Cultural and Cognitive Factors in Symptom Appraisal Concerning Menopause

MARIA JOÃO FIGUEIRAS (*)

1. INTRODUCTION

The subject of this essay is the cultural and cognitive factors associated with the symptom's appraisal of menopause. While some medical researchers have tried to strip the word menopause of all of its social and cultural «baggage», a recent review of the literature has given some relevance to its importance. According to this view (Landrine & Klonoff, 1992), the implication of cultural variables is fundamental for the definition, comprehension, reporting and experience of illness and health, and the case of menopause is no exception.

Cross-cultural investigations have shed some interesting light on this subject through the comparison of menopausal experiences in different cultures. Reports show considerable variability in the incidence of most of the symptoms. Supported by anthropology and sociology there has been a growing interest in the fact that some physical events such as «hot flashes» or bleeding ulcers, are not perceived, labeled or reported as painful or as symptoms, in some cultural and social contexts, while the opposite may happen in other cultures.

Thus, including cultural and social variables in the foreground of Health Psychology may facilitate the comprehension of important aspects of health and illness, in particular those associated with menopause, the subject of this essay.

2. BACKGROUND

2.1. *Contributions of sociology and anthropology*

The conception of illness, the explanation of its causes and the proposed modes of treatment, may also vary extraordinarily among cultures, as has been demonstrated by anthropologists, sociologists and psychologists (Harwood, 1981). Their contributions that include the evaluation of cultural and social contexts may therefore improve significantly our understanding of health beliefs and behaviour.

Medical sociology has made an essential contribution to the assessment and integration of cultural and cognitive differences concerning health and illness. In this framework, sociologists are concerned with the social impact of different illnesses, studying the cultural and social reactions as an important way of understanding illness.

Medical anthropologists, on the other hand, are interested in the cultural differences found in the definition of health and illness and in interpretation and treatment. In this context the inter-

(*) Unit of Psychology, UMDS Guy's and St. Thomas Hospital, University of London, United Kingdom.

actions of historical patterns in the cultural development, play a major role. If cultural differences have several implications for the way people perceive social situations, it is to be expected that their values and norms of behaviour towards illness will also vary from culture to culture.

Finally, psychologists are concerned with factors such as individual behaviour, personality and small-group influences on behaviour (Taylor, 1986). More specifically, health psychologists are interested in the patient's psychological adjustment and management while coping with health problems, that is, illness.

While it has been considered that health and illness are related only to the physical condition of the body, it has been shown that social factors have a profound effect upon the experience and the occurrence of illness, and in the way subjects react to being ill.

3. CULTURE AND COGNITION

Culture has been seen as a set of guidelines (both implicit and explicit) which an individual inherits as a member of a particular society, and which tells him or her how to view the world, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. (Helman, 1985). In Keesing's (1981) words culture is: «Systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that humans live.»

That is why the individual's reaction to illness, death or other misfortune cannot be understood without an understanding of the type of culture where they were raised. Furthermore, it is necessary to examine the social organization of health and illness in a particular society. The way people are recognized as «ill», the way they manifest their illness to other people, and the attributions of those to whom they present their illnesses, vary across cultures.

At an individual level, the process of defining oneself as «ill» can be based on three different types of perception: the subject's own perceptions, the perceptions of others, or both of these (Helman, 1986).

«Becoming ill» involves, therefore, subjective experiences of both physical and emotional changes, since there are some conventions about how people should behave when they are ill (Lewis, 1981). In that sense, becoming ill is a «social» and a cultural process where others must recognize that the subject's «well-being» is impaired.

Different values are attached to different parts of the body, determining which symptoms or signs are perceived and accepted by others around the patient. Different cultural contexts give significance to different kinds of complaints that may be socially acceptable in different ways. Sociologists have emphasized that health beliefs and the body itself have social, moral, and political meanings. They have demonstrated that ethnic groups differ in their concepts of health (Landrine & Klonoff, 1992) and specifically in their:

- Knowledge of modern, biomedical concepts of disease;
- Labels and categories for symptoms;
- Expectations of health care providers;
- Construction and experience of pain;
- Presentation of physical complaints, how they present and speak about symptoms;
- Understanding of a health-related interview, in the extent to which their physical complaints appear to refer to the social and interpersonal world; and
- Practices.

A symptom, or a sign, according to the context might be interpreted as «illness» or as «normal». It depends on how common the symptom is in that society, and whether it «fits» the major values of that group (Zola, 1973). It also depends on how people make social judgments about other individuals or social groups, about social roles and about their experiences in social and interpersonal settings.

As explained by Weiner (1979; 1985) attribution theory, people explain events, according to their own views; their own beliefs. With this general framework we can, therefore attempt to explain the specific cognitive context of health and illness. Here, the concepts of body image are related to the beliefs about its size, shape, structure, and forms of functioning. All these concepts are influenced by cultural background, which modulate the individual's responses to ill-

ness, and can have important effects on the health of the individual.

Some studies have suggested that people construct multidimensional prototypes of illness. These include: different dimensions of identity (label and symptoms), cause, consequences, duration and course, and cure (Turk, Rudy & Salovey, 1985). For this reason, within cultural contexts, the causes, the clinical situation and treatment can vary. Also, the social and psychological dimensions attributed to illness and health determine the meaning of the disease for the individual and, for those around him.

4. SYMPTOMS APPRAISAL

Certain predispositions of individuals, whether shaped by biology, culture or particular psychological histories, increase their vulnerability to both physical and psychological symptoms. Mechanic (1986) points out that the variability of patient behaviour in a given subculture, despite the similarity of symptoms, reflects major differences in psychological orientations and predisposition. It is important to give attention to individuals' appraisal of their symptoms and the assumptions they make about causes.

The concept of illness or disease refers to models characterized by constellations of symptoms and the conditions underlying them (Mechanic, 1986). There is a substantial relationship between the self-assessment reports of physical and psychological symptoms where it was found that symptoms are virtually synonymous with illness. This consistent association of symptom clusters with illness labels (see Lau, Bernard & Hartman, 1989) was the source of the first rule for self-appraisal, the symmetry rule, proposed by Leventhal and Diefenbach (1991).

People's prior experiences affect their interpretation of and response to the symptoms they perceive. The patient's knowledge of the illness may come from personal knowledge of his own health, from second hand sources such as friends and relatives' experiences, and medical articles or the media in general. Psychological factors play a very important role, as well, first, in how people recognize symptoms and interpret their meaning; second, in determining whether those symptoms are interpreted as illness or not.

5. MENOPAUSE

The terms menopause and climacteric are used in the literature to refer to the changes that occur over middle-age. The World Health Organization (WHO), defined menopause as the permanent cessation of menstruation resulting from loss of ovarian activity, and the climacteric or perimenopause was defined as the period of transition from reproductive to nonreproductive status, i.e. the period immediately before menopause and at least the first year afterward (WHO, 1981). For research purposes, menopause and the climacteric remain ill-defined periods associated with complete and partial ovarian failure, respectively (Schmidt, 1991).

Although it can occur as early as 45, or as late as 55, in average menopause occurs at age 50. The fact that menopause is characterized by the final menses, provides some consensus about the definition of the menopausal status, which is based on menstrual criteria. However, there are no generally accepted criteria for operationalizing menopausal status. It can be defined by several factors such as, last menstrual period, self-reported menopausal status or chronological-age. In that sense, the different time spans without menses, used to define the menopausal status can introduce confounding factors, because different life changes occur within this period.

«Change of life» is a western colloquialism referring to the cessation of menstruation, the climacteric time period, and the accompanying life events (Patterson & Lynch, 1988). The negative stereotypes and expectations which are still promoted in the psychological medical and lay literature, reinforce the idea of menopause as a change of life.

Historically menopause has been regarded as a negative experience. Victorian physicians viewed menopause as a sign of «sin and decay» (McCrea, 1983), and referred to middle-aged women as experiencing «involutional melancholia» when describing the depression and anxiety that occurred in the menopausal years. Psychoanalytic writers typically regarded menopause as a critical event in the life of middle-aged women. It was a threat to their adjustment and self-concept and often reinforced and promoted anxiety neuroses. Deutsch (1945), referred to loss of reproductive life as partial death.

In general, menopause has often been viewed by the medical community as a deficiency disease and negative event in women's lives (Avis & McKinlay, 1991). McCrea (1983) summarized medical definitions of menopause. These are: (a) a woman's potential and function are biologically destined, (b) a woman's worth is determined by fertility and attractiveness, (c) rejection of the feminine role will bring physical and emotional havoc, and (d) aging women are useless and unattractive. These, as universally accepted attributes of menopause must inevitably contribute to the acceptance of women of these stereotypes what is to be expected from their new situation. However, researchers claim that women in mid-life deal with a variety of changes one of which is the physiological and psychological event of menopause (Patterson & Lynch, 1988).

It is therefore evident that menopause is surrounded by many myths, as well as a definite lack of scientific information (DeLorey, 1984). In some contexts menopause is believed to be a demanding and difficult time of women's life. Benedek (1950) stressed this notion stating that during this period, women experienced stress associated with loss of femininity, loss of children and changes in their sexual life with their husbands.

The event of menopause has different meanings within cultures. Cross-cultural literature suggests that response to menopause is conditioned by the cultural context which shapes the pattern of women's roles. Such studies view culture as an organized system which attributes meanings to reality, thus giving each natural phenomenon a particular meaning and significance. Since meanings vary from culture to culture, differences can be attached to menopause (Beyene, 1986).

Bart (1971), after examining data from 30 societies world-wide, concluded that in cultures in which women reported the greatest amount of distress during the climacteric, the distress coincided with a patriarchal type of social power with few social roles for older women. In other words, older women who could no longer bear children had low social status. By contrast, in cultures where older women were valued and their roles implied responsibilities and privileges within the extended family, menopause was viewed as a less traumatic event.

On the whole, however, the negative expectations and stereotypes of menopause seem to persist in Western cultures. This situation leads to the thought that menopause is detrimental to women. Specifically it generates the perception that the change in the social role, associated with the report of physical symptoms, loss, and lack of information, is felt and experienced as a state of illness.

6. SYMPTOM APPRAISAL IN MENOPAUSE

6.1. *What is a symptom ?*

Whatever the source of the information may be, the several definitions of symptoms agree, showing that there is a consensus between medical and popular literature. A symptom in a medical sense is: «any subjective evidence of disease of a patient's condition, i.e., such evidence as perceived by the patient; a change in a patient's condition indicative of some bodily or mental state.» (Dorland's Illustrated Medical Dictionary, 1988). From another source, it is «a phenomenon of physical or mental disorder; a disturbance which leads to complaints on the part of the patient; usually a subjective state, such as headache or a pain, in contrast to an objective sign as papilledema» (Blakiston's Gould Medical Dictionary, 4th. Edition, 1979).

In a lay sense, a symptom is: «any change or abnormality in physical or medical condition due to and revealing the presence of a disease or disorder; outward sign; indication» (The Penguin Concise English Dictionary; Garmonsway G.N., 1991). A symptom, in sum, is an indication that individuals are in the presence of a change from their normal condition.

Different classifications of symptoms have been made by different authors in relation to menopause (Kaufert, 1981). Symptoms themselves are grouped into categories based upon etiology, such as somatic, vasomotor, and psychological. The primary symptoms – those related to ovarian failure, including vaginal dryness and hot flashes – are major subjects of biomedical research. Mood shifts like irritability, depression, and

emotional liability are «secondary symptoms» often relegated to the domain of social sciences (Davis, 1986). However, only a few symptoms ascribed to menopause are objective and open to clinical test; the majority are subjective (Kaufert, 1981) and never developed. Curiously, the only symptom which is systematically associated with the menopause is hot flashes; a simplistic way of characterizing a very complex process.

Contradicting this simplicity is the fact that when menopausal experiences of women in different western cultures are compared, considerable variability is found in the incidence of most symptoms (Beyene, 1986). Furthermore, the prevalence and severity of symptoms also vary between women in the same society and this seems to be related with factors such beliefs, knowledge and social factors. Although there are conflicting views on the psychosomatic and psychological symptoms of menopause, most western physicians agree that hot flashes are physiological symptoms – the direct result of estrogen deficiency, but most of the other symptoms remain to be explained. Actually, medical doctors reinforce the idea that menopause should be treated as a syndrome or a deficiency disease (Lock, 1986).

Leventhal, Nerenz and Steele (1984) emphasized the social psychological factors in appraisal. They argued that «Social comparison processes appear to be involved in much of the transfer of information that generates illness cognition. Symptom appraisals in particular appear likely to involve the sharing of information with people in the individual's social network – Family members, relatives, and friends». In that sense, social comparison information can shape illness-related and health appraisals, and are likely to be affected by a wide variety of both personal and social psychological factors (Leventhal, 1986).

As many people discuss their health problems with others, these interactions are likely to have a profound impact on the appraisal process. The self evaluation phase (looking for associated symptoms, waiting to see how the symptom change), leads eventually to the decision that one is, or is not, sick. Learning influences and social myths can also dominate the interpretation of the menopause process.

How symptoms are described is influenced by a number of factors including language facility, familiarity with medical terms, individual experiences and lay beliefs about the structure and function of the body. All these culturally-defined «languages of distress» will influence how private experiences or symptoms are signaled to others, and the types of reactions expected from them.

7. VOCABULARIES OF DISTRESS

Each culture or group has its own «language of distress». Its members have their own specific way of signaling, both verbally and non-verbally, that they are in discomfort. The form that this behaviour will take is largely culturally determined, is the response to this behaviour. It depends among other factors on «whether their culture values or disvalues the display of emotional expression and response to injury» (Landy, 1977).

According to sociologists the body has social meanings. The response to the bodily complaints may also depend on the social acceptability of certain types of complaints, and even on the nature and site of the complaints. Wolff (1963), pointed out that minor pains from certain parts of the body may be more frequent because they are culturally more acceptable and because they bring a more sympathetic response.

Studies presented in the literature illustrate that beliefs about the meaning and significance of menopause, the context in which it occurs, and the emotions associated with that context, can affect the presentation of complaints and their communication to others. The «vocabulary of menopause» shapes women's experience in a meaningful and convincing way. For example, for the women of Grey Rock Harbour (Canada), the words «menopause» and «climacteric» are unfamiliar. The term that is somewhat equivalent is «the change», which entails the processes that may accompany the cessation of menses and any coincident disturbances or benefits.

In this case, popular concepts such as «nerves» and «blood» serve to link symbol, affect and biology, and provide the basic structure of menopausal discourse. Characteristics of blood are used to explain many of the symptoms of menopause. Flashes and flushes are caused by «too much» or «bad blood» and are welcomed as

purifiers. Although emotional states are usually referred to in terms of nerves, being «low-lifed» may be the result of having too thin or not enough blood (Davis, 1986).

The discourse of menopause may occur in terms of objective realities, like the biological factors, and also in terms of subjective experience, such as mood-shifts. Also, language plays an important role in communication of distress. Both verbal and non-verbal languages associated with distress, vary within cultures depending on the acceptability or value attributed by the cultural context to the complaints.

Some cultural groups expect an extravagant display of emotionality in the presence of complaints, others value stoicism and restraint and the playing down of their symptoms. Zola (1966), in his studies about how people communicate their distress to others, found that there were two ways of perceiving and communicating one's bodily complaints: either «restricting» (typical of Irish), or «generalizing» (typical of Italians). The Irish focused on a specific physical disfunction, and restricted its effect to their physical functioning. Italians displayed more symptoms and a more «global malfunctioning». They emphasized their complaints in a more voluble, emotional and dramatic way than the Irish who were stoical about their complaints. It is reasonable to expect that persons from contexts where the expression of symptoms and seeking help is encouraged, will be more likely to do so, particularly under stressful circumstances.

In contrast, in cultural contexts where complaints are discouraged, individuals experiencing distress may seek alternative means for dealing with their difficulties. Zborowski (1952), pointed out the relevance of culture's expectations in the acceptance of behaviours concerning illness and in teaching roles (e.g. «be like a man»). It is therefore apparent that social learning will affect the vocabularies that the subjects use to define their complaints and their orientations when seeking various kinds of care (Mechanic, 1972).

Individuals with such backgrounds, where the expression of emotional distress is inhibited, might express psychological distress through the presentation of physical complaints. Whatever the mechanism, the perception of the intensity of symptoms, as well as the meaning associated with it, may influence whether a privately-experienced symptomatology is shared with other people.

8. THE PERCEPTION OF SYMPTOMS

The perception of symptoms can be influenced by cognitive, emotional and social factors (Skelton & Pennebaker, 1982). Each of these factors are relevant to the symptom's perception because they contribute in different ways for the construction of a «meaning», which can vary across contexts. Cognitive factors are relevant to the way that people make sense of the experience of being ill. They are also associated with the social organization of the group and the way the expression of emotions is recognized and understood by that group.

In the case of the menopause these factors are supposed to have different weights, depending of the patterns of women's socialization, the distribution of social roles, the psychological symptoms associated and, the meaning of distress in different cultural contexts. However, further research is needed to understand how and in what ways these factors operate in the perception of symptoms and, their appraisal across cultures.

Cultural differences can influence the presentation of symptoms and this process involves factors such as perception, attribution of cause, definition, appraisal and decision-making. The reality of health and illness may be constructed by the patient according to culturally bound beliefs, but their meaning is modified by individual experience, regardless of the cultural group to which the individual belongs.

As there are considerable differences in the subjective meaning of menopause, it is important to understand how these differences are related with individual biology and personal history. However, the availability of reference groups that share the individual's definitions and provide social support is essential to the maintenance of the particular interpretations.

A woman's perception of her menopause experience is largely determined by her perception of the physical, social and psychological changes she undergoes. In general, some people are consistently more likely to notice a symptom than others (Taylor, 1986), and thus individuals differ substantially in the point at which they decide

what is a symptom. Some individuals seem to give more attention to their internal states than others do (Pennebaker, 1983). For example, people who are focused on themselves are quicker to notice symptoms than people who tend to focus their attention on external happenings.

Menopause entails a variety of physical changes. Symptoms can stimulate the perception of health threat but they can also be a product of threat perception. As Leventhal et al. (1980) have argued, «given the symptoms, an individual will seek a diagnostic label, and given a label, he or she will seek symptoms». In that sense, symptom awareness is influenced by «a variety of accidental, historical and learning factors, in which the mechanism of identification plays a major role» (Hunter, Lohrenz & Schwartzman, 1964). The concept of identification as used by the authors, is more descriptive than explanatory. The descriptions are based in idiosyncrasies and can influence the interpretation and response to symptoms.

9. INTERPRETATION AND RESPONSE TO SYMPTOMS

The interpretation of symptoms is a heavily psychological process where expectations play a major role. People may ignore «symptoms» they are not expecting and amplify «symptoms» that they do expect. (Leventhal, Merenz & Strauss, 1980). The meaning attached to a symptom also depends substantially on what that symptom is. According to sociologists, symptoms that affect highly valued parts of the body may be interpreted as more serious and as more likely to require attention than symptoms that affect less valued organs. This evaluation is also dependent on the meaning attributed by the cultural context.

There are individual and sociocultural differences in response to symptoms. On the one hand, individual differences can be found within the same culture if one considers, among other factors, personality, social situation and context. On the other hand, studies reported in the literature found that ethnic groups differentially report symptoms and seek medical assistance for them (Mechanic, 1972).

The use of disease models in menopause research is problematic, since women's experience of menopause exists on a continuum from normal, for the vast majority of women, to abnormal for a minority. (Davis, 1986). Based on the assumption that women may undergo roughly similar physiological changes at menopause (Wright, 1983), their physical experiences entail the interaction of both biological and social factors in the response to symptoms. For the Mayan women, for example, menopause presents neither a life crisis nor psychological or physiological problems (Beyene, 1986). Their only recognized symptom of menopause is the final cessation of menses. Greek women on the other hand, even though they reported having experienced «hot flashes» and «cold sweats», did not consider these to be a disease symptom; they regarded menopause as a natural phenomenon that all women go through.

Symptom recognition is determined both by individual differences in attention to one's body and by transitory situational factors that influence the direction in one's attention. (Taylor 1986). Normally an individual may have a variety of symptoms without experiencing a fear of illness. The common occurrence of such symptoms and their diffuseness establish conditions under which widely varying attributions may reasonably occur.

10. COMMON-SENSE REPRESENTATIONS OF MENOPAUSE

Representations of specific illness events, for example, symptom clusters and their labels with their associated expectations regarding timelines, causes, consequences and beliefs about control (Lau & Hartmann, 1983), define a relatively «low»-level of information structure. These representations are both concrete and abstract. An illness episode can be identified by its somatic sensations (running nose, headache) and by its label (flu). Equally, menopause can be identified by symptoms such as depression or sleep problems or by its label.

Several different views are supported by ordinary people, and thus different representations are held. Besides the general meaning of «cessation of menses», menopause or so-called «change of life» is thought to represent a major cultural, psychological and physiological event for

middle-age women. These aspects contribute to the construction of a common-sense representation about menopause which serves as a guide to action. For example, Mayan women perceive menopause as an event that occur when a woman has used up all her blood, that is, menstrual blood. Thus they believe that the onset of menopause occurs early for those women who have had many children because they had used up their blood by giving birth often (Beyene, 1986). In some western cultures, there is a belief that menopause may occur as early (or as late) as the onset of menarche.

These representations are believed to be of major importance in defining the illness experience and in determining the relevance, organization, and interpretation of health, illness and treatment information. (Leventhal, 1982). One of the most important cognitive features of the lay health system is that it cannot be understood apart from every day reality and every day common-sense and knowledge (Blumhagen, 1980). According to anthropologists representations are «collective» of a particular culture and are dependent on the degree of sharedness about beliefs and cognitions.

As Skelton (1991) points out, beliefs are often represented as a set of propositions which can be judged as more or less true, depending on their fit with an objective world. Items termed beliefs are often deduced from illness narratives, which have been found to vary by social context, the audience of the narrative, and the stage in the illness process in which the account is elicited (Good, 1986). Thus, to some extent, each individual functions within a uniquely constructed reality, based on prior experience, including the social and cultural transmission of beliefs and expectancies concerning health and illness (Turk et al. 1986).

11. SOCIAL REPRESENTATION OF MENOPAUSE AND CULTURAL CONTEXT

The social representation of health is heavily related to the cultural context and thus to cognitions and beliefs that people have about well-being. Anthropological and sociological literature suggests that cognitive representations of health and illness reflect basic social and cultural values and shared understandings of dysfunction (Landrine & Klonoff, 1992). For example, the construction of obesity as an illness in western societies is not shared by other cultural groups. In western industrialized societies that value and reward female slimness, women follow different diets and try to conform the culturally defined standards of «beauty» and «health». By contrast, in parts of West Africa, wealthy men frequently send their daughters to «fatting-houses» where they are fed with fatty foods, with minimal exercise, to make them plump and pale – a culturally defined shape believed to indicate both wealth and fertility (Polhemus, 1978).

Another example concerns the concept of «stress» as a representation of illness etiology in some western societies. In most cultures the concept of stress is totally absent of the illness beliefs (Murdock, 1980). As Landrine and Klonoff pointed out, specific types of illness might carry a moral evaluation (stigma), and differ in the amount of shame and embarrassment associated with them (e.g. flu or AIDS). Cognitive processes mediate individual reactions to the environment, and play a primary role in health psychology research since they indicate how individuals make sense of health or illness issues.

As human life is punctuated by biologically critical points, menopause is principally defined as a biological phenomenon across cultures. Generally, among humans the experience of biological events may be influenced by a variety of non physiological factors, including cultural, psychological and environmental nature. Some studies have also identified the importance of social factors and life stress during this period of a women's life (Cook et al. 1981). These factors include:

- Alterations in family roles
- A changing social support network
- Interpersonal losses
- Aging and the onset of physical illness

However, middle-age, and in particular the climacteric or menopause, is not uniformly characterized by illness, widowhood, an empty nest or becoming a grand parent.

Good & Good (1980), argued that human illness is fundamentally semantic or meaningful to the individual. The construction of meanings is

influenced by both, the nature of the problematic experiences with which an individual is faced and, the nature of the situation in which they occur. An alternative way of understanding the meaning of menopause is to view it in terms of everyday folk discourse, rather than empirical, medical or scientific discourse. The experience of menopause is embedded in tradition, folk culture, social values and social construction of knowledge (Davis, 1986).

A review of the literature (Beyene, 1986; Davis, 1986; Lock, 1986), showed that there are different meanings of menopause in different cultures. A comparison between Mayan and Greek women indicates some similarities and marked differences in the two cultures. Women seem to share similar cultural variables with respect to beliefs and practices regarding menstruation and childbearing, and women's roles, but have differences in their experiences with menopause. Japanese women regarded menopause as a natural life cycle transition in which the biological marker of cessation of menstruation is not considered to be of great importance. Also, menopause can mean freedom from worry about pregnancy and other discomforts (Berkun, 1986).

Difficulties experienced during menopause may be associated with concurrent life change (Engel, 1987). In cases where menopause co-occurs with experienced recent loss or marital, psychological or social stress, symptoms tend to be worse and, some authors consider menopause as a particularly stressful event. Other researchers refer the loss of estrogen, as a cause for psychological stress, whereas others assert that the important losses are social and cultural, such as loss of femininity or youth. In this area further research is needed to understand how these concepts like «loss» or «femininity» are understood and valued in western cultures, once social roles are more likely to be «equal» between women and men. An alternative view (Neugarten et al., 1963), considers menopause to be an expected and appropriate event in the lives of middle-aged women and as such not psychologically stressful.

These perceptions can provide different social representations of menopause, such as:

- The end of reproduction in western societies
- A biological marker for an aging process in cultures that extol youthfulness (Sontag, 1972)
- A major negative event of the same magnitude as, for example, job loss or loss of a spouse.
- Natural menopause is a benign event for the majority of middle-aged healthy women.

The relationship between the biophysical and the behavioural factors of menopause has been obscured by the tendency of western biomedicine to conceive and define menopause as a disease episode rather than a natural process. This «disease», which is defined by medical researchers as an estrogen deficiency, is compared to long term deficiency conditions, such as diabetes or anemia, and is wrongly used as a direct representation of the full reality of menopausal experience. This view has been criticized by other researchers, like Kaufert et al. (1986).

The same authors have noted that the biomedical definition of menopause as primarily an endocrine disorder – estrogen deficiency –, often leads to the definition of «menopausal» only those symptoms which can be attributed to an estrogen deficiency, (such as hot flashes, night sweats, osteoporosis and atrophic vaginitis), while ignoring those symptoms (especially social or psychological ones), which are not easily corrected by the hormone replacement therapy (HRT).

Another problem of seeing menopause as a medical condition only is that because it is defined as an hormonal deficiency it can be diagnosed only by a physician (and by laboratory tests), and treatment can be prescribed only by a physician. Thus, it often becomes «a permanent condition to be permanently managed» by the medical system. Furthermore, this narrow definition of menopause determines only the symptoms of menopause, and its temporal boundaries, providing the criteria – last menses – for determining when menopause begins and when it ends. Defined as exclusively an estrogen deficiency and therefore physiological condition, menopause becomes an objectively measurable and knowable process from the medical viewpoint, where the subjective meanings of that experience are ignored.

In a challenge to the biomedical model it is argued by Kaufert that menopause is not an event that limits women's physical or psychological

capacities, but a natural part of aging, associated with other social transitions, such as retirement or children leaving home, among others. Considering that menopause is viewed as a psychological and physiological event, it is important to determine the influence of these variables upon women's altitudes towards menopause.

12. WOMEN'S ATTITUDES TOWARDS MENOPAUSE

Women's attitudes and experiences about menopause vary significantly. Several studies have suggested that attitudes towards menopause can be influenced by socio-demographic, physical and psychological characteristics. An examination of attitudes towards menopause across age-groups, showed that women do not necessarily view menopause in a negative way or even as a significant event in their lives. (Neugarten, 1963). The greatest differences were found between younger women (21-30) and middle-aged women (45-55). It has also been found that attitudes seems to improve from pre to post-menopausal stages. These women viewed the post-menopausal stage as one in which they were freer, felt better, more confident, and calmer than before menopause (Patterson & Lynch, 1988)

Krescovich (1980) and Frey (1982) found that educated women had more positive attitudes and this was related to occupation. LaRocco and Polit (1980) also found that education was related to knowledge about menopause and this relation can partially explain a more positive attitude. Some literature suggests that attitudes towards one's role may influence the experience of menopause and be associated with perceived health status, social and personal identity among mid-life women.

The societal conflict concerning the maintenance of women's roles may predict that the social representation of menopause as a disease will be present. However, in a society where this conflict is not evident, these constructions are absent. Thus, complaints about the ostensibly biologically based «symptoms» of menopause exhibit considerable variability across societies and cultures (Landrine & Klonoff, 1992).

REFERENCES

Avis, N.E. & McKinlay, S.M. (1991). A longitudinal analysis of women's attitudes toward the menopause: results from the massachusetts women's health study. *Maturitas*, 13: 65-79.

Berkun, C.S. (1986). In behalf of women over 40: Understanding the importance of the menopause. *Social Work*, 31(5): 378-384.

Beyene, Y. (1986). Cultural significance and physiological manifestations of menopause A Biocultural Analysis. *Culture, Medicine and Psychiatry*, 10(1): 47-71.

Bungay, G.T., Vessey, M.P. & McPherson, C.K. (1980). Study of symptoms in middle life with special reference to the menopause. *British Medical Journal*, July: 181-183.

Croyle, R. (1992). Appraisal of Health Threats: cognition, Motivation, and social comparison. *Cognitive Therapy and Research*, 16(2): 165-182.

Currer, C. & Stacey, M. (1986). *Concepts of Health, Illness and Disease - A comparative perspective.* Berg Publishers Ltd.

Davis, D.L. (1986). The meaning of menopause in a newfoundland fishing village. *Culture Medicine and Psychiatry*, 10: 73-94.

Engel, N.S. (1987). Menopausal stage, current life change, attitude toward women's roles, and perceived health status. *Nursing Research*, 36(6): 353--357.

Greene, J.G. & Cooke, D.J. (1980). Life stress and symptoms at the climaterium. *British Journal of Psychiatry*, 136: 486-491.

Hall, J. & Doman, M.C. (1988). What patients like about their medical care and how often they asked: A meta-analysis of the satisfaction literature. *Social and Scientific Medicine*, 27(9): 935-939.

Helman, C. (1986). *Culture, Health and Illness*. Bristol: John Wright and Sons.

Holte, A. (1992). Influences of natural menopause on health complaints: a prospective study of healthy Norwegian women. *Maturitas*, 14: 127-141.

Hunter, M. (1992). The women's health questionnaire: a measure of mid-aged women's perceptions of their emotional and physical health. *Psychology and Health*, 7: 44-54.

Hunter, M.S. (1990). Somatic experience of the menopause: a prospective study. *Psychosomatic Medicine*, 52: 357-367.

Kaufert, A.P. & Gilbert, P. (1986). Women, Menopause, and Medicalization. *Culture Medicine and Psychiatry*, 10(1): 7-21.

Kaufert, P. (1981). Symptom Reporting at the Menopause. *Social Science and Medicine*, 15E: 173-184.

Kaufert, P.A. & Gilbert, P. (1981). The context of menopause: Psychotropic drug use and menopausal status. *Social Science and Medicine*, 23(8): 747--755.

Kauferl, P. et al. (1986). Menopause research: The korpilampi workshop. *Social Science Medicine*, 22(11): 1285-1289.

Landrine, H. & Klonoff, E.A. (1992). Culture and Health-Related Schemas: A review and Proposal for Interdisciplinary Integration. *Health Psychology*, 11(4): 267-276.

Lennon, M.C. (1982). The Psychological Consequences of Menopause: The importance of timing of a life stage event. *Journal of Health and Social Behaviour*, 23: 353-366.

Leventhal, H., Leventhal, E. & Diefenbach, M. (1992). Illness cognition: Using common sense to understand treatment adherence and affect cognition interactions. *Cognitive Therapy and Research*, 16(2): 143-163.

Lock, M. (1986). Introduction. *Culture, Medicine and Psychiatry,* 10(1): 1-5.

Lock, M. (1986). Ambiguities in aging: japanese experience and perceptions of menopause. *Culture, Medicine and Psychiatry*, 10(1): 23-36.

Locker, D. (1981). *Symptoms and Illness – The cognitive organization of disorder*. London: Tavistock Publications.

Lonner, J.W. & Berry, W.J. (1986). Field Methods in Cross-Cultural Psychology. *Cross-Cultural Research and Methodology Series*, Vol. X.

Marshall, R. (1988). Interpretation in doctor-patient interviews: a sociolinguistic analysis. *Culture, Medicine and Psychiatry*, 12: 201-218.

Matthews K.A. et al. (1990). Influences of natural menopause on psychological characteristics and symptoms of middle-aged healthy women. *Journal of Consulting and Clinical Psychology*, 58(3): 345--351.

Mayou, R. (1976). The nature of bodily symptoms. *British Journal of Psychiatry*, 129: 55-60.

Mechanic, D. (1972). Social psychologic factors affecting the presentation of bodily complaints. *The New England Journal of Medicine*, 286(21): 1132--1139.

Mechanic, D. (1986). The concept of illness behaviour: culture, situation and personal predisposition. *Psychological Medicine*, 16: 1-7.

Neugarten, B. et al. (1963). Women's attitudes toward the menopause. *Vita Humana*, 6: 140-151.

Neugarten, B.L. (1965). Menopausal Symptoms. In Women of Various Ages. *Psychosomatic Medicine*, 27(3): 266-273.

Patterson, M.N. & Lynch A.Q. (1988). Menopause: Salient issues for Counselors. *Journal of Counseling and Development*, 67: 185-188.

Pennebaker, J.W. (1984). Accuracy of Symptom Perception. In *Social Psychological Aspects of Health* (A. Baum, S. Taylor & J.E. Singer, Eds.), pp. 189-217, London: Lawrence Erlbaum Ass. Publishers.

Salovey, P. & Birnbaum, D. (1989). Influence of mood on health-relevant cognitions. *Journal of Personality and Social Psychology*, 57(3): 539-551.

Sarafino, E.P. (1990) *Health Psychology Biopsychosocial Interactions*. New York: John Wiley & Sons.

Schmidt, P.J. & Rubinow, D.R. (1991). Menopause-related affective disorders: a justification for further study. *American Journal of Psychiatry*, 148(7): 844-852.

Skelton, J.A. & Strohmetz, ?? (1990). Priming symptoms reports with health-related cognitive activity. *Personality and Social Psychology Bulletin*, 16(3): 449-464.

Skelton, J.A. & Croyle, R.T. (1991). *Mental representation in health and illness*. London: Springer-Verlag.

Taylor, S. (1990). Health Psychology – the science and the field. *American Psychologist*, 45(1): 40-50.

Turk, D.C., Rudy, T.E. & Salovey, P. (1986). Implicit models of illness. *Journal of Behavioral Medicine*, 9(5): 453-474.

Wright, A.L. (1983). A cross-cultural comparison of menopausal symptoms. *Medical Anthropology*, Summer: 20-35.

Zola, I.K. (1966). Culture and symptoms – an analysis of patients presenting complaints. *American Sociological Review*, 31: 615-630.

SUMMARY

Menopause is a biological and psychological phenomenon in the lives of middle-aged women. It is important to understand how biological variation is linked to the subjective experience of menopause. In different cultures menopause is seen variously as a normal passage in life, and as a prototype of an illness, the symptoms associated with it being seen to need medical assistance.

These different views are influenced by cognitions, attributions and pre-existing beliefs about menopause and their relationship with psychological and social dimensions such as changing of roles, occupation, aging, stress among others. Although there is considerable variability in symptom appraisal within cultures, the meaning of menopause is also different across cultures.

As a part of life, menopause is not necessarily traumatic, does not place healthy women at risk of an affective disorder, and is considered by some to be a normal phase that may or may not be accompanied by physical discomfort (Berkun, 1986).For these reasons, in the context of human aging menopause should be viewed as a process and not an event (Lock, 1986). The weight of evidence from anthropology and sociology strongly suggest that the experience of the menopause is shaped by historical factors and environmental and cultural contexts, and by the individual's per-

sonal history, both in the biological and in the social senses. Psychological research is needed to determine the cognitive, emotional and social mediators of these factors.

RESUMO

A menopausa é um fenómeno biológico e psicológico na vida das mulheres de meia idade. É importante compreender como é que a alteração biológica se relaciona com a experiência subjectiva na menopausa. Em diferentes culturas a menopausa é vista de formas diferentes: como uma transição normal da vida ou, então, como prototipo de uma doença, cujos sintomas associados justificariam assistência médica.

Estes pontos de vista diferentes são influenciados pelas cognições, atribuições e crenças sobre a menopausa e pela sua relação com dimensões psicológicas e sociais, tais como mudança de papéis, profissão, envelhecimento e stress, entre outras. Tal como há grande variabilidade na avaliação dos sintomas dentro da mesma cultura, também o significado da menopausa é diferente de cultura para cultura.

Como parte integrante da vida, a menopausa não é necessariamente traumática, não coloca a mulher saudável em risco de perturbação afectiva e é considerada por alguns como uma fase normal que pode ser ou não acompanhada por desconforto físico (Berkun, 1986). Por estas razões, a menopausa deve ser considerada um processo e não um acontecimento, no contexto do envelhecimento humano (Lock, 1986). A antropologia e a sociologia sugerem fortemente que a experiência da menopausa é influenciada por factores históricos e ambientais, pelos contextos culturais e pela história individual, quer no sentido biológico quer no social. É necessária investigação psicológica com a finalidade de determinar os mediadores cognitivos, emocionais e sociais desses factores.