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ABSTRACT

The purpose of this non-experimental study was to determine if menopause has an effect on marital satisfaction, depression, and weight gain in women. Participants were a convenience sample of 100 volunteers. The participants completed a survey to determine the effects of menopause on marital satisfaction, depression, and weight gain. An analysis of the results revealed that menopause does not have a significant impact on marital satisfaction or weight gain. The results did reveal a significant connection between menopause and depression.

INTRODUCTION

The United States Census reported that in 2018, 50.8% of the population were women (United States Census, 2018). Of that 50.8 %, 32.3% were of menopause age, age 40-60 years (United States Census, 2018). That 32.3% equals 53,003,246 women who are of an age to experience menopause. Within this population of over fifty-three million women, it is estimated that 20% of those were divorced (United States Census, 2018). When compared with men, women are more often the initiators of divorce (Hewitt, Western, & Baxter, 2006). Even though women know that they will not fare well economically, women still initiate divorce more often than men (Leopold, 2018). Perceived relationship quality plays a major role in women's decision to initiate divorce (Rosenfield, 2018) This fact supports the importance of marital satisfaction in maintaining happy marital relationships.

The Mayo Clinic defines menopause as the life stage that occurs when a woman's menstrual cycle ends. Menopause usually occurs between the ages of 45 and 55 and is known as a time of change or shift from one phase to another in a woman's life. (Popescu,2015). Menopause is diagnosed after a woman has gone 12 months without a menstrual period (Mayo Clinic, 2020). According to the Mayo Clinic, menopause happens in a woman's forties or fifties, but the average age of onset, in the United States, is 51. Depressed mood, anxiety, and a decreased sense of well-being are common during the menopausal transition (Kling et al., 2019). Additionally, women who have a history of mood disorders or stressful early childhood life events experience a greater incidence of more severe

psychological symptoms during menopause (Kling et al., 2019). Weight gain may also be a challenge during menopause. Even those who have not had previous weight problems may gain weight during and after menopause (Scheinberg, 2019). Weight gain, depression, and change in marital satisfaction are all influenced by the onset of menopause.

MARITAL SATISFACTION AND MENOPAUSE

Marital satisfaction can be defined as the attitude an individual has toward his or her marital relationship (King, 2016). It is difficult to conclude if marital satisfaction affects women's health and menopause experience or if the reverse is true. One thing is true, physical, as well as psychological health affects the quality of marriages (Robinson Kurpius, Nicpon, & Maresh, 2001). Women who experienced greater marital satisfaction have been shown to have less severe menopausal symptoms and negative moods (Caico, 2013; Robinson Kurpius et al., 2001). The severity of menopause symptoms (e.g., hot flashes, night sweats, sleep disturbance, mood issues, vaginal dryness, sexual pain), may also impact a woman's partner and her relationship with her partner. Therefore, addressing menopause symptoms may provide benefits beyond personal symptom relief (King, 2016). Addressing these symptoms brings a greater understanding of their effects, which leads to better management of the symptoms.

Caico (2013) provides two explanations concerning the correlation between menopause and marital satisfaction. The first explanation is that menopause may not be the cause of marital dissatisfaction (Caico, 2013). With this in mind, during this stage of life, marital satisfaction increases when each person in the marital relationship attempts to understand and fulfill the other person's needs (Yoshany, Morowatisharifabad, Mihanpoor, Bahri, and Jadgal, 2017). Caico's second explanation purports that improving partner relationships may help with menopausal symptom burden. Even with this understanding, determining whether menopause affects the marriage relationship or if the condition of the marriage affects the menopause symptoms can be difficult to conclude (Caico, 2013). The level of marital satisfaction seems to have some effect on menopausal symptoms. However, whether an unhappy marriage causes a negative experience in menopause or the reverse is in question.

WEIGHT GAIN AND MENOPAUSE

Menopause can have a profound effect on weight in women. Metabolic changes during menopause can influence weight. Most women are at higher risk for weight gain after menopause (Schub & Karakashian, 2017). Furthermore, post-menopausal women tend to have a higher percentage of body fat as well as a higher percentage of abdominal fat (Marcel & Ashley, 2018). Therefore, the effects of menopause can cause a serious reduction in physical activity for many women (Luntz, 2009). This reduction in physical activity can lead to weight gain and fatigue. Scheinberg (2019) stated that even those who have not had previous weight problems may gain weight during and after menopause. Exercise and lower calorie intake can help to control weight changes brought on by menopause (Jull et al., 2014). Women who are going through menopause or who have gone through menopause need to adhere to a healthy lifestyle in both diet and exercise. The weight of women is greatly affected by menopause.

BODY IMAGE AND QUALITY OF LIFE

Poor body image, which is linked to obesity, can lead to women experiencing a lower quality of life. There is a strong correlation between purpose in life and overall quality of life among women experiencing the effects of menopause. According to Jafary, Farahbakhsh, Shafiabadi, and Delavar (2011), there is also a strong connection between body image and quality of life as well as quality of life and overall health. Quality of life can also be affected at any age. However, older women are more likely to suffer from poor quality of life (Jafary et al., 2011). The knowledge that poor body image has a profound effect on quality of life is important in understanding how menopause can have an effect on women. Obesity also is linked to a lower quality of life as well as chronic health problems (Audet, Dumas, Binette, & Dionne, 2017). Thus, menopause affects the physical quality of life. Furthermore, the effects of obesity have a profound impact on women who are going through menopause.

DEPRESSION AND MENOPAUSE

The greatest cause of disability in the world is depression, and the rate that depression affects women is almost double the rate that depression affects men (Borkoles et al., 2015). The fluctuation in hormonal levels during menopause may cause depression. Thus, menopause may have a profound depressional effect on adult women. These findings are crucial to the link between depression and menopause in women.

Just as the symptoms of menopause differ between peri-menopausal women and post-menopausal women, the levels of depressional effects on women differ as well. Peri-menopausal women experience a higher frequency of depressional symptoms than women going through menopause or women who are post-menopausal (Borkoles et al., 2015). Feeling sad or blue, which can also be viewed as mild depression, is prevalent among women who are experiencing the menopausal transition (Yangin, Sözer, Şengün, & Kukulu, 2008). While depressive symptoms are more prevalent in women as they are transitioning into menopause, the exact time when symptoms first appear cannot be determined (Willi & Ehlert 2019). Wariso (2016) stated that there are different stages of disability related to depression experienced during menopause. There are also major depressive episodes in perimenopausal women (Wariso, 2016). In addition, it was found that a woman's socioeconomic background and education also influenced depression during menopause (Wariso, 2016). Women at a lower economic level as well as women with a lower level of education had higher rates of menopausal depression (Yangin et al., 2008). Thus, there seems to be a strong correlation between menopause and the incidence of depression in women.

SOCIAL SUPPORT AND MENOPAUSE

Vijayvargiya and Singh (2019) explained the importance of social support for women who are experiencing menopause. When women in menopause receive little social support and experience distressing relationships, they are more prone to experience stress and illness during menopause (Vijayvargiya & Singh, 2019). Dare and Green (2011) also agree that social support is an important element in women's lives, especially during midlife. It is during this period when social support can be helpful when navigating the changing 'goalposts' of everyday life (Dare & Green, 2011). Positive social interaction provides an outlet for stress and gives a foundation of community and connection during menopause (Dare & Green, 2011). This community is an essential component in navigating the challenges of menopause.

Community is formed by reaching out for social support. Social support results in needed social connections during menopause. Unfortunately, those connections are not always available or utilized by women in this stage of life (Dare & Green, 2011). Women who are lacking a community in which they can share their menopause experiences are unable to utilize the positive effects of community support. In these instances, they may have friends within their social network who are reluctant to discuss the issues that occur during menopause. (Walter, 2000). This reluctance to engage in conversation about a woman's menopause experience may be due to the history of menopause being seen only as a physical issue (Walter, 2000). This belief limits menopause to a medical condition that can only be analyzed through the lens of pathology (Walter, 2000). Menopause viewed in this manner can contribute to a poor understanding of the menopausal transformation (Walter, 2000). A complete understanding of menopause, as well as community support, plays a vital role in managing and dealing with the symptoms and effects of menopause.

As women's bodies transform during menopause, feelings of loss of control and uncertainty give way to shame and diminished self-love (Walter, 2000). During this time of life, women may require motivation to reach out for support and develop confidence in relationships. Many women may benefit from motivation found outside of the immediate family, such as individual or group psychotherapy (Brown, 2006). Brown also states that psychoeducational groups could prove to be effective in providing support while navigating these life changes. Psychoeducation and group therapy could be even more useful than individual therapy (Brown, 2006). This may be due to the fact that the experience of interacting with others who share in the same experiences, leads to greater success in therapy (Brown, 2006). As women in their midlife years reach out to those in groups or communities, they are able to build a personal network of support, care, and empathy (Dare & Green, 2011). This has positive implications for women's health and well-being during midlife and beyond (Dare & Green, 2011). The struggles that come with menopause have the potential to be lessened by a positive and supportive social network.

HUSBAND'S ROLE IN MENOPAUSE EXPERIENCE

Husbands can be a significant source of support to their wives during menopause. Thus, husbands having a proper understanding of this stage of life is important. The way husbands perceive menopause has the potential to increase the occurrence of negative feelings about menopause in women (Dillway, 2008). According to Dillway (2008), men are not purposefully ignorant or unsupportive. In most cases, men do not have extensive knowledge of menopause (Papini, Intrieri, & Goodwin, 2002). Just as there are many aspects of menstrual changes during a woman's lifespan that men are ill-informed about, men are also ill-informed concerning menopause. (Papini, Intrieri, & Goodwin, 2002). Lack of knowledge about the changes their wives are going through may contribute to barriers and conflicts in the marital relationship (Cacapava Rodolpho et al., 2016). Men must be educated concerning the effects of menopause to better support their wives and improve marital satisfaction.

Husbands who have gained knowledge of the effects of menopause may be able to promote a more positive outlook concerning the challenges facing their wives. One difficulty facing women in menopause is the false assumption many wives have about their husbands' perceptions of their bodies (Dillway, 2008). Men are more accepting of their wives' bodies than their wives understand, making it possible for women to make wrong assumptions about their husbands concerning their views of their wives' bodies. (Markey, Markey, & Birch, 2004). It is more accurate that a woman's body satisfaction is associated with her perception of her husband's satisfaction with her body, rather than any actual dissatisfaction on the part of her husband (Markey, Markey, & Birch, 2004). These assumptions were found to contribute to the belief that husbands are not as supportive through menopause as they could be (Dillway, 2008). Increasing menopausal health awareness among husbands can increase the confidence of wives (Yoshany et al., 2017). This, in turn, serves to perpetuate a more positive attitude toward the process of menopause (Yoshany et al., 2017). Most husbands are more accepting of the physical changes that menopause brings than many wives often assume.

Dillway (2008) cautions women against defining the male partner's outlook as completely negative concerning menopause. When given the information needed, men are willing to change to help support their partners. (Cacapava, Rodolpho, Hoga, & Santa Rosa, 2016). When men reach out to support their wives, they grow in tolerance and understanding of their wives' symptoms (Cacapava Rodolpho et al., 2016). That knowledge leads to a more supportive attitude toward their wives (Cacapava Rodolpho et al., 2016). Husbands can be a positive and supportive resource to their wives during the

menopause process, making this life-stage a more pleasant experience for both husband and wife.

COUNSELING AND MENOPAUSE TRANSITION

Menopause is an inevitable and life-changing transition. The effect on many women's emotional health can be dramatic (Baldo, Schneider, & Slyter, 2003). For the mental health counselor, having a complete understanding of the invisible nature of menopause on the psychological well-being of women is of vital importance (Baldo, Schneider, & Slyter, 2003). Counselors can offer menopausal women an understanding of menopause within the context of their own lives and help to make this transition a more positive experience. (Huffman & Myers, 1999). Counseling can help bridge the gap between the information available and a woman's understanding of what is happening during this time (Baldo, Schneider, & Slyter, 2003). Counseling can also offer a woman in menopause a safe environment in which to sort out the life-changes that come with menopause.

There is a possibility that because some medical professionals view menopause as a physical issue rather than a psychological issue, women are less likely to share their menopause experience and seek counseling for the emotional distress they experience (Walter, 2000). Psychologists and other medical professionals with such views must bear some responsibility in this as menopause has often been seen less as a psychological or mental health issue, but more of a physical or medical issue (Walter, 2000). To allow for a change in this mindset, counselors need to be knowledgeable about and comfortable with the topic of menopause (Huffman & Myers, 1999). Menopause is a complex issue, and solely viewing menopause as a physical issue without recognizing the emotional aspects is not an appropriate approach to maximizing the effectiveness of the therapeutic relationship with a woman in menopause (Robinson Kurpius et al., 2001). Effective therapists must be careful to assess their client's mental health, being mindful of both physical and psychological concerns facing their clients (Baldo, Schneider, & Slyter, 2003). Counselors offer resources for midlife women to understand the impact of menopause while providing renewed hope and understanding through this life transition (Baldo, Schneider, & Slyter, 2003). Mental health professionals are, in many cases, the link to helping menopausal women understand the impact of menopause within a physical, as well as a psychological context (Baldo, Schneider, & Slyter, 2003). Hence, mental health counseling can offer many helpful tools and strategies for women to navigate the transition to menopause.

When working with women of menopausal age, counselors should consider marital satisfaction (Robinson Kurpius et al., 2001). Marital satisfaction contributes to emotional health in women during this life stage, both positively and negatively (Robinson Kurpius et al., 2001). The contribution can be positive if a woman's perspective can be shifted from seeing menopause as impending doom to recognizing the potential for rediscovering and reviving one's love and sexuality (Atwood, McElgun, Celin, & McGrath, 2008). This shift can allow for self-development opportunities that foster growth and expansion of interpersonal relationships (Atwood, et al., 2008). Counselors will be more effective when they view women who are in their midlife years from a more holistic viewpoint; one that includes the experience of menopause and the effects of menopause on the marital relationship. Menopause profoundly affects women in many areas. There are physical as well as psychological factors. Understanding these factors is key to diminishing the negative effects of menopause to allow for increased improvement in the overall quality of life of women.

PURPOSE OF THE STUDY

The purpose of this investigation was to determine the effects of menopause on adult women in three different areas. For the purpose of this study, menopause will be defined as the natural and permanent cessation of the menstrual period for women who are typically between the ages of 45 and 55. The period of life known as menopause affects women in both physical and physiological ways (Baldo, Schneider, & Slyter, 2003). Thus, there is value in investigating this period of a woman's life.

This study focused on three specific areas, namely: marital satisfaction, depression, and weight gain. Marital satisfaction can be defined as the attitude an individual has toward his or her marital relationship (King, 2016). This investigation strove to identify a connection between menopause and depression. Depression was defined as a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness that interferes with daily life (American Psychological Association, 2020). Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities (American Psychological Association, 2020). Weight gain was defined as weight gain that occurs when more energy is ingested than expended (Stuhldreher, DeAngelo, & Moglia, 2019). These three areas were the focus of this study.

The findings of this study may benefit women of menopausal age as they navigate the physical and physiological changes caused by the occurrence. Results will provide valuable information that may alter the perception of women as they enter menopause. This would then allow women to more effectively manage these events.

HYPOTHESES

H_1 – It is hypothesized that menopause has an effect on marital satisfaction.

H_2 – It is hypothesized that menopause has an effect on the incidence of depression.

H_3 – It is hypothesized that there is a relationship between menopause and weight gain in women.

METHOD

PARTICIPANTS

The participants in this study were a convenience sample of 100 women, of which 93.9% were married and 6.1% were unmarried. They were between the ages of 23 and 72, with an average age of 50.82 years. Of the respondents, 53.1 % responded that they were in menopause and 46.9% responded that they were not in menopause. The average age reported for menopause onset is 47.52 years old. The study was comprised of 89.8 % white females, 8.2% African American females, 1% Hispanic females, and 1% Asian females. Of the women surveyed, 1% had a doctorate, 29.3% had a master's degree or graduate certificate, 30.3 % had a bachelor's degree, 29.3% had some college or an associate degree, 7.1% completed high school, and 3.0 % did not complete high school.

INSTRUMENTATION

The primary instrumentation for this study was a Menopause survey. This survey consisted of four demographic questions, two short answer questions, and a compilation of three separate surveys. The first of the surveys was the ENRICH Marital Satisfaction Scale, known as the EMS Scale. The second survey was the Beck Depression Inventory-S19. The third survey was the Body Weight-Image-Self-Esteem Evaluation-B-WISE survey.

The EMS Scale is found to be a reliable and valid scale for the measurement of marital satisfaction (Fowers & Olson, 1993). The EMS Scale is a survey in which respondents rate 15 items on a 5-point Likert scale with the following response options: 1 (Strongly Disagree), 2 (Moderately Disagree), 3 (Neither Agree nor Disagree), 4 (Moderately Agree), and 5 (Strongly Agree) (Fowers & Olson, 1993).

The measured areas of the EMS Scale include idealistic distortion, marital satisfaction, personality issues, communication, conflict resolution, financial management, leisure activities, sexual relationship, children and parenting, family and friends, equalitarian roles, and religious orientation (Fowers & Olson, 1993). The EMS Scale includes the Marital Satisfaction and Idealistic Distortion scales of the ENRICH Inventory and provides a psychometrically sound means of measuring marital satisfaction (Fowers & Olson, 1993).

The Enrich Marital Satisfaction Score is scored using the formula, EMS score = PCT – [(.40 x PCT)(ID x .01)] (Fowers & Olson, 1993). The assessment is 15 questions, of which 10 questions make up the raw score for Marital Satisfaction and 5 questions make up the Idealistic Distortion score (Fowers & Olson, 1993). First, the negative items are reverse scored, and, then, the responses summed (Fowers & Olson, 1993). This procedure is also done for the questions that make up the Idealistic Distortion score (Fowers & Olson, 1993). When the two scores are totaled the scores are compared to the National Norms for the ENRICH Marital Satisfaction and Idealistic Distortion Scales, and the scores percentiles are recorded (Fowers & Olson, 1993). The percentile for the Marital Satisfaction Score is multiplied by .40, and the percentile for the Idealistic Distortion is multiplied by .01. Those two products should be multiplied, and the product subtracted from the original Marital Satisfaction score percentile. The difference is the EMS Marital Satisfaction Score used in this study (Fowers & Olson, 1993).

Fowers & Olson (1993) have shown this scale to be reliable and valid in measuring overall marital satisfaction, as revealed by a Cronbach's alpha internal reliability of .86 and a reliability coefficient over time of .86. During a period of 4 weeks, the test-retest reliability was assessed with 115 individuals (Fowers & Olson, 1993). Concerning validity, the EMS Scale had correlations of .71 for men and .77 for women with the single-item satisfaction measure (Fowers & Olson, 1993). Thus, the EMS scale was used as it has proven to be valid and reliable.

The Beck Depression Inventory-S19 is the most frequently used instrument to measure depression; it was first created by Aaron Beck in 1961 (Sauer, Zieger, & Schmitt, 2019). The Beck Depression Inventory-S19 (BDI-S19) is a survey in which respondents rate 19 items on a 4-point Likert scale, ranging from the following options: 0 = Never, 1 = Very Rarely, 2 = Rarely, 3 = Occasionally, 4= Frequently. Using a Rasch model approach to examine the properties of the questionnaire, it was found that the BDI-S19 proved to have good reliability and unidimensionality (Sauer, Zieger, & Schmitt, 2019). The Rasch analysis also concluded that the BDI-S19 was a precise and efficient instrument to use to assess depression in an individual (Sauer, Zieger, & Schmitt, 2019). The Beck Depression Inventory-S19 was used as it has proven to be reliable and valid.

The Beck Depression Inventory-S19 is scored by adding the responses together. The sum of those responses represents the total score on the BDSI-S19. The total maximum score is 76. The closer to the maximum score the more severe the depression is considered to be (Indiana State Medical Association, 2020).

The Body Weight-Image-Self-Esteem Evaluation or B-WISE is an instrument that was originally developed in 2004 (Awad & Voruganti, 2004). This is a survey in which respondents rate 12 statements on a 3-point Likert scale where answers range from the following options: 1 (Never), 2 (Sometimes), and 3 (Always). The survey is scored with a range, which varies from item to item depending on the positive or negative nature of the statement. The higher the score the better adjusted a respondent is (Awad & Voruganti, 2004).

The Body Weight-Image-Self-Esteem Evaluation reliability exhibited satisfactory internal consistency with a Cronbach's alpha coefficient of .79 (Awad & Voruganti, 2004). The split-half measure of reliability yielded a Spearman-Brown coefficient of .76 (Awad & Voruganti, 2004). Pearson correlations were computed between scores on a test-retest one week later, yielding a test-retest coefficient of .81 (Awad & Voruganti, 2004). The intra-class correlation coefficient was .80, which could be considered moderately high (Awad & Voruganti, 2004). The validity of the B-WISE was defined by the fact that the B-WISE scores were able to independently distinguish four sample groups that were arbitrarily categorized based on body mass index (normal weight, overweight, obese, and extreme obesity) (Awad & Voruganti, 2004). The Body Weight-Image-Self-Esteem Evaluation was used as it is shown to be valid and reliable.

Demographic information was obtained with four multiple-choice questions and two short answer questions with distinct answers. A copy of the Menopause Survey is included in Appendix A.

PROCEDURE

A non-experimental design was used for this study. IRB exemption approval was obtained. All participants were informed that this survey was anonymous and that they were voluntary participants. They were not coerced in any way, and they were informed that they could stop participating at any time. Each respondent was sent a link to a Google Form survey. The surveys were completed throughout a two-week period. Results were automatically collated through Google Forms. The participation of each respondent served as proof of informed consent. Independent sample *t*-tests were used to analyze the data and test the hypotheses to determine the effects of menopause on marital satisfaction, the incidence of depression, and weight issues. The hypotheses were tested at an alpha level of 0.05.

RESULTS

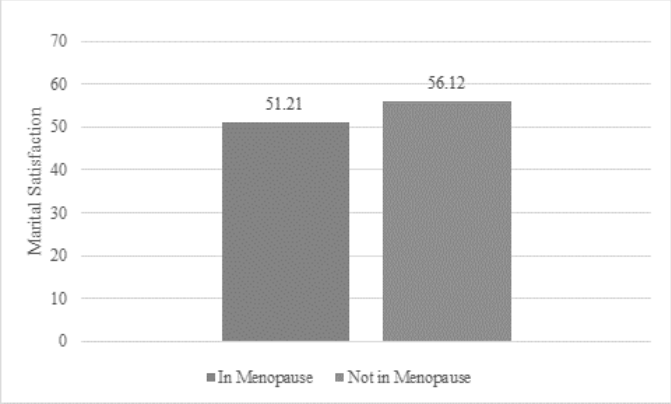

Figure 1. Menopause status and marital satisfaction.

An independent samples t-test was calculated comparing the mean ENRICH Marital Satisfaction survey scores of married female participants who reported themselves as being in menopause to the mean score of married female participants who reported themselves as not being in menopause. No significant difference was found t (86) =1.62, p>.05. The mean ENRICH Marital Satisfaction score for women who report that they are in menopause (m=51.20, sd = 15.61) was not significantly different from the ENRICH Marital Satisfaction score for women who report that they are not in menopause (m=56.12, sd = 12.71). The null hypothesis was not rejected and the alternative hypothesis could not be supported.

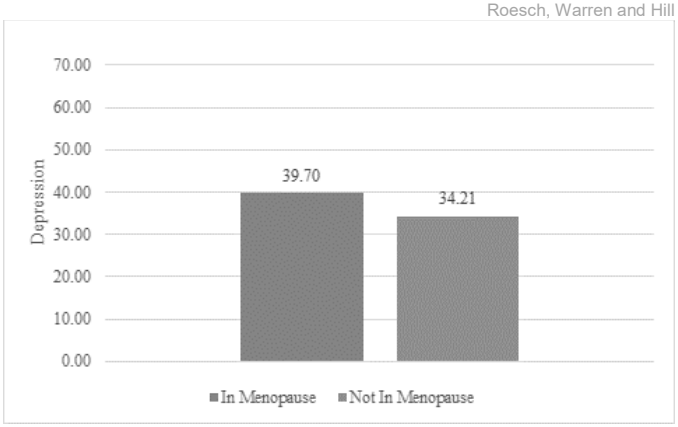

Figure 2. Depression and menopause status.

An independent samples t-test was calculated comparing the mean Beck's Depression Inventory survey scores of married female participants who reported themselves as being in menopause to the mean score of married female participants who reported themselves as not being in menopause. A significant difference was found t (88) = 2.12, p>.05. The mean of Beck's Depression Inventory survey score for women who reported that they were in menopause (m=39.70, sd = 12.29) was significantly different from the mean of Beck's Depression Inventory survey score of women who reported that they were not in menopause (m=34.21, sd = 12.24). The null hypothesis can be rejected, and the alternative hypothesis could be supported.

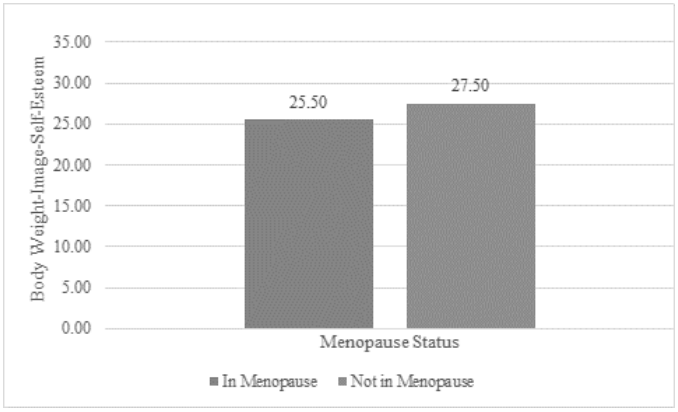

Figure 3. Bodyweight-image-self-esteem and menopause status.

An independent samples *t*-test was calculated comparing the mean body weight-image-self-esteem evaluation-BWISE scores of participants who are not in menopause to the mean score of participants who are in menopause. No significant difference was found t (91) = 1.18, p>.05. The mean body weight-image-self-esteem evaluation-BWISE score of respondents not in menopause (m=24.78, sd = 2.80) was not significantly different from the mean score of respondents in

menopause (m=25.46, sd = 2.75). The null hypothesis was not rejected and the alternative hypothesis could not be supported.

DISCUSSION

FINDINGS

The results of the study revealed that menopause had no significant influence on marital satisfaction. The table in Figure 1 does show that women who were not in menopause did have higher marital satisfaction scores than women who reported being in menopause, but the results were not statistically significant. Caico (2013) reported that determining if menopause affects the marriage relationship or if the condition of the marriage affects menopause symptoms can be difficult to conclude, and this study found the same.

The results of this study revealed that menopause has a significant impact on depression. Yangin et al. (2008) also found that mild depression is prevalent among women who are experiencing the menopausal transition. Additionally, Borkoles et al. (2015) found that the greatest cause of disability in the world is depression, and women are affected twice as much as men. The study also found that there was not a significant link between menopause and weight gain. However, as reported by Scheinberg (2019), even those who have not had previous weight problems may gain weight during and after menopause.

IMPLICATIONS

The most important implication from the results of this study is the need for education about menopause and the extent to which women's mental health is affected by it. Menopause is one of the three stages in the change of life that women experience. Perimenopause is the first stage, followed by menopause, and, then, post-menopause. Unfortunately, most women do not understand these three stages or have the ability to identify them. Education concerning menopause is helpful not only to women but to all of the people in their lives. This education could be key in promoting better monitoring of depression symptoms. This education can positively impact the emotional and mental health of women in menopause.

Implications for the counseling profession could be profound as well. Counseling ethics require that if there is a possible medical solution to a client's issue, the counselor must educate the client concerning the possibility. Education for the counselor is key to providing this information to their clients.

LIMITATIONS

This study had limitations. The sample was limited to a relatively small group of volunteers. This convenience sample method has the potential to threaten the internal validity of the study. Of this group, the demographic characteristics were not diversified. Most respondents were Caucasian evangelical Christian women. Both the sample size and the demographics of the respondents pose a threat to the external validity of the study. The status of menopause was self-reported. Participants may not have had a complete understanding of the medical definition of menopause. Some of the respondents could have been in perimenopause or postmenopausal and mistakenly believed they were in menopause. The sensitive nature of the subjects could also have caused the women not to self-report with full honesty even though confidentiality was assured. The self-reporting nature of the survey contributes to the threat to the construct validity of the research.

FUTURE RESEARCH

While there is a wealth of knowledge concerning what menopause is, there does not appear to be a large effort to use this information to educate women about menopause. Society uses the word menopause as a catch-all for the change of life that women go through sometime between the ages of 40-60. Each stage of menopause brings challenges for women to navigate. Lack of education makes this navigation more difficult. A priority of future research needs to be education. There is an opportunity for researchers to understand menopause from a physical, as well as, from a mental health standpoint. Medical professionals and mental health counselors benefit from this research. The research provides valuable insights to help them grow in their understanding of menopause to better provide adequate care and counsel for their clients. The research showed such a connection between menopause and depression that this must be investigated. The tie to mental health is extremely important and must be considered for all women as they enter this phase of life. The phenomenon of weight gain among women in menopause should also be studied further.

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APPENDIX A

Menopause Survey

1. What is your ethnicity?

Mark only one oval.

- African American or Black
- American Indian
- Asian
- Hispanic non-White
- White
- Hawaiian Native or Pacific Islander Other:

_____

2. What is your age (in years)?

_____

3. What is your highest level of education?

Mark only one oval.

- Did not complete high school
- High school graduate
- Some college or an associate's degree
- Bachelor's degree
- Master's degree or graduate certificate
- Doctorate degree
- Other:

_____

4. Are you in menopause?

Mark only one oval.

- Yes
- No

5. If you are in menopause, at what age did you begin to experience menopause?

_____

6. Are you married?

Mark only one oval.

- Yes No

In this section, provide responses on a scale of 1 - 5 where 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Neither Agree nor Disagree, 4 = Moderately Agree, and 5 = Strongly Agree

Mark only one oval per row.

	1	2	3	4	5
My partner and I understand each other perfectly.	⬭	⬭	⬭	⬭	⬭
I am not pleased with the personality characteristics and personal habits of my partner.	⬭	⬭	⬭	⬭	⬭
I am very happy with how we handle role responsibilities in our marriage.	⬭	⬭	⬭	⬭	⬭
My partner completely understands and sympathizes with my every mood.	⬭	⬭	⬭	⬭	⬭
I am not happy about our communication and feel my partner does not understand me.	⬭	⬭	⬭	⬭	⬭
Our relationship is a perfect success.	⬭	⬭	⬭	⬭	⬭
I am very happy about how we make decisions and resolve conflicts.	⬭	⬭	⬭	⬭	⬭
I am unhappy about our financial position and the way we make financial decisions.	⬭	⬭	⬭	⬭	⬭
I have some needs that are not being met by our relationship.	⬭	⬭	⬭	⬭	⬭
I am very happy with how we manage our leisure activities and the time we spend together.	⬭	⬭	⬭	⬭	⬭
I am very pleased about how we express affection and relate sexually.	⬭	⬭	⬭	⬭	⬭
I am not satisfied with the way we each handle our responsibilities as parents.	⬭	⬭	⬭	⬭	⬭
I have never regretted my relationship with my partner, not even for a moment.	⬭	⬭	⬭	⬭	⬭
I am dissatisfied about our relationship with my parents, in-laws,and/or friends.	⬭	⬭	⬭	⬭	⬭
I feel very good about how we each practice our religious beliefs and values.	⬭	⬭	⬭	⬭	⬭

7. In this section, provide responses on a scale of 1 - 6 where 1 = Never, 2 = Very Rarely, 3 = Rarely, 4 = Occasionally, 5 = Frequently, and 6 = Always.

Mark only one oval per row.

	Never	Very Rarely	Rarely	Occasionally	Very Frequently	Always
I feel sad.	◯	◯	◯	◯	◯	◯
I feel discouraged about the future	◯	◯	◯	◯	◯	◯
I feel like a failure	◯	◯	◯	◯	◯	◯
I have a hard time enjoying things	◯	◯	◯	◯	◯	◯
I feel guilty	◯	◯	◯	◯	◯	◯
I feel punished	◯	◯	◯	◯	◯	◯
I am disappointed in myself	◯	◯	◯	◯	◯	◯
I blame myself for my faults and weaknesses	◯	◯	◯	◯	◯	◯
I think about killing myself	◯	◯	◯	◯	◯	◯
I cry	◯	◯	◯	◯	◯	◯
I feel annoyed and irritated	◯	◯	◯	◯	◯	◯
I have no interest in people	◯	◯	◯	◯	◯	◯
I put off making decisions	◯	◯	◯	◯	◯	◯
I worry about my looks	◯	◯	◯	◯	◯	◯
I have to push myself to do things	◯	◯	◯	◯	◯	◯
I don't sleep well	◯	◯	◯	◯	◯	◯
I feel tired	◯	◯	◯	◯	◯	◯
I have no appetite	◯	◯	◯	◯	◯	◯
I am worried about my health	◯	◯	◯	◯	◯	◯

Section 4

8. In this section, provide responses on a scale of 1 - 3 where 1 = Never, 2 = Sometimes, and 3 = Always.

Mark only one oval per row.

	1	2	3
I am upset with my present weight	◯	◯	◯
I feel active and energetic	◯	◯	◯
I am going to enjoy myself more often	◯	◯	◯
I am not able to control my hunger and craving for food	◯	◯	◯
I dislike the way I look	◯	◯	◯
I am self-conscious in the company of others because of my weight	◯	◯	◯
I am reminded of my body shape and appearance during the day	◯	◯	◯
I am avoiding friends and relative because I am out of shape	◯	◯	◯
I know why I put on weight and I know how to lose it	◯	◯	◯
I believe that excess weight is not good for my general health	◯	◯	◯
I am taking steps to control my weight	◯	◯	◯
Generally, I am feeling good about myself	◯	◯	◯

THANK YOU FOR YOUR PARTICIPATION