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# Attitudes and Concerns About Menopause Among Black Women: What Busy Clinicians Need to Know

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Problems in health disparities have received greater attention since the Institute of Medicine report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” was published in 2002.<sup>1</sup> Even more recently, clinicians have begun to recognize that health disparities apply to more than recognition and management of specific disease entities such as cardiovascular disease, asthma and diabetes. Indeed, removing health disparities must include a greater recognition and understanding of normal life events as they are experienced by individuals in various ethnic and minority groups.

Menopause constitutes one such life event. The literature is rich with information about menopause experiences and perceptions among white women. However, few studies on menopause have included significant numbers of black women or have focused specifically on black women’s views. Despite this, some important differences in the experience of menopause among black women have been identified in the few studies that have been published. For example, black women rated themselves as being earlier in the transition to menopause process, regardless of changes in their menstrual or bleeding patterns,<sup>2</sup> and may experience the onset of menopause earlier than their white counterparts.<sup>3</sup> While black women experienced more severe vasomotor symptoms,<sup>4,5</sup> they also tended to have a

more positive attitude toward menopause and were less likely to experience irritability and depression.<sup>6-9</sup> Additionally, black women reported less urinary leakage and sleeping problems,<sup>5</sup> and had much greater reductions in estrogen levels as they aged as compared with their white counterparts.<sup>10</sup>

Because these studies suggest that differences indeed exist, and to gain a greater understanding about the menopause transition among black women, we conducted an exploratory study to examine the perceptions and experiences of black women in the transition to menopause.<sup>11,12</sup> This two-city study consisted of 43 generally healthy black women who identified themselves as experiencing menopause or change of life symptoms unrelated to surgical or medicinal intervention. A series of seven focus groups were held in two cities—four in an east coast city and three in a northeast city. The focus groups were audiotaped and verbatim transcripts from the audiotapes were analyzed by grouping concepts and identifying themes. The focus group facilitators recorded extensive field notes and developed first impression summaries immediately following each group meeting. The themes and meanings gleaned from the transcripts were compared and contrasted with field notes, audiotaped recordings and the first impression summaries to reveal group menopausal perceptions and

experiences. Here we discuss clinical lessons learned from the information shared by the study participants. These findings are intended as examples for clinical lessons only, and are not intended to suggest that all black women experience the symptoms described by the study participants.

## **Keep an Open Mind— Ask About Symptoms**

The study participants identified many common symptoms of menopause throughout the focus group discussions. They also identified several bothersome symptoms that are less commonly identified and are infrequently discussed in the literature. As expected, common symptoms included hot flashes, sweats (drenching episodes of perspiration, sometimes accompanied by or following hot flashes, but often just sweats), irregular menses and heavy bleeding, sleep changes and night sweats, vaginal dryness, sexuality changes and decreased libido, and urinary urgency. Other common symptoms were also described, such as forgetfulness, depression, moodiness, irritability, fatigue, headache, weight gain, and skin and hair changes. Other symptoms, less commonly identified in the literature, included dizziness, vaginal discharge, vaginal and body odor, hot feet, swollen hands, body rashes, bloating and joint stiffness.

Some of the participants also described experiencing “rage,” which

was identified by participants as a bubbling up of indignation directed toward others—family members, coworkers, or friends. The women said they had taken enough and had earned the right to be respected and treated well and not have to take “crap” from others anymore. It was as if achieving menopause transported them into another phase of life, one in which the women fully expected to be treated better and were unwilling to settle for anything less. But frequently rude or irreverent treatment by others was experienced, and this produced a “rage” in the women. Although “rage” has not been reported in the literature as a common menopause symptom, in practice and in the course of discussing these findings, many women, both white and black, have anecdotally described similar feelings. Several have indicated that it is more a part of “coming of age” rather than being specifically related to menopause, and that it is not part of the white or black culture, but rather may be an outgrowth of some individual women’s life experiences.

Other reports have identified less irritability and depression, and fewer sleeping difficulties among black versus white women.<sup>5,9</sup> Despite this, but in agreement with reports that black women experience more vasomotor symptoms,<sup>4,5</sup> among the myriad of symptoms described, hot flashes, forgetfulness, moodiness, “rage,” irritability, sleep changes and night sweats, weight gain, sweats, and body and vaginal odor were identified as the most bothersome. Some of these findings are supported in one other study that evaluated black women’s attitudes, perceptions and practices related to menopause in which participants identified sleep disruption, fatigue, tender breasts and weight gain as causing them the most problems.<sup>13</sup> The symptoms described by our participants frequently interfered with their daily living—causing the women to feel embarrassed about being in public.

Symptoms were associated with a great deal of uncertainty. Uncertainty was associated with what the symptoms meant—every single participant described not realizing she was experiencing menopause until she discussed her symptoms with other community women. Interestingly, several women thought they had other problems rather than menopause symptoms, such as cancer, heart problems or lupus, or were just “going crazy.” After they identified that the symptoms were indeed menopause, the uncertainty was associated with when the symptoms would appear, how long they would last (both for the individual episode and over time) and how they might be able to cope with the symptoms they experienced.

The symptoms described here are those reported by a small group of black women who were experiencing symptoms and who self-selected to participate in our study. They are not representative of the black female population, and the symptoms they expressed are not representative of all black women experiencing menopause. However, their experiences do provide important information suggesting that many women may be experiencing symptoms that they attrib-

ute to menopause, that are infrequently described in the literature or are not generally associated with menopause by clinicians.

It is critically important that we clinicians explicitly ask women experiencing menopause to describe their symptoms. They may be experiencing unusual symptoms like body odor worries, feelings of “rage” toward others, or hot feet and swollen hands. Additionally, the symptoms they identify as most bothersome may be different from those we think might be troubling them the most. Our assumptions about what symptoms they are experiencing or about what is most bothersome may be incorrect.

### Providing Support—Recognize Strategies Used for Coping with Menopause

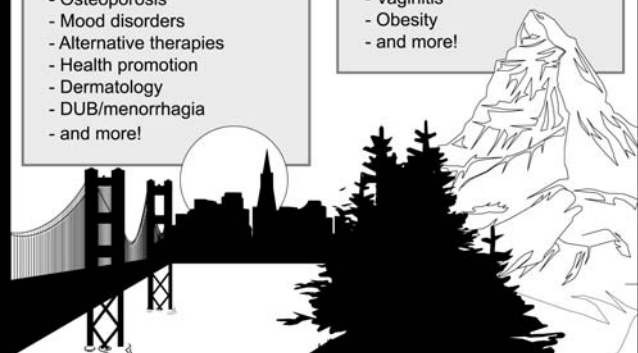
Interestingly, and in contrast to previously reported studies,<sup>6-9</sup> the black women in our study did not perceive menopause positively. While they did not seem to mind the association of menopause with aging (viewing elders as respected members of their communities) they definitely did mind the symptoms, uncertainty and upheaval associated with the transition to menopause. Menopause and its associated symptoms were described as “horrible,” “life-changing,” “confusing,” “unpredictable” and “taking over my life.”


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menopause, the participants developed several creative coping strategies. Some of these strategies are linked to the culture of black communities, others are creative methods for dealing with the discomforts of menopausal symptoms, and still others are associated with an effort to improve overall health at midlife. For example, coping through faith and by asking God for help, forcing oneself not to dwell on her problems, laughing, and sharing stories with friends and family members and sharing burdens with others are related to spirituality, and were strategies described by our participants as common community methods for coping with problems in general. Other strategies used to lessen hot flash and sweating discomfort in particular included changing clothing styles and fabrics, cutting hair very short, getting regular exercise, doing deep-breathing exercises, placing cold compresses at the back of the neck, and using fans. Participants also described trying to reduce life stress (increased stress made hot flashes worse) and reducing caffeine, alcohol and sugar intake (ingestion of these substances also worsened symptoms). Still other strategies were employed that helped to improve overall health, such as following a healthy diet, drinking more water, taking vitamins and mineral supplements, getting adequate rest, and attending to general health issues such as getting health screening exams, mammograms, and the like.

The participants all commented on the value of the focus

group discussion—suggesting to us that holding group sessions for educating women about menopause and strategies for symptom management would be ideal. Each participant described feeling better knowing that she wasn't the only one experiencing such an array of symptoms. In addition, the less common symptoms came out as the group members became comfortable with one another, suggesting that greater disclosure may actually occur in a comfortable group setting rather than one-to-one discussion in some instances.

In our practices, we need to validate creative methods for coping with the disruption of menopause symptoms. We must recognize that effective coping takes many forms—from spiritual to emotional to physical. Validating efforts to manage symptoms within the context of the patient's life and culture is an important tool. This not only strengthens the clinician-patient relationship and provides support for healthful and effective strategies, but also provides an opportunity for us to learn about possible strategies that we have not previously considered.

Consider using group settings for women to discuss symptoms they are experiencing and strategies they are using to manage menopause. Group discussion can be empowering for a woman as it provides an opportunity for her to interact with others, identify that she is not alone, learn from peers and share strategies she has been using. It is also an effective method for getting information to several individuals at the same time, thus reducing practice appointment burden for individual counseling sessions.

### **Consider Her Opinions About Treatment Options**

Few of our participants elected to take prescription hormone therapy (HT) to manage their symptoms (68% had never tried HT, 16% were currently using it at the time of the study). This was despite the fact that every participant was aware of the option and most had been offered a prescription for HT at some point by her clinician. This rate of HT use in our study was lower than the rate reported in a study of 106 black women of various socioeconomic statuses (58% used or would consider use).<sup>13</sup> While it is encouraging that our participants did not experience the disparity of not being informed of or offered HT, it is interesting that so few decided to try it (32% had tried HT). In fact, despite the description of symptoms as "horrible" and "taking over my life," several participants stated that they might consider HT, but only if their symptoms actually "got bad enough"!

Most participants avoided HT because they felt it was not natural, didn't like to take pills, or had fears about side effects. Several noted that "my mother and grandmother didn't need it, so neither do I." Many had questions about the safety of HT and asked about bone protection, heart disease, and risks for breast cancer. Instead of HT, they preferred nonpharmacologic treatment strategies. These strategies encompassed changes in lifestyle as described previously (clothing, diet,

exercise, etc) and alternative and complementary therapies. Several of the women took vitamin E supplements, soy or phytoestrogens. Calcium supplements were also common, and while some women used them together with magnesium for hot flashes, they all recognized the need for calcium for bone protection. Prayer and spirituality were mainstays for managing the complexity of symptoms that accompany menopause, and were also effective ways to reduce and manage stress.

As clinicians, we need to recognize that culture and life events affect how women perceive various treatment options. The women in our study put great stock in how their mothers or other older women in their communities had managed menopause symptoms. Few were interested in trying prescription hormones or newer treatment options to deal with the inconvenience and bother of symptoms, despite the negative effects they described the symptoms as having on their daily lives. They valued clinicians who were willing to discuss alternative and complementary therapies, and wanted to have access to information about alternative treatment options from other women.

### **Dispelling Myths—Share Information**

Although all of the participants in our study had access to clinicians, had some way to get information on menopause and health issues, and were well informed in some areas, they described several myths about menarche, menses cessation and use and effectiveness of HT. Participants generally believed that menopause (associated with menses cessation) was directly linked to when menses began. If one began menstruating at an early age it was thought that she would then experience her menopause early as well. Conversely, if she began menstruating at a later age she would then experience menopause at a later age. They seemed to believe that there were a pre-set number of cycles or years for menstruation that

### **Table.**

#### **Practical Communication Strategies for Use in Clinical Practice**

- **Identify what symptoms the individual woman is experiencing**—even if the symptoms are not actually caused by menopause, she may associate them with menopause and fully believe that they are due to menopause.
- **Focus on the symptoms she identifies as most distressing**—not only will this help her to trust that you hear her, it can provide a good motivation for healthful behavior changes.
- **Provide clear and accurate information regarding menses and menopause**—dispel myths about menarche and menopause.
- **Provide clear and accurate information regarding management options**—include lifestyle, alternative and complementary therapies, and pharmacological agents.
- **Support healthy lifestyle changes that might also reduce menopause symptoms**—focus on following a healthy diet, getting regular exercise, and avoiding sugar, caffeine, and alcohol.
- **Develop information sessions for women in your practice**—groups may work best; provide time for exchange between participants as well as information sharing from clinicians.

was close to or the same for every woman. There were also myths about why menarche occurred when it did. Many participants thought that diet had an effect on the rate of development in young girls. Eating a diet high in foods that had been fed steroids or antibiotics (eg, chicken) was believed to cause earlier sexual development and menstruation among young black girls.

Myths also surrounded HT. Several women thought HT could cause unusual symptoms such as increased sexual desire (excessively increased libido), or might prove addicting to them over time. The risks and potential side effects associated with HT were also poorly understood. Several refused prescriptions because they did not want to develop larger breasts, gain weight, increase the size of their fibroids, or bleed all the time. Expectations for the amount of time to symptom relief and effectiveness of HT were generally inappropriate among the few that did try it. One woman tried HT tablets for 2 weeks, but then quit because they were not making a difference in her hot flashes. Another decided she would try the patch (stating that it was not as bad as pills since it did not have to be swallowed). This woman, however, placed the patch on her breasts and when she developed breast soreness at the patch

application sites she was convinced she had given herself breast cancer. Still others misunderstood the packaged warnings about the possible risks, and discarded purchased prescriptions after reading the insert lists of risks and possible side effects.

Even in this group of rather well-educated urban black women (all had a high school diploma or more education) who had access to health information, unfounded fears and myths about menstrual life and treatment options abounded.

Clinicians need to ask women about their understanding of menopause, when it is expected, what symptoms are associated with it, and what external variables can affect its course. Providing clear and accurate information may help reduce guilt and certainly can help women make informed decisions about treatment options. For example, if their daughters began to menstruate before 12 years of age, many of the women felt guilty about having fed them chicken. Likewise, dispelling myths about treatments that do not work and clarifying risk levels and the individual likelihood of developing side effects from various treatment choices is important.

### **Use an Individualized Approach**

Clearly, an individualized approach is

needed to help women navigate the muddy waters of menopause. It is very important to listen to every woman's story—in her narrative you can identify what symptoms she is experiencing, what is most bothersome to her, and what she wants to get under control. Attending to symptoms she experiences, even if they are not clearly associated with menopause (such as weight gain, which is more likely a midlife phenomenon rather than a menopause-related phenomenon<sup>14</sup>) may help you identify recommendations that will aid her in dealing with the issues she finds most troublesome. Identifying what she finds bothersome may also provide a potent motivator for lifestyle and health changes that can have beneficial effects in reducing her overall health risks (Table).

When dealing with black women, or women of any cultural group, it is important to consider their unique cultural perspective and encourage them to identify what they might be willing to try. Offering treatments that a woman has already decided will not work or is unwilling to try because her elders did not need them will ultimately be as frustrating for her as it is for you. One of the hallmarks of the women who participated in our study was a stoicism or tendency to grin and bear it—but that did not mean their symptoms were minor or that they had a positive view of menopause. Perhaps the real problem was that they had not yet identified a useful program for minimizing symptoms that was culturally acceptable and that fit into the context of their lives. Programs are needed that combine lifestyle changes and alternative and complementary therapies, and are developed with the black female culture in mind.

In the black female culture most health information is sought from mothers and elder women in the community.<sup>15</sup> This was true of the women in our study who had many misconceptions about menses, menopausal symptoms and potential treatment options

that were perpetuated among women in their communities. Despite each of them having access to healthcare providers, they cited women in their communities, self-help literature, and the Internet as more frequent sources for healthcare and menopause information than their clinicians, suggesting that there may be some reluctance to discuss such private/personal matters with clinicians and/or distrust of clinicians and information obtained from them. Individual assessment regarding what symptoms are being experienced and clear education by clinicians are needed to focus on the symptoms that individual women are experiencing as most bothersome, as well as to dispel myths that some women may carry. Interventions must be sensitive to the preconceived biases that exist among many black women, and must have support from elder women in their communities, if they are to be accepted and adopted by women currently experiencing the transition to menopause. ■

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