7) will look at general feelings of health care. The last section will cover hormone replacement therapy, risks, benefits and regimen for taking HRT (see Appendix C, Table 8).

Menopause

Several terms will be defined for their use in this paper. Menopause and menopausal transition for this research will be defined by the following:

menopause is the cessation of menstrual periods for one year, and menopausal transition is the period of time during which menstrual changes are observed. These changes include: quality and quantity of flow and length of cycle intervals (Mansfield, Jorgensen, and Yu 1989). The climacteric is the time leading up to menopause and is associated with elevation of the pituitary hormones: luteinizing hormone (LH) and follicle stimulating hormone (FSH) (Collins, 1988). Hormone replacement therapy (HRT) is the treatment used to alleviate the signs and symptoms women experience with menopause.

Barbo (1987) states "it is important to separate the changes owing to hormonal decline at the menopausal transition and beyond from other aberrant changes and serious pathology that are a risk to a woman's life" (p.12). Barbo describes all the physiological changes that women can experience: hot flushes, breast changes, vulva changes, vaginal changes, cervical changes, urinary tract, uterus, ovary, and skin changes.

Menopause happens to every woman whether Black, White, Hispanic, Asian, etc. Because of cultural, social, and individual factors, each woman's experience is presumed to be unique in its subjective symptoms and meaning. Some suffer in silence with the signs and

symptoms of menopause. An acceptance by health care providers of the age range of menopausal transition, which may begin as early as the mid-thirties and last until the mid-fifties or later is why Mansfield et al. (1989) pointed out that researchers should be careful to use a wide sample. Mansfield et al., however, do not address the need to sample across the cultural range to prevent culturally distorted findings. The variety of experiences and beliefs are reflected by Patricia Allen (described in Sheehy, 1992), an attending physician at New York Hospital, when she stated "I believe in treating each patient as an individual" (p.17). She goes on to say, "This perimenopausal period should be a transformation, so that a woman gets to become - physically, emotionally, and spiritually - the best that she ever was" (p.17).

According to Cook (1993), "women are beginning to reject the image of menopause as a time of emotional imbalance, depression, and the beginning of the end" (p. 223). She goes on to say, "Instead, women are creating an image of individual growth and vitality and aging with dignity" (p.223). She reports that women are finally realizing that at least a third of their lives will be lived after menopause; therefore, why not live it in enjoyment (Cook, 1993). This is in contrast to

the negative views of menopause reported by Mansfield and Voda (1993). According to Mansfield et al. (1989), "negative symbolism was perpetuated widely during the late 1960's by such authors as David Reuben, who wrote that a 'woman comes as close to a man' at menopause and is 'no longer a functional woman'" (p. 44). These contrasting views of menopause, however, have been written surrounding white women's menopausal experiences.

Bernhard and Sheppard (1992) stated "many myths exist concerning menopause, but the most significant and enduring one is that menopause is a negative experience" (p. 456). They found few studies that exist on menopausal women, with even fewer focusing on the health of these women. Bernhard and Sheppard's (1992) study of 101 women (96% white and 4% non-white) documented the women's perceptions about health in a select group of menopausal women, aged 43 to 58. All were generally well-educated, employed, and affluent. The results were that 91% of the women reported symptoms of feeling tired, 87% hot flushes, and 76% being irritable and nervous (Bernhard & Sheppard, 1992).

Women's Health Care Practices

Part of the literature review focused on the popular and self-help literature aimed at the midlife health care consumer (see Appendix C, Table 6). The self-help literature available tended to be books which were holistic, addressing more than hormones and tissue changes with the climacteric. Following the literature on health practices, the research on Black women's health practices and health beliefs will be summarized in this section. Then hormone replacement therapy will be described as related to menopause.

Literature was found for the lay person who is interested in knowing more about general health care practices for this period in their life. One book, Menopause Naturally, by Sadja Greenwood (1992), a physician, covers a multitude of health care concerns of women in later years who are preparing for the second half of their lives. Greenwood (1992) covers not only menopause but also nutritional needs, relaxation, and vitamin/mineral needs.

Cook (1993) in her review of general health of menopausal women found that some self-care practices described by women are: accepting the importance of exercise, prevention of osteoporosis, and promotion of

overall health and fitness (see Appendix C, Table 5). One implication from this review pointed out that bone mass is naturally higher in Blacks, obese, and tall women, and lower in white or Oriental, thin, short, and sedentary women.

Makuc, Fried, and Kleinman (1989) looked at national trends in preventive health care for women. This study investigated three screening methods for women: breast examination, pap tests, and blood pressure checks. The study used data collected from the National Health Interview Survey (NIHS) which are household surveys conducted by the National Center for Health Statistics (NCHS). The results of this research showed changes over time by age and race with both older women and Black women experiencing the greatest gains. In terms of breast examinations, Black women in 1985 were more likely than white women to have breast exams; however, the percent of women who had never had a breast exam was the highest in both Black and white women who were poor and older. The percentage of pap tests revealed that older poor white women were less likely to have had the screening test than the older poor Black women. With blood pressure checks Black women were more likely than white women to have annual checks (Makuc, et al. 1989).

Black Women's Health Care Beliefs and Practices

Studies of health care beliefs and practices of African American women were reviewed because of their more holistic view of Black women's health and the lack of either research or popular literature specific to Black women's menopausal transition (see Appendix C, Table 7). Three articles about general health care beliefs and health care practices of African American women will be summarized in the following section. Then studies related to female health problems will be summarized.

Camino (1989) writes about the nerves and worries of Black women. The label "nerves" is described by Black women as one of the illnesses that arises from worrying too much. Camino (1989) questioned 24 adults, all of whom were Black and from a low socioeconomic area, about worriation. In her study, she found that the word "illness" meant something besides an immediate physical disorder and that it communicated messages about distress in physiological, social, and cultural circles. Camino (1989) found that symptoms described as "nerves" were accepted by Black women as being part of normal female behavior.

Smyth and Yarandi (1992) looked at Type A and Type B behavioral responses and stress in 280 employed rural

Black women. Type A Black women had a significantly lower coping score than Type B Black women using the Revised Ways of Coping Scale. Associated with the decrease in coping with stress, the study showed a higher risk among Type A Black women for hypertension and coronary heart disease. Smyth and Yarandi (1992) concluded that "maladaptive coping behaviors usually occur when life goals are not clearly defined and persons are confronted with multiple and continuing stressors" (p.264).

A qualitative research study was carried out by Flaskerud and Rush (1989) to describe the traditional health beliefs and health practices of Black women and ascertain how they are related to beliefs about acquired immunodeficiency syndrome (AIDS). They found that Black women classify illness into natural and unnatural categories. Their study showed that these traditional beliefs about sources of illness created some confusion in regards to the transmission of AIDS. The Black women agreed that AIDS could attack people whose resistance was low but could also affect those who had not engaged in sexual contact or needle sharing. One finding was the belief that washing after sex could prevent human immunodeficiency virus (HIV) infection. Another health practice reported by Black

women was the use of laxatives when the body had taken on an illness. The results of this research suggest that persons designing educational programs or doing research must not negate the Black woman's beliefs about living a healthy lifestyle and must include traditional practices while keeping today's health care concerns in mind.

The three studies described above focused on the low socioeconomic populations in the inner cities or rural Southeastern portion of the United States. There were no articles that looked at the professional Black woman. These studies pointed out the importance of cultural beliefs to the African American woman and their health care practices with traditional illnesses. However, the research did not mention health beliefs regarding menopause or midlife changes.

Black women's health care beliefs and practices with respect to breast cancer. Because it is believed that there is a higher incidence of breast cancer for some women who take menopausally prescribed HRT, the literature on Black women and breast cancer was also examined. Six articles on health care practices and health care beliefs of Black women related to cancer, breast cancer and breast self-care were reviewed (Appendix C, Table 7). Sung, et al. (1992) found "Black

women are more likely than white women to have advanced breast cancer, as well as cervical cancer and to have a lower survival rate from those cancers" (p. 382). The authors of this preliminary report of an ongoing study found that Black women believe that "breast cancer is a disease of well-to-do white women" (p. 382). This report was a beginning study which used a volunteer convenience sample, and data were still being collected.

Nemcek (1989), in her study of 95 Black women found that age and exposure to breast cancer were important variables influencing the frequency of breast self-examination (BSE) practice. Nemcek (1989) was quick to point out, however, that the study results did not support the study hypothesis that "higher breast cancer knowledge scores would be associated with greater frequency with which BSE is practiced" (p. 341). The author of the study reported that there was no previously published study of Black women and BSE practice that could be found. Nemcek had reported that the only research study found had to do with health locus of control of primarily white college educated women, that of Hallal, reported in 1983 (cited in Nemcek, 1989). Nemcek in her own study, as well as in her review of literature, found that Black women have more of an external locus of control, believing that

other people and sources out of their control were responsible for their getting breast cancer. Nemcek (1989) concludes that BSE should be part of an educational program that teaches Black women BSE as a self-care practice, one she can do herself, thus giving her more of an internal locus of control.

In their research report of 186 Black women aged 35 to 75 y/o, Price, Desmond, Slenker, Smith, and Stewart (1992) state that "over the past 30 years the mortality rate of cancer has increased 40% in Blacks and 10% in whites, while the overall incidence of cancer has increased 27% in Blacks and only 12% in whites" (p. 192). Price et al. (1992) constructed a structured interview questionnaire based on the Health Belief Model, which assumes that well being is a common objective for all persons (Appendix C, Table 7). According to this model, people display behaviors that promote and maintain wellness. The barrier identified most was the cost of mammography. According to Price et al. (1992) "women most likely to accept mammography were those who did not perceive expense, fear of detection, embarrassment, and procedural discomfort as barriers, and who were knowledgeable regarding mammography, believing early detection and treatment to be useful, and that cancer was avoidable" (p. 192).

Saunders' (1989) research used data that were collected on San Fransisco women of all ethnic groups who were diagnosed with breast or cervical cancer. He found that the survival rates for women with early diagnosis of breast and cervical cancer are greater than those with late diagnosis. However, late diagnosis for breast cancer was common for all age groups regardless of race. Black women with breast cancer tend to come from lower socioeconomic status. The study also pointed out that a number of late diagnoses for cervical cancer, especially among older women, could be the result of older women not seeking care for pap tests or the thought that cervical cancer is a young women's disease (Saunders, 1989).

Nielsen (1989) wrote an article about the need for mammography screening with a sector of the Black female population in Dade County because Black women in Dade County had a substantially higher proportion of advanced breast cancer than white women. A cancer Early Detection Program (EDP) was developed and aimed at reducing late diagnosis of cancer in Black women by using a Sylvester mammography van in the neighborhoods. Although the Sylvester mammography van operated for 18 months, Nielsen (1989) found that women over the age of 65 did not use it as a source of health care.

Recruitment efforts had sampled only 12.8% of this population.

Willis, Davis, Cairns and Janiszewski (1989) designed a study to increase Black women's knowledge about breast cancer, the use of BSE and other screening methods. It was found in this pilot project that many of the questionnaires were returned incomplete. Too few participants completed the questionnaire's demographic characteristics to allow for the planned statistical analyses.

Of the six studies reviewed, three were intervention studies (Nielsen, 1989; Willis, et al. 1989; Sung, et al. 1992), one was comparative (Price, et al. 1992), and two were descriptive (Saunders, 1989; Nemeck, 1989). Populations studied ranged from 15 to 75 years in age and included rural as well as urban women. All six studies looked at Black women's BSE and/or cervical cancer variables related to health care. In general, the literature pointed out that Black women usually experience a higher incidence in breast cancer probably due to late diagnosis. Of particular importance to the proposed study is that barriers, especially costs (Price et al. 1992), may be related to the lateness of diagnosis (Sung, et al.

1992; Saunders, 1989) in breast and cervical cancers. Knowledge itself has not been found to be a significant predictor of BSE self-care (Nemeck, 1989); and questionnaires sent to low income southern Black women did not yield complete data (Willis, et al. 1989). This information is useful to the proposed study in that it informs the researchers about problematic areas to avoid in developing the research plan.

Hormone Replacement Therapy

There are opposing views on menopause as to whether or not a woman needs hormone replacement. The biological view followed by scientists, biologists, and physicians, purports that menopause is a hormonal deficiency disease which is a woman's destiny. The literature on HRT was reviewed (Appendix C, Table 8) briefly here to identify issues related to HRT and health. As stated earlier, research reporting on Black women was lacking in the literature base. This literature review is therefore not limited by race or culture.

A different view, exemplified by Greenwood (1992) gives women the opportunity to seek natural and alternative therapies instead of using only hormone replacement therapy. Menopausal information should be distributed by all primary care providers of women so

as to empower all women to make wise choices. Greenwood (1992) aims to help women understand themselves, build self-esteem, stay connected to the world, and nurture one's creative outlets by maintaining strong bonds with other women. Although hormones are an option in menopause, the most important issue for women at this time is continuing to feel like an entity of the world, a sense of continued belonging.

Not all women are candidates for hormone replacement therapy. Some of the absolute and relative contraindications are:

absolute
- history of breast cancer
- active thrombophlebitis
- known or suspected pregnancy

relative
- history of endometrial cancer
- any undiagnosed abnormal vaginal bleeding
- history of thrombophlebitis (Gambrell, 1992).

Therefore patients should be evaluated prior to starting hormone replacement therapy. "Tests that may be useful include vaginal hormone cytology, cervical mucus fern pattern, progestogen challenge test and measurement of the serum follicle-stimulating hormone (FSH) level" (Gambrell, 1992, p. 91S).

The benefits of HRT encompass not only the decrease in menopausal signs and symptoms but also a decrease in osteoporosis and a safeguard against heart

disease. Collins (1988) (described in Appendix C, Table 5) pointed out that heart disease still remains the most common cause of death in postmenopausal women (p. 600). One major implication of Bernhard and Sheppard's (1992) study (described in Appendix C, Table 5) is that "nurses, physicians, and other women's health care providers should ask mid-life women about their health and their symptoms, how they are managing their health, and about the self-care responses they are using" (p. 460). As Wells (1989) points out "a physician who waits for a patient to complain of terrrible hot flashes has missed a golden opportunity to help her" (p. 62). He also states "that at no other time in a woman's life do so many things happen at the same time" (p. 62). Lichtman (1991) in her review of literature on hormone replacement therapy states that "the use of HRT should be individualized according to patient's needs, desires, and individual symptoms and/or risk profiles" (p. 40).

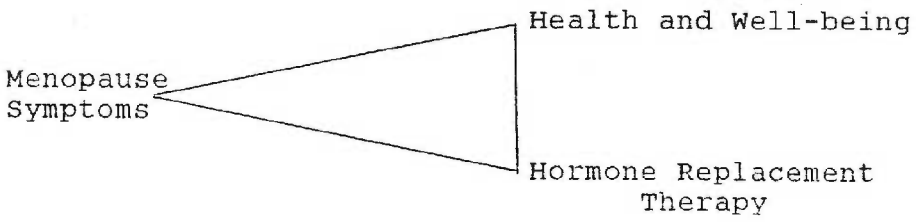
The literature points out the two ways oral hormone treatment can be given. One regimen is the cyclic therapy where estrogen is taken on days 1 through 25 with progesterone taken orally the last 10 to 12 days of the cycle. Another is the continuous method where estrogen and progesterone are taken daily. This

schedule produces endometrial atrophy and amenorrhea which many women prefer to monthly menstrual periods induced by HRT. The addition of progesterone to HRT has helped in eliminating endometrial hyperplasia (Gambrell,1992).

Although these studies look at preventive methods for women to promote health and wellness, there was no mentioning of menopausal changes in Black women and how HRT can help eliminate their signs and symptoms which develop with the onset of decreased estrogen production. The question remains, what health care practices, if any, do Black women follow during menopause and how do they perceive hormone replacement therapy?

## Conceptual Framework

The conceptual framework focuses on a three-dimensional concept of women's perceptions about the menopausal experience. The three dimensions are symptoms of menopause, health and well-being, and hormone replacement therapy, all in context of the woman's menopausal status.



The three dimensions are interrelated. Women's perception of menopausal changes may affect how they feel about their health and well-being status and then may directly relate to the use of hormone replacement therapy. The use of hormone replacement therapy may in turn affect women's perceptions about their health and well-being along with menopausal changes.

The research questions are:

1. For a given menopausal status, what is the perception of African American women about menopause symptoms and related health status?
2. For a given menopausal status, what is the African American woman's beliefs and practices about hormone replacement therapy?

## Methods

The objective of this descriptive study was to assess African American women's perceptions of menopausal symptoms, hormone replacement therapy and related health status. The fact that no prior research could be found, gave the researchers an opportunity to investigate beliefs about menopause in Black women.

### Human Subjects

The study was reviewed and approved by the Committee on Human Research (see Appendix D). Protection of human subjects was obtained through the use of confidential questionnaires by a voluntary sample (see Appendices E and F). Due to the

sensitivity of Blacks to revealing personal demographic information (Willis et al., 1989) there was no identification or follow-up of individual respondents in this study. Questionnaires were stored in a locked file cabinet at one of the researcher's homes.

Instrument and Measures

This descriptive study collected data by using a revised version of Mansfield and Voda's Midlife Women's Health Survey which was developed in 1992. The adapted questionnaire was revised by selecting specific questions from the Midlife Women's Health Survey to better fit the author's research needs (see Appendix G). Six out of the original ten questions were chosen. The section on demographics was expanded from three questions to seven questions in order to best describe the population being surveyed. This questionnaire was chosen because it had already been tested with multiple groups, and had a good size data base on white women which could be used to compare to findings from a Black women's sample.

To answer the research questions, the adapted MWHS questions were separated and analyzed descriptively. Research question 1 was answered by items: 3a, b, c, 4, and 5. Research question 2 was answered by items: 6a, b, c, and d. Menopausal changes

looked forward to from 3a were defined as:

-end of menstruation
-no fears of unplanned pregnancy
-no more concerns of birth control
-end to PMS or moodiness
-end to fibroids
-feeling wiser
-feeling more attractive
-more energy
-increase in sex drive

Menopausal changes that were worrisome from 3b were:

-hot flashes
-vaginal dryness
-weight gain
-decrease in sex drive
-feeling less attractive
-hormonal decline and related problems
-moodiness
-not being able to reproduce
-the unknowns
-loss of energy

Item 3c was answered qualitatively.

Health and well-being conditions related to menopause were indexed by item 4 and defined as:

-hot flashes
-depression
-lots of energy
-vaginal dryness
-headaches
-insomnia
-weight gain
-feelings of calm or focus
-food cravings
-irritability/anger
-feelings of attractiveness

Women's health information seeking about 10 areas was indexed by item 5. Hormone replacement therapy from item 6 was defined as the use of estrogen, progesterone, or combination of both in a cyclic or

continuous regimen.

Reliability and validity estimates for the original version of the MWHS were not available. P.K. Mansfield (personal communication, February 8, 1994) co-author of the Midlife Women's Health Survey stated that reliability and validity data were not obtained due to this being an ongoing study where the questionnaire is revised from year to year. Therefore specific psychometric data were not available. Despite the lack of reliability and validity estimates, the survey appeared the most feasible and would provide a basis for comparison between white and Black women.

The adapted version of the MWHS was checked for content and face validity. These were obtained through the use of four African American women of varying socioeconomic status, who knew the authors. The women were asked to review the questionnaire for language barriers and cultural sensitivity. Suggestions regarding the demographic information section was made by one out of the four women surveyed and it was revised accordingly. The revised section was resubmitted to all four women and it met with their approval.

Sample and Setting

The researchers met with nine individuals and one

small group to recruit subjects. There were a total of 44 surveys distributed in three different locations. Eleven surveys were returned, a 25% return rate.

These descriptive results therefore consist of responses from these 11 women. Nine of the respondents reported being African American, one considered herself Black, while another identified herself as being of both African American and Native American descent. The participants ranged in ages from 37 to 63 years. There was one individual who chose not to disclose her age. This resulted in a median age of 49.5 years (see Appendix H, Table 8). The women filled in their monthly income resulting in a range from $600.00 to more than $2500, with an average of $1768.75 per month (see Appendix H, Table 9). Three of the respondents did not disclose income.

All of the respondents worked at health care facilities. The job descriptions ranged from clerical positions, housekeeping aide, medical/health assistants, and nurses (see Appendix H, Table 10). The number of years of education ranged from 10 to 16, with one respondent not disclosing. There was one respondent who did not graduate from high school, two respondents were high school graduates, six respondents had some college education, and two had completed 16

years of education (see Appendix H, Table 11). Of the 11 respondents, six had partners, three were divorced/separated, one single and one widowed (see Appendix I, Table 12). The number of people in each household ranged from one to four persons/household (see Appendix I, Table 13).

Analysis

Subjects were divided into pre-, peri-, and postmenopausal status using responses to question 1 of the revised version of the Midlife Women's Health Survey (1992) by Mansfield and Voda on menstrual status. The premenopausal group (n=4) consisted of women menstruating in their normal menstrual pattern. The perimenopausal group (n=2) included women whose periods were changing or who had not had a period in three months. The postmenopausal group (n=5) consisted of individuals who had not menstruated for at least one full year or who had been oophorectomized. The ages of the premenopausal group ranged from 37 to 48 years. The ages of the perimenopausal and postmenopausal groups ranged from 40-47 and 51-63, respectively (see Appendix J, Table 14). Four of the postmenopausal respondents had surgically induced menopause due to total hysterectomies with oophorectomies. There was one respondent who naturally reached menopause by age

52.5 years. For the five women who considered themselves in the menopausal transition, the most frequent response chosen to the revised (MWHS) question 2, the reason for believing self to be menopausal, was "I'm in the right age bracket" (n=4) responses. All subjects chose more than one reason (see Appendix J, Table 15).

When respondents were asked if there was anything else they wanted to tell the authors about their menstrual/menopause status: one respondent mentioned having had "an ectopic pregnancy", one woman complained of "having a period for three to four months before completely stopping menstruation", another woman had "stopped twice naturally for approximately four months and then started again naturally", and another subject complained of "heavy periods".

To answer the first research question, that of "**For a given menopausal status, what is the perception of African American women about menopause symptoms and related health status,**" five questions on the revised (MWHS) were utilized (3a, 3b, 3c, 4, & 5). Each will be addressed below.

Parts 3a, 3b, and 3c looked at changes. Part 3a addressed changes respondents looked forward to at menopause. As can be seen by Appendix K, Table 16, the

responses to this question varied significantly by menopausal status. The response most frequently selected was "an end to menstruation/periods".

Part 3b asked subjects what changes worried them most. As in the prior question, response choice varied with menopausal status. Nine of the respondents chose "weight gain" as their primary worry. Seven chose "the unknowns", six chose "hormonal decline and related problems", six chose "vaginal dryness", five chose "decrease in sex drive", "other health problems", and "moodiness", four were concerned about "hot flashes", two chose "feelings of less attractiveness" and "loss of energy", and one stated concerns over "taking hormones" (see Appendix K, Table 17).

Part 3c was an open-ended question asking about any changes subjects have experienced or had been told about by female relatives. Two respondents mentioned "hot flashes" and "the event of not knowing when hot flashes would occur" plus "men not wanting you sexually". One had concerns about "anxiety and panic attacks, nervousness, and loss of energy". One stated that she was told at age 40 she was too young to experience these changes. Another respondent had very few hot flashes but had some vaginal dryness in The past.

Question 4 asked subjects how often they experienced certain conditions. Possible responses were arranged on a Likert type scale (1....2....3....4....5), where 1 was Hardly Ever, 3 was Sometimes, and 5 was Nearly Always. Answers were stratified by menstrual status and average responses were calculated for each item (see Appendix L, Table 18). For the premenopausal group, the conditions subjects reported experiencing most often were "feeling calm" and "food cravings", each averaging 3.25 on the Likert scale. "Irritability" with an average of 4.5, and "depression", with an average of 4.0 were reported most often by the perimenopausal group. For the postmenopausal group "weight gain" and "attractiveness" averaged 4.60 and 4.0, respectively.

Question 5, parts 1 and 2 asked about whom the respondents discussed certain conditions with, and whether the discussion was initiated by the respondent, the doctor, the nurse practitioner, or a family member (see Appendix M, Tables 19 & 20). Respondents could indicate one or more sources when specifying which ones initiated the discussion. Because there was no noticeable pattern differentiating menstrual status groups, the data are reported for the whole group

together. The category of cardiovascular disease was discussed by seven of the subjects with all seven being initiated by the doctor and one being initiated by a respondent, as well (see Appendix M, Tables 19 & 20). Hormone therapy (n=6) was a topic initiated five times by the doctor and once by the nurse practitioner. Discussion of body changes (n=8) was initiated four times by the doctor, twice by respondents, once by a nurse practitioner, and once by a family member. Moods (n=8) were initiated three times by the respondents, twice by a doctor, and three times by a family member. Menstrual cycle changes (n=6) were initiated four times by the respondents, once by the doctor, and once by the nurse practitioner. Cancer (n=6) was initiated four times by the doctor and twice by the respondents. Sexuality (n=6) was initiated three times by family members, twice by the respondents and once by the doctor. The topic of hot flashes (n=6) was initiated twice by the doctor, twice by a family member, once by a respondent, and once by the nurse practitioner. Osteoporosis (n=4) was initiated four times by the doctor. PMS (n=5) was initiated three times by the respondents, once by the doctor and once by a family member.

Respondents were questioned about other symptoms, possibly related to menopause that they may have been experiencing. Four respondents provided the following answers: "concerns about broken veins", "cellulite", "hairloss as male pattern baldness", "feelings of tiredness", "frequent periods-once to twice/month", "spots on skin", "uncontrollable hair", and the "belief of panic and anxiety attacks being related to menstrual cycle because that's when they occur".

Question 6a, 6b, 6c, and 6d answered research question number two: **For a given menopausal status, what is the African American woman's beliefs and practices about hormone replacement therapy?** Question six asked about whether or not any form of estrogen/progesterone/combination of therapy was followed. Five respondents, all postmenopausal, were using conjugated estrogen (Premarin) 0.625-1.25 mg and one subject was taking Provera 2.5 mg in addition to the estrogen. The amount of time on hormone replacement therapy ranged from 1 to 27 years. When considering reasons for starting HRT subjects could choose one or more options offered. The reasons selected for starting hormone replacement therapy were: following hysterectomy (n=4), physician recommended (n=2), vaginal dryness (n=1), sleep

problems (n=1), and hot flashes (n=1) (see Appendix N, Table 21).

Part 6d asked about feelings about hormone replacement therapy. Subjects were asked to select one option which best described their feelings about HRT. Almost half of the five postmenopausal respondents (n=2) had "no feelings" - "taking hormone replacement therapy because it is the best choice". Other subjects chose the following: "very satisfied-symptoms much improved" (n=1), "satisfied but concerned about side effects" (n=1), and "dissatisfied-thinking about stopping due to too many possible risks (n=1) (see Appendix N, Table 22).

An open-ended question, the seventh option, elicited other feelings about HRT. Responses included "not sure if some problems are related to hormone replacement therapy such as weight gain or the possiblity of forming blood clots".

Discussion

There was difficulty accessing the target population. Church groups were initially excited about the research but when approached about getting a group together they felt it was inappropriate for church elders to ask their congregations to be a part of this research.

Another difficulty was the target population's concern with how their data were to be utilized. Too many times the Black community has felt betrayed by apparent misuse of respondents' data. Many Black women may feel tired of being over analyzed, tired of the differences everyone seems to focus on. This population feels there are more similarities than differences and there is a need to begin to focus on the similarities. Evelyn C. White (1994) has addressed in her book; The Black Women's Health Book: Speaking for Ourselves, the inequities that Black women have felt with issues that have resulted from research on this population.

She states:

> "this book is also a heartfelt protest against the racism that cripples the medical establishment and consequently our lives. It says Black women have had enough of the statistics that tell us that the life expectancy for whites is 75.3 years compared with 69.4 for blacks; that the infant mortality rate for Blacks is 20 deaths per 1000, about twice the rate suffered among whites; that 52 percent of the women with AIDS

are Black; that more than 50 percent of Black women live in a state of emotional distress; and that Black women stand a one in 104 chance of being murdered compared with a one in 369 chance for white women" (p. xv).

## Comparisons

### Comparison of Data

A comparison of the data from the original 1992 Midlife Women's Health Survey (MWHS) and the revised version of the MWHS was examined by the authors of this study. In the analysis of the revised version of the MWHS, the authors divided the respondents into three groups: pre-, peri-, and postmenopausal status as did Mansfield and Voda in their original 1992 (unpublished, personal communication) analysis. However, the authors of this study were given the frequency of responses only for the total sample on the original Midlife Women's Health Survey (1992), which did not allow for further comparisons across menopausal status. The ages for the Mansfield and Voda sample ranged from 35 to 55, while those of the present study were 37 to 63 years.

The percentages of respondents who felt they were in the menopausal transition were: in Mansfield and Voda's results 67.5% and 36.4% in the present study

(see Appendix O, Table 23). The two phrases most often selected from Mansfield and Voda's analysis of reasons chosen addressing menopausal transition were: "I'm in the right age bracket" chosen 55.0% and "my menstrual cycles/periods are changing" chosen 51.4% as compared to the revised version of the MWHS where "I'm in the right age bracket" was chosen 36.5% and "I'm experiencing physical changes" chosen 27.2% of the time (see Appendix O, Table 24).

The changes that were looked forward to with Mansfield and Voda's analysis showed "end to menses" selected 75.1% as compared to the present authors' analysis "end to menses" being chosen 100% (see Appendix P, Table 25). To this question, there was no other statement chosen more frequently in Mansfield and Voda's analysis but with the present study's analysis 54.5% of the respondents were also looking forward to "feeling wiser" (see Appendix P, Table 25). The changes that were worrisome to respondents in Mansfield and Voda's analysis were "decreased hormones" selected by 57.1% and "weight gain" selected by 55.6% while in the present authors' analysis, respondents worried about "weight gain" 81.1% and "the unknowns" 63.6% of the time (see Appendix P, Table 26).

The conditions subjects reported feeling by Mansfield and Voda's results showed "lots of energy" and "feeling calm" with equal mean responses of 2.7 as compared to the present study's results which showed "attractiveness" and "weight gain" with mean responses of 3.5 and 3.4, respectively (see Appendix Q, Table 27). Issues discussed with health care providers showed in Mansfield and Voda's analysis that menstrual cycle changes were discussed 58.7% and hormone therapy was discussed 47.1% as compared with the present study's analysis which showed cardiovascular disease discussed 63.6% and menstrual cycle changes, moods, body changes, and hormone therapy each getting equal responses of 54.5% of the time (see Appendix R, Table 28).

No further comparisons were done due to lack of cross tabulations on the original Mansfield and Voda's Midlife Women's Health Survey data. Therefore the authors of this research were unable to compare the cross tabulations of the data derived from the revised version of the MWHS with that of the original MWHS data obtained by Mansfield and Voda.

Comparison of with the Literature

A comparison between the literature and the results of the data analysis on the revised version of

the MWHS showed many similarities. Camino reported that providers need to be aware of Black women's symptoms that are manifested as worries (see Appendix C, Table 6) as may apply to one respondent on the revised version of the MWHS who felt anxiety and panic attacks could be associated with her menstrual cycle.

Willis et al. (1989) in her research found that too few respondents had completed the personal data on questionnaires to allow for statistical analysis (see Appendix C, Table 7). The demographic data obtained from the revised MWHS resulted in some respondents not disclosing age, income, or education level (see Appendix H, Tables 8-11). Sung et al. (1992) found that there was difficulty in reaching Black women and difficulty with compliance due to lack of interest of subjects but the information obtained through interviews immediately, gave successful results (see Appendix C, Table 7). The authors of this research had problems in accessing this targeted population possibly due to feelings of being over analyzed and concerns regarding use of the research data.

The data base on Black women and their specific health care needs was found to be limited in the review of literature. In Price et al. (1992) the authors could find only one study on Black women's perceptions

of mammography (see Appendix C, Table 7), much as the authors of this research found no data base on Black women and menopause, Black women and hormone replacement therapy/estrogen replacement therapy (see Appendix B, Tables 3 and 4).

Bernard and Sheppard (1992) found the most frequent symptom reported was "feeling tired", while the authors of this research found respondents experiencing feelings of "weight gain" and "attractiveness" as being issue of concern.

Mansfield and Voda's work in 1993 using the 12 page Midlife Women's Health Survey found that approximately 1/2 of the women in their study received information from friends on menopause (see Appendix C, Table 5). The results of the revised version of the MWHS showed the issues discussed most frequently with family members were "moods" and "sexuality" however, there was no option of "friend" included on the revised survey to choose or select the category "friend" (see Appendix M, Table 20).

Strengths

The strengths of this research are as follows: 1) Respondents were divided into pre-, peri-, and postmenopausal groups; and responses were analyzed based on menopausal status.

2) Face validity was obtained for the revised version of the MWHS by four Black women who verified the survey for accuracy in terms of cultural sensitivity and language barrier difficulties.

3) This study examined an area/topic not currently found in the literature on Black women's perceptions of menopause or Black women's views on health care in general.

4) This study used quantitative and qualitative questions giving respondents the chance to tell a little more about their feelings/experiences.

Weaknesses

The weaknesses of this research centered around:

1) The tool which was difficult to understand and answer resulted in questionable responses by respondents.

2) Directions were unclear and the researchers in this study wondered if respondents truly understood the questions, for example question 4 with the responses on a Likert type scale.

3) Due to the difficulty accessing the targeted population the sample size was small.

Recommendations

Recommendations for future research would be to sample a wide varity of minority groups. Changes need

to be made on the tool itself such as formatting questions 1 and 2 for clarity. Questions 3 and 4 with items on attractiveness need to be revised or further refinedsince ambiguous answers were obtained from this item. Question 4 needs to have added a category for "never" on the Likert response scale. Question 5 needs to be revised for clarity. The columns on doctor/nurse practitioner should be collapsed into "health care provider" and male/female distinction for sex of provider should be added. Also another columnn for "friend" should be added due to the sharing of information on menopause which was found by Mansfield and Voda to be among friends (see Appendix C, Table 5). On the demographic section the question concerning race should be rephrased to state "what race do you identify with" and add Black as an option and state to circle all that apply.

The importance to clinical practice is an emphasis on the individualistic needs of women in regards to menopause. As providers of women's health care, there is a need to question women on their general state of health. Each woman's experience is presumed to be unique in its subjective symptoms and meaning. Hormone replacement therapy may not be the answer for all

women, and as providers we need to offer supportive therapy as a form of treatment.

Summary

This descriptive research examined the signs and symptoms African American women related to menopause and their beliefs about hormone replacement therapy. The research was done to gain a better understanding of the African American women's needs surrounding menopause. Of the 44 surveys distributed, 11 were returned which gave the researchers a 25% return rate. Analysis of the survey was done by dividing the subjects into pre-, peri-, and postmenopausal groups to determine frequency of responses across menopausal statuses. Results of this research were compared with findings from the review of the literature and also compared with Mansfield and Voda's results from their research using the original Midlife Women's Health Survey. Recommendations for revision of the tool, ideas for future research and implications for clinical practice were addressed.

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# APPENDIX A

## TABLES 1 & 2

## Census Data and Socioeconomic Characteristics for Black Women and Black Families in the City of Portland

**Table 1 Ages and Numbers of Black Women vs. White Women in Portland**

**Ages of Black women from 1990 Census tract**

| | |
|---|---|
| 35-39 | 1,336 |
| 40-44 | 1,018 |
| 45-49 | 730 |
| 50-54 | 632 |
| 55-59 | 538 |
| 60-64 | 544 |
| 65-69 | 526 |
| 70-74 | 443 |

**Ages of White women from 1990 Census tract**

| | |
|---|---|
| 35-39 | 20,891 |
| 40-44 | 17,040 |
| 45-49 | 11,479 |
| 50-54 | 8,826 |
| 55-59 | 8,173 |
| 60-64 | 9,261 |
| 65-69 | 10,342 |
| 70-74 | 9,429 |

**Table 2 Social and Economic Characteristics of Black Families in Portland**

| | |
|---|---|
| Median income in 1989 dollars for Black families in the City of Portland | $19,695/year |
| Percentage of Black families in 1989 living below poverty level | 28.2%<br>(Approx. 1/3 of population) |
| 1990 stats for all Blacks in the City of Portland for years of education: high school graduate or higher | 72.8% |
| % with bachelor degree or higher | 12.7% |

APPENDIX B

TABLES 3 & 4

Identified Researchable Terms for the Literature Review

**Table 3 Number of Articles in Bibliographic Data Base Identified with General Terms**

| | |
|---|---|
| Black women | 60 |
| Menopause | 176 |
| Health care practices | 24 |
| Hormone replacement therapy | 17 |
| Estrogen replacement therapy | 147 |

**Table 4 Number of Articles in Bibliographic Data Base Identified with a Combination of Terms**

| | |
|---|---|
| ERT and Black women | 0 |
| HRT and Black women | 0 |
| Menopause and Black women | 0 |
| Menopause and ERT | 0 |

# APPENDIX C

## TABLES 5 thru 8

## Articles Reviewed in Preparation for the Research

**TABLE 5 MENOPAUSE**

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| J.B. Collins, 1988 (Physician) | Not applicable | Clinical/narrative | Explain symptomolgy related to menopause and discuss hormone replacement therapy. | • Disabling symptoms associated with menopause are seen in only 15% of women.<br>• 75% of women experience "hot flashes" but only 10-15% warrant treatment.<br>• Supporting evidence increases towards hormone replacement therapy. |
| P.K. Mansfield, 1989<br>C.M. Jorgensen<br>L. Yu (Nurses) | Not applicable | Clincial/narrative | To encourage sound research about the menopausal transition by providing guidelines for researchers. | • Women lack knowledge of the biological changes of menopause.<br>• Lack of knowledge by providers concerning premenopausal/menopausal changes.<br>• Need for norms to be established on menstrual patterns. |
| G. Sheehy, 1992 (Author) | Not applicable | Narrative book | To erase the stigma of menopause. | • Women need to be treated as individuals.<br>• Japanese women consider menopause uneventful. |

TABLE 5 MENOPAUSE (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| P.K. Mansfield, 1993<br>A.M. Voda (Nurses) | Nonclincial convenience sample<br>505 middle-class women ages<br>35-55 y/o from across U.S. | 12 page Midlife Women's Health Survey (MWHS) | To study how contemporary, healthy, midlife women perceive menopause and what their sources of information on menopause are. | • Contemporary women still influenced by providers and the media.<br>• Views on developing diseases from menopause ie osteoporosis and cancer.<br>• Approximately 1/2 of women in this study received information from friends on menopause. |
| L.A. Bernhard, 1992<br>L. Sheppard (Nurses) | Large midwestern population,<br>101 menopausal women<br>43-58 y/o | Descriptive, cross-sectional survey<br>4 standardized survey instruments | To determine the relationships among perceived menopausal symptoms, and self- care responses in peri- and postmenopausal women. | • Average number of symptoms experienced, 13.<br>• "Feeling tired" most frequent symptom.<br>• Women who use more self-care responses tend to have a better perception of their health.<br>• Providers need to question women about their health. |

**TABLE 6 WOMEN'S HEALTH PRACTICES**

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| S. Greenwood, 1992 (Physician) | Not applicable | Narrative book | To integrate Dr. Greenwood's work with mid-life women and an interest in promoting health. | • Natural and alternative treatments for menopause.<br>• Facts on osteoporosis.<br>• Menopause at 40 y/o.<br>• Natural estrogen replacement therapy. |
| L.A.Camino, 1989 (PhD) | Southern neighborhood with 19 Black women and 5 Black men, with blue and pink color jobs, living in low socioeconomic area where many incomes are from Social Security benefits. | Descriptive/in depth interviews recorded or handwritten. | To challenge the underlying assumptions about the communicative power of folk illness as idioms of distress. | • Providers need to be aware of Black women's symptoms that are manifested as worries.<br>• Providers need to ask direct questions.<br>• Low income Black women are highly sensitive to self-disclosure outside of their families.<br>• Supportive therapy needs to be a part of treatment. |

TABLE 5 MENOPAUSE (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| D. Barbo, 1987 (Physician) | Not applicable | Clinical/narrative | To describe the physiology of menopause. | • Menopause an event, not a disease.<br>• Average age of menopause 51 y/o with a range of 41-59.<br>• Hormone replacement therapy (HRT) can improve physiological function. |
| M.J. Cook, 1993 (Nurse) | Not applicable | Clincial/narrative | To review the physcial changes of menopause, looks at hormone replacement therapy, and self-esteem issues. | • Women are beginning to reject the image of menopause as an unstable time in their life.<br>• Women are making more informed decisions about their health.<br>• Need for more education on menopause for all women. |

TABLE 6 WOMEN'S HEALTH PRACTICES (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| D.M. Makuc, 1989 (Dr. PH)<br>V.M. Fried (Nurse)<br>J.C. Kleinman (PhD) | 40,000 households/year looked at ages 20-39, 40-59, and 60-79 Black and white women nonpoor versus poor. | Continuing household survey/interviews | To investigate national changes between 1973-74 and 1985 in women's use of three preventive health services based on data from the National Health Interview Survey (NHIS). | • Older women and Black women make the most gains for breast exams.<br>• 1985 Black women were more likely than white women to have a recent pap smear, but older poor women of both races were less likely to be tested.<br>• Study showed small number of women screened for pap or breast exams. |

**TABLE 7 BLACK WOMEN'S HEALTH CARE BELIEFS AND PRACTICES**

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| M.A. Willis, 1989 (Nurse)<br>M. Davis (Nurse)<br>N.U. Cairns (PhD)<br>R. Janiszewski (MS) | 148 particpated. Located through outpatient clinics, hospitals, churches. Black women, 56% between ages of 15-35 y/o<br>21.9% high school graduates<br>35.2% some college<br>11.9% college graduates | Descriptive questionnaire self-reporting | To teach breast self examination (BSE) to Black women (teaching intervention). | • Questionnaires too long.<br>• Too few completed the personal data on questionnaires to allow for statistical analysis.<br>• BSE practice is subject to limitations of self-reported data. |
| J.F.C. Sung, 1992 (PhD)<br>R.G. Coates (PhD)<br>J.E. William (MEd)<br>J.M. Liff (PhD)<br>R.S. Greenberg (Physician, PhD)<br>G.A. McGrady (Physcian, MPH)<br>B.Y. Avery (MEd)<br>D.S. Blumenthal (Physician, MPH) | 321 participants, volunteer convenience sample. Black women aged 18 y/o or older (163 experimental group + 158 control group) lower socioeconomic levels located throughout community. | Ongoing experimental 2 group study. | To test the effectiveness of a culturally sensitive, in-home education program conducted by lay health workers (LHW) as a teaching intervention for screening for breast and cervical cancer. | • Difficulty in reaching Black women and difficulty with compliance due to lack of interest by subjects.<br>• Information obtained immediately was more successful. |
| J.H. Price, 1992 (PhD, MPH)<br>S.M. Desmond (PhD)<br>S. Slenker (PhD)<br>D. Smith (Nurse)<br>P. Stewart (BA) | Low socioeconomic Black women n=186 from an inner city community health clinic; ages 35-75 y/o. | Quasi-experimental close-ended questionnaire | To examine differences in perceptions of breast cancer (CA) and mammography between Black women who wanted mammograms and those who did not, the authors used an interview technique based on the Health Belief Model. | • Most noteworthy finding was that the group questioned had little knowledge regarding breast cancer (CA).<br>• 31% believed breast cancer (CA) wouldn't affect them.<br>• Whether or not the women wanted a mammogram was associated with her perceptions re: susceptibility.<br>• The authors could find only one study on Black women's perceptions of mammography. |

TABLE 7 BLACK WOMEN'S HEALTH CARE BELIEFS AND PRACTICES (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| K.A. Smyth, 1992 (Nurse)<br>H.N. Yarandi (PhD) | n=280 employed Black women ages 20-65 y/o residing in a rural area in Southeast U.S.<br>Convenience sample. | Descriptive/quantitative | To test a conceptual model showing effects of the variables for age, weight, type, cholesterol, systolic blood pressure, and coping on the stress response in Southern Black women | • Type A Black women have lower coping score.<br>• Path model indicates a negative effect of coping on stress response.<br>• Type A's may be at greater risk for developing coronary heart disease (CHD). |
| L.D. Saunders, 1989 (Epidemiologist) | San Francisco women selected from cancer registry (SMSA) age groups <30, 30-39, 40-49, 50-59, and 60-69, all ethnic groups. | Secondary data collected between 1974 and 1985 | To examine differences in the timeliness of diagnosis of female breast and cervical cancer in different age groups and ethnic groups. | • Early diagnosis of breast and cervical cancer results in better survival rates.<br>• Late diagnosis for breast cancer common for all age groups.<br>• Black women with breast cancer come from poorer social classes.<br>• Possible beliefs that cervical cancer is a disease of young women. |
| B.B. Nielsen, 1989 (Nurse) | Black women in Dade County, Florida over 4300 women have been screened ages 45-64 y/o (58% of population) | Pilot project/ongoing | To shift the stage of diagnosis of breast cancer from late to early. This article discusses a pilot project where nurses play a major role. | • Breakdown of target population served: Black women 41.6%, Hispanic women 57.6%, and White women 6.8%<br>• Ages 65 and older rarely (12.8%) attended breast screening. |

TABLE 7 BLACK WOMEN'S HEALTH CARE BELIEFS AND PRACTICES (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| M.A. Nemcek, 1989 (Nurse) | 95 Black women employees of large southern hospital. Housekeepers, laundry workers, kitchen workers, ages 25-60 y/o. Convenience sampling. | Descriptive/correlational study | To investigate breast self examination (BSE) practice and examine the relationship among the frequency of BSE and health locus of control, breast cancer (CA) knowledge and demographic factors. | • Respondents perceived themselves as only moderately susceptible to breast cancer.<br>• Older women were more likely than younger women to practice BSE.<br>• 69% had no idea when the best time was to practice BSE.<br>• Authors found no studies of Black women's knowledge about BSE and breast CA. |
| J.H. Flaskerud, 1989 (Nurse)<br>C.E. Rush (BS) | n=15 from Women-Infants-Children (WIC) program 27-48 y/o<br>n=7 from grandmothers, mothers, representing older women in WIC program 59-68 y/o | Checklist based on traditional health beliefs and practices | To determine if traditional health beliefs and practices of Black Americans reported in the literature were consistent with those of a target population of low-income Black women in Los Angeles county and the relationship of these beliefs to acquired immune deficiency (AIDS). | • Natural sources of illness-failure to protect oneself from the forces of nature.<br>• Confusion about the source and course of acquired immune deficiency (AIDS).<br>• Illness allowed by God to test one's faith.<br>• Stress, a source of illness. |

**TABLE 8 HORMONE REPLACEMENT THERAPY**

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| D.L. Booher, 1990 (Physician) | Not applicable | Clinical/narrative | To describe the use of estrogen supplements in menopause. | • Describes endrocrine changes, menopausal hormone replacement therapy (HRT), and benefits of such treatment. |
| L. Weinstein, 1990 (Physician)<br>C. Bewtra (MB, BS)<br>J.C. Gallagher (Physician) | n=92 women who were menopausal for at least one year. n=31 women in Group 1 and n=40 women in Group 2 who completed the study. The population was not described. | Quasi -experimental | To evaluate further a continuous regimen of 0.625mg of conjugated equine estrogen with 2 different doses in mg of medroxyprogesterone acetate for 52 weeks. | • Systolic blood pressure raises significantly from 123.5 to 126.9 mmHg in the total group.<br>• The subtle differences noted between the 2 dosages of medroxyprogesterone acetate do not allow the authors to significantly distinguish one as being better than the other.<br>• "All patients had atrophic endometruim except for 2 taking 2.5mg medroxyprogesterone acetate who had proliferative changes. This regimen offers a substantial decrease in bleeding episodes and marked protection to the endometrium from development of a neoplastic process" (p.1538). |

TABLE 8 HORMONE REPLACEMENT THERAPY (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| V.A. McKeon, 1990 (Nurse) | Not applicable | Clinical/narrative | To cover current guidelines for education and counseling for estrogen replacement therapy (ERT). | • Discusses indications for ERT.<br>• Symptoms of estrogen deficiency i.e.: vasomotor, somatic, and psychological symptoms.<br>• Insomia, nervousness, nausea, dizziness, headaches, palpitations, diaphoresis, nightsweats.<br>• Disease prevention.<br>• Urogential atrophy, osteoporosis.<br>• Risks of ERT- endometrial adenocarcinoma, breast cancer, hypertension, thromboembolism, gallbladder disease.<br>• Side effects of estrogen- weight gain, nausea, breast tenderness, secretions, cervical mucous, breakthrough bleeding. |
| R.K. Ross, 1988 (Physician)<br>A. Paganini-Hill (PhD)<br>S. Roy (Physician)<br>A. Chao (MPH)<br>B.E Henderson (Physician) | Current LA County OB/GYN Society members-physicians. n=330 gynecologists responded from a convenience sample | Descriptive/defined only as a short questionnaire with questions focusing on:<br>1) number of years in practice<br>2) patient population<br>3)prescribing practice for HRT | To determine how such factors as years of practice and demographic characteristics of patient populations are related to prescribing strategies. | • 94% routinely use estrogens for postmenopausal women with intact uteri (80% used Premarin).<br>• 86% also routinely used a progestin in the HRT regimen of postmenopausal women.<br>• Factors such as size and location of practice, percent of minority patients and years in practice did not have a major impact on prescribing practice. |

TABLE 8 HORMONE REPLACEMENT THERAPY (CONT.)

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| R.D. Gambrell, 1992 (Physician) | Not applicable | Clinical/narrative | To describe the latest in hormone replacement therapy (HRT). | • Discusses estrogen deficiency. Four types of testing: vaginal smear, cervical mucus fern pattern, progestogen challenge test, serum follicle stimulating hormone (FSH) level.<br>• Addition of progestogen with estrogen proven to be beneficial for women. |
| R.G. Wells, 1989 (Physician) | Not applicable | Clinical/narrative | To discuss hormone replacement therapy (HRT) before menopause. | • Defines premenopause, perimenopause, and postmenopause.<br>• Difficulty diagnosing the climacteric.<br>• Menustration and midlife changes.<br>• Candidates for HRT, benefits of HRT, breast cancer (CA) + HRT, HRT administration, monitoring HRT, HRT after hysterectomy, management of persistent bleeding.<br>• Contraindictions to HRT.<br>• Nonprescription medicine, listening and educating women. |

**TABLE 8 HORMONE REPLACEMENT THERAPY (CONT.)**

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| American College of Physicians, 1992 | Not applicable | Clincial/narrative | To describe guidelines for counseling asymptomatic postmenopausal women about hormone replacement therapy to prevent disease and prolong life. | • When treating menopausal symptoms, hormones should be given for a limited time 1 to 5 years.<br>• A woman should understand the probable risks and benefits of hormone therapy, decide how valuable she considers the potential effects of therapy, and participate with her physician in deciding whether to take preventive hormone therapy.<br>• Covers general recommendations, hormone regimens, management strategies, methods of endometrial evaluation, and potential risks and benefits of hormone therapy. |
| R. Lichtman, 1991 (Nurse-midwife) | Not applicable | Review of literature | To suggest individualized approach to hormone replacement therapy based on symptomatology and risk factors. | • Discusses both estrogen replacement therapy and hormone replacement therapy.<br>• The link to endometrial cancer.<br>• Therapeutics and preventive uses of hormone replacement therapy and estrogen replacement therapy.<br>• Provides two tables for studies on the relationship of progestins to lipid level and studies on estrogen and breast cancer. |

**TABLE 8 HORMONE REPLACEMENT THERAPY (CONT.)**

| Author/Year | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| D. Grady, 1992 (Physician, MPH)<br>S.M. Rubin (MPH)<br>D.B. Petitti (Physician, MPH)<br>C.S. Fox (MS)<br>D. Black (PhD)<br>B. Ettinger (Physician)<br>V.L. Ernster (PhD)<br>S.R. Cummings (Physician) | Not applicable | Review of the English-language literature since 1970 reporting the effect of estrogen therapy and estrogen plus progestin therapy on heart disease, endometrial cancer, breast cancer, osteoporosis, and stroke. | To quantify risks and benefits of hormone replacement therapy in asymptomatic postmenopausal women. | • There is evidence that estrogen replacement therapy decreases risk for coronary heart disease and for hip fractures.<br>• Long-term estrogen therapy increases risk for endometrial cancer and may be associated with a small increase in risk for breast cancer.<br>• The risk of increase in endometrial cancer can probably be avoided by adding a progestin to the estrogen regimen for women who have a uterus.<br>• Hormone therapy should probably be recommended for women who have had a hysterectomy and for those with coronary heart disease/ at risk for coronary heart disease. |

**TABLE 8 HORMONE REPLACEMENT THERAPY (CONT.)**

| Author/Year/Discipline | Subjects n | Study/Design and Data Collection | Purpose | Findings |
|---|---|---|---|---|
| L.C. Huppert, 1987 (Physician) | Not applicable | Clinical/narrative | To review menopausal changes, indications for hormone replacement therapy use, and risks of hormone replacement therapy. | • In the last several decades there has been a major upheaval in attitudes toward hormone replacement therapy.<br>• It is estimated that at least 3/4 of menopausal women experience some degree of symptomology referable to estrogen deprivation.<br>• The properly chosen patient can benefit from hormone treatment and also be protected by the newer methods of replacement.<br>• Indications for use: vasomotor i.e.: hot flushes, atrophic changes, osteoporosis, atherosclerosis, and feelings of well-being.<br>• Risks: endometrial cancer, breast cancer, thromboembolitic disease, hypertension, cholelithiosis. |

# APPENDIX D

## Human Subjects Committee Approval

OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098
Mail Code L106, (503) 494-7887 Fax (503) 494-7787
*Institutional Review Board/Committee on Human Research*

DATE: February 23, 1994

TO: Nancy Macy, BSN
Jennifer Bowles, BSN
c/o Dr. Margaret Imle, Advisor SN-FAM

FROM: Nancy White, Admin. Asst.
Committee on Human Research L-106

SUBJECT: Project entitled "Cultural Beliefs of Menopause in the African American."

It is my understanding that this project involves survey procedures. This study would fit exemption category #2 of the federal regulations (45 CFR Part 46.101 (b)) and is considered to be exempt from review by the Committee on Human Research.

This study has been put into our exempt files, and you will receive no further communication from the Committee concerning this study. However, if the involvement of human subjects in this study changes, you must contact the Committee on Human Research to find out whether or not these changes should be reviewed. If possible, please notify the Committee when this project has been completed.

If you have any questions regarding the status of this study, please call me at 494-7887.

# APPENDIX E

## Advertisement for Recruitment

Advertisement

Oregon Health Sciences University
Masters Research Project

To Whom It May Concern,

We are graduate students at the Oregon Health Sciences University researching the beliefs of menopause of African American women, and would like to contact a wide range of women from the ages of mid 30's to mid 70's, to participate in our study. It is our hope to meet with groups of African American women who would be willing to answer our questionnaire. Refreshments will be served to the groups at the time the questionnaire is distributed. The questionnaires will be ready beginning Friday, March 18 through Saturday, April 2nd for those groups interested in taking part in this important research. Any assistance you can give us in identifying and contacting groups of African American women will be greatly appreciated. You may contact us at:

Jennifer Bowles 635-2826 or Nancy Macy 297-5047

Thank you for your time and effort.

Nancy Macy, RN, BSN &
Jennifer Bowles, RN, BSN
Advisor: Margaret Imle
494-3823

# APPENDIX F

## Acknowledgment of Receipt of Consent Form

Oregon Health Sciences University
Masters Research Project

Hello

We are graduate nursing students at the Oregon Health Sciences University researching the beliefs of menopause of the African American woman, and would like to invite you to participate in our research. In our practice as Womens' Health Care Nurse Practitioners, we provide services for a diverse population that encompasses all races. Our research is being done in an attempt to determine what the health beliefs and health needs are of African American women in regards to menopause, and what health care providers can do to better meet these needs. We would greatly appreciate it if you would take a few minutes to answer the attached questionnaire and enclose it in the envelope provided. Anticipated time for completion is approximately 15 minutes. There is no cost to you for your participation.

No medical risks are expected in this study. Should any of the questions be uncomfortable or upsetting to you, you do not have to answer the question. The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish the injury occurred through the fault of the University, its officers or employees. If you have further questions, please call Dr. Michael Baird at (503) 494-0814.

The return of your completed questionnaire will imply that you have read this letter and agree to participate in this study. You may refuse to participate or withdraw from this study at any time. If you do not wish to participate, simply throw the questionnaire away.

Please do not put your name on the questionnaire or envelope, this questionnaire is completely anonymous and confidential. Neither your name nor identity will be used for publication or publicity.

We will be reporting on our findings and if you would like a copy of our report, please leave your name and address with us and we will be happy to mail these results to you.

Thank you for your time and effort,

Nancy Macy, RN, BSN &
(503) 297-5047
Jennifer Bowles, RN, BSN
(503) 635-2826
Advisor: Margaret Imle
(503) 494-3823

# APPENDIX G

## Revised Version of Midlife Women's Health Survey/Questionnaire

Survey No._____
Date _____

# Midlife Women's Health Survey

## Menstrual and Menopausal Status

1. Please circle the number of the ONE statement that best describes your current menstrual/menopausal status.

1....I AM MENSTRUATING IN MY REGULAR PATTERN
2....MY PERIODS ARE CHANGING (AMOUNT, LENGTH, SPACING, ETC.)
3....I AM NOT SURE IF I AM STILL MENSTRUATING BECAUSE I HAVE NOT HAD A PERIOD FOR AT LEAST 3 MONTHS
   A. When was your last period? (month and year)
   _____
4....I HAVEN'T MENSTRUATED FOR ONE FULL YEAR OR LONGER
   A. How old were you when your periods stopped naturally? _____
5....I HAD A HYSTERECTOMY
   A. How old were you? _____
   B. For what reason?

      1..FIBROID TUMORS
      2..HEAVY BLEEDING
      3..CANCER
      4..OTHER _____

   C. Were your ovaries also removed?

      0..NO
      1..YES
      2..Don't know

Is there anything else you would like to tell us about your menstrual/menopausal status? _____
_____

2. Do you consider yourself to be in the menopausal transition? (circle 0, 1, or 2)
   0..NO

   1..YES > Why do you think so? (Circle all answers that apply)
      1..I'M IN THE RIGHT AGE BRACKET
      2..I AM EXPERIENCING PHYSICAL CHANGES
      3..MY MOODS ARE CHANGING
      4..MY MENSTRUAL CYCLES/PERIODS ARE CHANGING
      5..MY SEXUAL FEELINGS ARE CHANGING
      6..I HAVE HOT FLASHES

   2..UNCERTAIN > Why are you uncertain? _____
   _____

Changes

3. Whether or not you have stopped menstruating, please share with us your thoughts about menopause.

   A. Which changes are (were) you most looking forward to at menopause?

   NO YES (circle 0 or 1)

   0 .. 1 .. a. An end to menstruation/periods
   0 .. 1 .. b. No more fears of unplanned pregnancy
   0 .. 1 .. c. No more concerns about birth control methods

   0 .. 1 .. d. An end to PMS or moodiness
   0 .. 1 .. e. An end to certain health problems such as fibroids
   0 .. 1 .. f. Feeling wiser/more free with age

   0 .. 1 .. g. None
   0 .. 1 .. h. Feeling more attractive
   0 .. 1 .. i. More energy

   0 .. 1 .. j. Increase in sex drive
   0 .. 1 .. k. Other _____

   B. What changes worry (worried) you most?

   NO YES (circle 0 or 1)

   0 .. 1 .. a. Hot flashes
   0 .. 1 .. b. Vaginal dryness
   0 .. 1 .. c. Weight gain

   0 .. 1 .. d. Decrease in sex drive
   0 .. 1 .. e. Feeling less attractive
   0 .. 1 .. f. Hormonal decline and related problems

   0 .. 1 .. g. Other health problems
   0 .. 1 .. h. Moodiness
   0 .. 1 .. i. Not being able to reproduce/have a baby

   0 .. 1 .. j. The unknowns
   0 .. 1 .. k. Loss of energy
   0 .. 1 .. l. None
   0 .. 1 .. m. Other _____
   _____

   C. Please tell us other changes you have experienced or that female relatives have told you about.

   _____
   _____

Health and Well-Being

4. Here is a check list of conditions that some women, but not others, report feeling. We ask you to indicate how often you experience each of these (Circle the number):

| HARDLY EVER | | | SOMETIMES | | NEARLY ALWAYS | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | a. | Hot flashes |
| 1 | 2 | 3 | 4 | 5 | b. | Depression |
| 1 | 2 | 3 | 4 | 5 | c. | Lots of energy |
| 1 | 2 | 3 | 4 | 5 | d. | Vaginal dryness |
| 1 | 2 | 3 | 4 | 5 | e. | Headaches |
| 1 | 2 | 3 | 4 | 5 | f. | Insomnia |
| 1 | 2 | 3 | 4 | 5 | g. | Weight gain |
| 1 | 2 | 3 | 4 | 5 | h. | Feelings of calm or focus |
| 1 | 2 | 3 | 4 | 5 | i. | Food cravings |
| 1 | 2 | 3 | 4 | 5 | j. | Irritability anger |
| 1 | 2 | 3 | 4 | 5 | k. | Feelings of attractiveness |

Please tell us any other symptoms that you are experiencing that may be related to menopause, or that you are unsure about.

_____

_____

_____

5. Aside from talking to friends or family members, have you discussed any of the following issues with your physician or other health care professional?

| NO | YES (circle 0 or 1) | | Who initiated discussion? YOU (circle 2) | DOCTOR (circle 3) | NURSE PRACTITIONER (circle 4) | FAMILY MEMBER (circle 5) |
|---|---|---|---|---|---|---|
| 0 | 1 | a. Menstrual cycle changes | 2 | 3 | 4 | 5 |
| 0 | 1 | b. Your moods | 2 | 3 | 4 | 5 |
| 0 | 1 | c. Your PMS | 2 | 3 | 4 | 5 |
| 0 | 1 | d. Your body changes | 2 | 3 | 4 | 5 |
| 0 | 1 | e. Your hot flashes | 2 | 3 | 4 | 5 |
| 0 | 1 | f. Sexuality | 2 | 3 | 4 | 5 |
| 0 | 1 | g. Hormone therapy | 2 | 3 | 4 | 5 |
| 0 | 1 | h. Osteoporosis | 2 | 3 | 4 | 5 |
| 0 | 1 | i. Cancer | 2 | 3 | 4 | 5 |
| 0 | 1 | j. Cardiovascular disease | 2 | 3 | 4 | 5 |

6. Are you taking any form of estrogen/progesterone/combination at the present time? (circle 0 or 1)

0..NO 1..YES

If you are:

A. What brand, product and dosage? _____

B. When did you begin? 19__

C. Why did you begin? (Circle yes for each reason)

| NO | YES | |
|---|---|---|
| 0 | 1 | a. Hot flashes |
| 0 | 1 | b. Sleep problems |
| 0 | 1 | c. Emotions |
| 0 | 1 | d. Vaginal dryness |
| 0 | 1 | e. Menstrual bleeding symptoms |
| 0 | 1 | f. Personal appearance |
| 0 | 1 | g. Physician recommended |
| 0 | 1 | h. Following hysterectomy |
| 0 | 1 | i. Other _____ |

D. Which best describes your feelings about your hormone therapy? (Circle one)

1.... VERY SATISFIED, SYMPTOMS MUCH IMPROVED
2.... SATISFIED, BUT SOMEWHAT CONCERNED ABOUT POSSIBLE NEGATIVE SIDE EFFECTS
3.... DISSATISFIED, SYMPTOMS NOT NOTICEABLY IMPROVED
4.... DISSATISFIED, EXPERIENCING SOME NEGATIVE SIDE EFFECTS
5.... DISSATISFIED, THINKING ABOUT STOPPING-TOO MANY POSSIBLE RISKS
6.... NO FEELINGS - TAKING HORMONES BECAUSE IT'S THE BEST CHOICE
7.... OTHER (DESCRIBE) _____
_____

Please go to next page and continue.

Facts about yourself

It is important for each and everyone of you to fill out the personal information on this sheet, so we may verify at what age menopausal signs and symptoms have been experienced. Other information will be utilized to ascertain what segment of the population we have surveyed. All of this information will remain confidential.

7. What is your current marital status (circle one):
   1 .. MARRIED/LIVE-IN PARTNER
      a. How many years? _____
   2 .. DIVORCED/SEPARATED
   3 .. SINGLE
   4 .. WIDOWED
      b. In what year did your spouse die? 19__

8. Your date of birth: mo_____ day_____ year_____

9. How many people live in your household? _____

10. How many years of education have you completed? _____

11. What is your race? (circle one)

   1 .. Caucasian
   2 .. African American
   3 .. Native American
   4 .. Hispanic
   5 .. Asian
   6 .. Other (please specify) _____

12. What is your average family income each month? _____

13. What is your occupation? _____

14. What health coverage system do you have or use?
_____

Thank You for agreeing to complete this questionnaire and for being part of our study. Please return this questionnaire in the provided envelope.

This questionnaire was adapted from The Midlife Women's Health Survey, an ongoing research project conducted by Dr. Phyllis Kernoff Mansfield of The Pennsylvania State University and Dr. Ann Voda, of the University of Utah, who is Director of the Tremin Trust Menstrual Health Research Program.

APPENDIX H

TABLES 8 thru 11

Demographics on Education, Age, Monthly Income, and Occupations

## Table 8 Age

| | |
|---|---|
| Range | 37 - 63 years |
| Median | 49.5 years |
| Total | n=10 |

## Table 9 Monthly Income

| | |
|---|---|
| Range | $600.00 - $2500 + / month |
| Average | $1768.75 / month |
| Total | n=8 |

## Table 10 Occupations

| | |
|---|---|
| Health assistant | n=1 |
| Nurse | n=2 |
| Office assistant | n=1 |
| Medical assistant | n=3 |
| Housekeeping aide | n=1 |
| Member assistant | n=1 |
| Clerical | n=1 |
| Communication clerk | n=1 |
| Total | n=11 |

## Table 11 Education

| | |
|---|---|
| Range | 10 - 16 years |
| Mean | 13.4 years |
| Standard Deviation | +/- 1.71 years |
| Total | n=10 |

# APPENDIX I

## TABLES 12 & 13

## Demographics on Marital Status and Number of Persons/Household

**Table 12 Demographics on Marital Status**

| Marital Status | Frequency |
|---|---|
| Married/Live-in partner | n=6 |
| Divorced/separated | n=3 |
| Single | n=1 |
| Widowed | n=1 |

**Table 13 Demographics on Number of Pesons/Household For Each Menopausal Status**

| Premenopausal Respondents | Number of Persons in their Household |
|---|---|
| n=2 | 1 |
| n=2 | 3 |
| **Perimenopausal Respondents** | |
| n=1 | 2 |
| n=1 | 3 |
| **Postmenopausal Respondents** | |
| n=1 | 2 |
| n=1 | 3 |
| n=3 | 4 |

# APPENDIX J

## TABLES 14 & 15

## Menopausal Status and Menopausal Transition

**Table 14 Groups of Menstrual/Menopausal Status**

| Menstrual/Menopausal Status | Age Range |
|---|---|
| Pre | 37-48 |
| Peri | 40-47 |
| Post | 51-63 |

**Table 15 Reasons Chosen Addressing Menopausal Transition**

| Statement (phrase) | Frequency |
|---|---|
| 1) I'm in the right age bracket | n=4 |
| 2) I am experiencing physical changes | n=3 |
| 3) My moods are changing | n=2 |
| 4) My menstrual cycles/periods are changing | n=1 |
| 5) My sexual feelings are changing | n=2 |
| 6) I have hot flashes | n=2 |

# APPENDIX K

## TABLES 16 & 17

## Changes Looked Forward To and Changes that are Worrisome

## Table 16 Changes That are Looked Forward to at Menopause

| Changes | Pre n=4 | Peri n=2 | Post n=5 | Total n=11 |
|---|---|---|---|---|
| End to menses | n=4 | n=2 | n=5 | |
| No more pregnancies | n=2 | n=1 | n=1 | |
| No more BCM | n=3 | n=1 | n=1 | |
| No more PMS | n=1 | n=2 | n=1 | |
| Decreased health problems | n=1 | n=1 | n=3 | |
| Feeling wiser | n=2 | n=2 | n=2 | |
| None | n=0 | n=0 | n=0 | |
| Feeling more attractive | n=1 | n=0 | n=0 | |
| Increased energy | n=0 | n=1 | n=0 | |
| Increased sex drive | n=0 | n=1 | n=0 | |
| Other | n=0 | n=0 | n=1 | |

## Table 17 Changes That are Worrisome

| Changes | Pre n=4 | Peri n=2 | Post n=5 | Total n=11 |
|---|---|---|---|---|
| Hot flashes | n=3 | n=1 | n=0 | |
| Vaginal dryness | n=3 | n=1 | n=2 | |
| Weight gain | n=3 | n=1 | n=5 | |
| Decreased sex drive | n=2 | n=2 | n=1 | |
| Less attractive | n=2 | n=0 | n=0 | |
| Decreased hormones | n=1 | n=2 | n=3 | |
| Other health problems | n=1 | n=2 | n=2 | |
| Moodiness | n=2 | n=1 | n=2 | |
| Unable to bear kids | n=0 | n=0 | n=0 | |
| Unknowns | n=2 | n=2 | n=3 | |
| Decreased energy | n=1 | n=1 | n=0 | |
| None | n=0 | n=0 | n=0 | |
| Other | n=0 | n=0 | n=1 | |

APPENDIX L

TABLE 18

Conditions Respondents Reported Feeling

**Table 18 Conditions Subjects Reported Feeling/Mean Response**

| Conditions | Pre | Peri | Post |
|---|---|---|---|
| Hot flashes | n=0.50 | n=3.00 | n=2.80 |
| Depression | n=2.00 | n=4.00 | n=2.60 |
| Lots of energy | n=1.50 | n=0.05 | n=3.00 |
| Vaginal dryness | n=1.50 | n=2.00 | n=2.00 |
| Headaches | n=2.75 | n=2.00 | n=3.00 |
| Insomnia | n=2.00 | n=2.00 | n=2.40 |
| Weight gain | n=2.00 | n=3.00 | n=4.60 |
| Feeling calm | n=3.25 | n=1.50 | n=2.60 |
| Food cravings | n=3.25 | n=3.50 | n=3.00 |
| Irritability | n=1.75 | n=4.50 | n=2.80 |
| Attractiveness | n=2.75 | n=3.50 | n=4.00 |

APPENDIX M

TABLES 19 & 20

Issues Discussed with Health Care Providers and the Source of Initiating the Discussion

## Table 19 Issues Discussed with Health Care Providers

| Issues | Frequency |
|---|---|
| Menstrual cycle changes | n=6 |
| Your moods | n=6 |
| Your PMS | n=4 |
| Your body changes | n=6 |
| Your hot flashes | n=5 |
| Sexuality | n=5 |
| Hormone therapy | n=6 |
| Osteoporosis | n=4 |
| Cancer | n=5 |
| Cardiovascular disease | n=7 |

## Table 20 Who Initiated Discussion of Issues

| | Source of Initiating Discussion | | | |
|---|---|---|---|---|
| | You | Doctor | Nurse Practitioner | Family Member |
| Issues | | | | |
| Menstrual cycle changes | n=4 | n=1 | n=1 | n=0 |
| Your moods | n=3 | n=2 | n=0 | n=3 |
| Your PMS | n=3 | n=1 | n=0 | n=1 |
| Your body changes | n=2 | n=4 | n=1 | n=1 |
| Your hot flashes | n=1 | n=2 | n=1 | n=2 |
| Sexuality | n=2 | n=1 | n=0 | n=3 |
| Hormone therapy | n=0 | n=5 | n=1 | n=0 |
| Osteoporosis | n=0 | n=4 | n=0 | n=0 |
| Cancer | n=2 | n=4 | n=0 | n=0 |
| Cardiovascular disease | n=1 | n=7 | n=0 | n=0 |
| Totals | n=18 | n=31 | n=4 | n=10 |

APPENDIX N

TABLES 21 & 22

Reasons and Feelings about Hormone Replacement Therapy

## Table 21 Postmenopausal Reasons for Beginning Hormone Replacement Therapy

| Reasons/Conditions | Frequency |
|---|---|
| Hot flashes | n=1 |
| Sleep problems | n=1 |
| Emotions | n=0 |
| Vaginal dryness | n=1 |
| Menstrual bleeding symptoms | n=0 |
| Personal appearance | n=0 |
| Physician recommended | n=2 |
| Following hysterectomy | n=4 |
| Other | n=0 |

## Table 22 Feelings About Hormone Replacement Therapy

| Statements | Frequency |
|---|---|
| **Satisfied** | |
| Very satisfied, symptoms much improved | n=1 |
| Satisfied, but somewhat concerned about possible negative side effects | n=1 |
| **Dissatisfied** | |
| Dissatisfied, symptoms not noticeably improved | n=0 |
| Dissatisfied, experiencing some negative side effects | n=0 |
| Dissatisfied, thinking about stopping-too many possible risks | n=1 |
| No-feelings taking hormones because it's the best choice | n=2 |
| Other | n=0 |

APPENDIX O

TABLES 23 & 24

The Percentages of Respondents in the Menopausal Transition and the Comparison of Reasons in the Studies Addressing Menopausal Transition

## Table 23 Percentages of Respondents Who Feel They are in Menopausal Transition

| | |
|---|---|
| Mansfield and Voda | 67.5% |
| Macy and Bowles | 36.4% |

## Table 24 Comparisons of Reasons Chosen Addressing Menopausal Transition in%

| Statement (phrase) | Mansfield & Voda n=329 | Macy & Bowles n=11 |
|---|---|---|
| 1) I'm in the right age bracket | 55.0% | 36.5% |
| 2) I am experiencing physical changes | 29.5% | 27.2% |
| 3) My moods are changing | 10.6% | 18.1% |
| 4) My menstrual cycles/periods are changing | 51.4% | 9.1% |
| 5) My sexual feelings are changing | 10.9% | 18.1% |
| 6) I have hot flashes | 23.1% | 18.1% |

APPENDIX P

TABLES 25 & 26

Comparison of Changes That are Looked Forward To and Changes That are Worrisome

## Table 25 Comparison of Changes That are Looked Forward to at Menopause in %

| Changes | Mansfield & Voda n=329 | Macy & Bowles n=11 |
|---|---|---|
| End to menses | 75.1% | 100% |
| No more pregnancies | 21.0% | 36.5% |
| No more BCM | 24.9% | 45.5% |
| No more PMS | 31.0% | 36.4% |
| Decreased health problems | 19.5% | 45.5% |
| Feeling wiser | 21.9% | 54.5% |
| None | 18.2% | 0.0% |
| Feeling more attractive | 6.1% | 9.1% |
| Increased energy | 17.3% | 9.1% |
| Increased sex drive | 10.9% | 9.1% |
| Other | 1.8% | 9.1% |

## Table 26 Comparison of Changes That are Worrisome in %

| Changes | Mansfield & Voda n=329 | Macy & Bowles n=11 |
|---|---|---|
| Hot flashes | 41.6% | 36.4% |
| Vaginal dryness | 31.3% | 54.5% |
| Weight gain | 55.6% | 81.8% |
| Decreased sex drive | 21.6% | 45.5% |
| Less attractive | 23.7% | 18.2% |
| Decreased hormones | 57.1% | 54.5% |
| Other health problems | 24.0% | 45.5% |
| Moodiness | 21.0% | 45.5% |
| Unable to bear kids | 3.0% | 0.0% |
| Unknowns | 30.4% | 63.6% |
| Decreased energy | 23.1% | 18.2% |
| None | 11.9% | 0.0% |
| Other | 7.0% | 0.0% |

APPENDIX Q

TABLE 27

Comparison of Conditions Subjects Reported Feeling/Mean Response

**Table 27 Comparison of Conditions Subjects Reported Feeling in Mean Response**

| Conditions | Mansfield & Voda n=329 | Macy & Bowles n=11 |
|---|---|---|
| Hot flashes | 1.5 | 2.0 |
| Depression | 1.9 | 2.6 |
| Lots of energy | 2.7 | 2.0 |
| Vaginal dryness | 1.9 | 1.8 |
| Headaches | 2.1 | 2.7 |
| Insomnia | 1.9 | 2.2 |
| Weight gain | 2.6 | 3.4 |
| Feeling calm | 2.7 | 2.6 |
| Food cravings | 2.5 | 3.2 |
| Irritability | 2.3 | 2.7 |
| Attractiveness | 2.6 | 3.5 |

APPENDIX R

TABLE 28

Comparison of Issues Discussed with Health Care Providers in Percentages

**Table 28 Comparison of Issues Discussed with Health Care Providers in %**

| Issues | Mansfield & Voda n=329 | Macy & Bowles n=11 |
|---|---|---|
| Menstrual cycle changes | 58.7% | 54.5% |
| Your moods | 16.1% | 54.5% |
| Your PMS | 12.5% | 36.4% |
| Your body changes | 27.7% | 54.5% |
| Your hot flashes | 27.1% | 45.5% |
| Sexuality | 7.0% | 45.5% |
| Hormone therapy | 47.1% | 54.5% |
| Osteoporosis | 38.9% | 36.4% |
| Cancer | 32.8% | 45.5% |
| Cardiovascular disease | 23.1% | 63.6% |