ORIGINAL RESEARCH

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Representations of Menopause in Peruvian Women

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ABSTRACT Objective: To describe the representations of menopause in women who received care in first-level health care facilities in the city of Lima. **Material and Methods:** Observational cross-sectional research in women aged ≥40 years. A simple random probability sample was used. The "Menopause Representations Questionnaire" was used, which has a reliability between 0.68 and 0.79. The questionnaire is composed of 22 questions and four dimensions, all questions are measured using a Likert scale. **Results:** The final sampling consisted of 819 women. The average age was 52.5 years. 69% reported having a stable union, 54.6% were working, 68.1% did not seek medical help, 31.9% used hormone therapy. Identity dimension: The presence of hot flashes, night sweats had an average of 3.9. Positive consequences dimension: Having more freedom to plan activities without worries had a mean value of 3. The control, awareness and causes dimension: Menopause is considered a natural phase of a woman's life with a value of 4.3. The control, awareness and causes dimension presented a mean value of 4.1 and the negative consequences dimension 2.72. Women who seek medical help showed differences in the identity, positive and negative consequences dimensions ($p<0.05$). **Conclusion:** Women perceive menopause as a natural phase of their lives and disagree with the idea that menopause means a decrease in quality of life.

Keywords: Menopause; representations; symptoms

Menopause is defined as the cessation of menstruation due to the loss of ovarian follicular activity, which usually decreases after the age of 40, and in most women is completely lost after the age of 50.[1] An aging population is considered a major social challenge due to the increase in life expectancy, which exceeds the eighth decade, especially in developed countries, transforming them into societies with a rectangular demographic structure. It is estimated that by 2030, the number of postmenopausal women in the world will reach 1.2 billion.[2] In Peru, 39.1% of women are over 60 years of age. The average age of menopause is approximately 51 years; therefore, more than a third of a woman's life is spent after menopause, which implies the need to provide specialized medical care to this group.[3,4]

Today, menopause is seen as a physiological process and a transitional phase in a woman's natural aging cycle. Menopause, perimenopause and postmenopause are stages in which a woman stops menstruating. Perimenopause is the first stage and may begin 8 to 10 years before menopause.[5,6] The latter is characterized by a decrease in estrogen levels, with an average duration of 10 years. Often, after the age of 40, the protective effect of estrogens is lost, leading to symptoms such as hot flashes, night sweats, vaginal dryness, recurrent urinary tract infections and dyspareunia.[7,8] Other ailments such as sleeping prob-

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lems, headaches, fatigue, mood swings, loss of concentration and other conditions such as hypertension, metabolic syndrome and chronic diseases such as cardiovascular disease, osteoporosis and Alzheimer's disease also arise.[9,10]

Although menopause is a universal phenomenon, it is affected by sociocultural aspects. Women's experiences during the menopausal transition vary and are managed differently. For many, menopause is experienced in a patriarchal cultural context in which women relegate their own needs, including health needs, in favor of those of their family. This context can lead to a passive approach to menopausal symptoms, influenced by beliefs, traditions and cultural aspects.[11,12]

Despite the predominance of the biomedical model in the study of menopause, there is a growing interest in research that addresses cross-cultural and sociological aspects. The biomedical model postulates that menopause involves a series of physical and emotional problems caused by hormone deficiency.[13] It is relevant to note that anxiety, depression, cognitive deficiencies and sexual problems are among the symptoms most reported by middle-aged women. On the other hand, sociocultural models maintain that menopause is a natural process that has a minimal impact on women and that the problems associated with this stage are cultural constructs. Among the most significant elements of this approach are: negative stereotypes, attitudes towards aging and social roles.[14]

Hunter and O'Dea pioneered the methodological assessment of menopausal representations by means of a questionnaire applied to a sample of British women. This measurement was based on Leventhal's disease self-regulation model, which suggests that individuals construct cognitive and emotional representations about their illness. These representations influence their behavioral and emotional coping responses to illness and in turn determine health outcomes.[15] Early findings showed that representations about menopause are clinically significant; where low control beliefs were related to cognitive representations. This has allowed us to propose coping strategies, life satisfaction and well-being among middle-aged women.[16,17]

An innovative approach to studying menopause is based on a representational model, focusing on how women cognitively represent menopause. This approach considers women's psychosocial and cultural context, as well as their experience of physical changes, to determine the meaning and impact of menopause.[18] This research seeks to describe the representations of menopause in women receiving care in first level health centers in the city of Lima during the year 2023.

MATERIAL AND METHODS

The research is observational and prospective with a cross-sectional design, carried out in a cohort of women who received care in first level health facilities in the city of Lima. Women aged ≥40 years who attended gynecological consultation for various reasons in these facilities between January and June 2023 participated in the study. A simple random probability sample was used. The inclusion criteria were: women aged ≥40 years, absence of menstrual period for at least one year, ability to read and write, and having given their consent to participate in the research.

The instrument used is a self-administered instrument called "Menopausal Representations Questionnaire" in the Spanish version.[19] The participants completed this questionnaire, which has previously demonstrated adequate content validity and internal reliability, with values for the four dimensions ranging from 0.68 to 0.79. The questionnaire is composed of the following dimensions: identity (9 questions), positive consequences (4 questions), negative consequences (4 questions) and, awareness and causes (5 questions). All questions were evaluated using a Likert scale ranging from 1 to 5 (from "strongly disagree" to "strongly agree"). The scores were obtained by calculating the mean value of the responses for each dimension.

The research procedures were carried out in accordance with the Declaration of Helsinki, ensuring the confidentiality of all participants throughout the research. This was approved by the Ethics Committee of the Peruvian Climacteric Society (date: December 12, 2022; no: 073-2022/SPC.

The statistical analysis of qualitative variables was presented through absolute and relative frequencies, while quantitative variables were expressed as mean and standard deviation (SD). Mean scores were determined for each domain and Spearman's correlation analysis was performed. All statistical procedures were performed using SPSS software, version 26.

RESULTS

Considering the quality control of the records, 89 women were excluded, resulting in a final sample of 819 women. Data adequacy was confirmed by the Kaiser-Meyer-Olkin test, with a value of 0.832, p=0.05, and a total variance explained by the four dimensions of 48.4%. The mean age was 52.5 years, with a SD of ±6.3. Regarding marital status, 69% indicated being in a stable union and 12.9% were divorced. A total of 84.7% have a university degree and high school education. 54.6% are employed, while 41.6% are engaged in domestic work. 37% of the women have had two children, 27.8% have three children and 17.8% have more than four children.

With respect to seeking medical help for menopause management, 68.1% do not seek help, while 31.9% stated that they do seek help. 31.9% use hormone therapy for menopause and 68.1% do not use therapy. 91.5% reported natural menopause and 8.5% had surgically induced menopause.

In relation to the findings corresponding to the identity dimension: the presence of hot flashes and/or night sweats had a mean value of 3.9. Sexual changes, such as vaginal dryness or less sexual desire, had a mean value of 3.8. Mood changes (feeling more anxious, irritable and depressed) obtained the same mean value. In the dimension of positive consequences: feeling more freedom to plan activities without worries had a mean value of 3.0, which represents neutrality (neither disagreement nor agreement). Feeling physically better had a value of 2.6. As for the dimension of negative consequences: getting sick easily as a result of menopause had a mean value of 3.0, and having a poor quality of life as a result of menopause had a value of 2.4. In the control, awareness and causes dimension: considering menopause as a natural phase of a woman's life had a mean value of 4.3. While viewing menopause as the end of the reproductive phase, seeking medical help to control menopausal symptoms and attributing these changes to hormonal fluctuations had a mean value of 4.2 (Table 1).

The consolidation of the results by dimensions is expressed by the mean value: in the identity dimension it was 3.30 (SD ±0.65); in positive consequences, 2.76 (SD ±0.76); in negative consequences, 2.72 (SD ±0.81); in control, awareness and causes, 4.10 (SD ±0.57); and a total valuation of 3.36 (SD ±0.42) (Figure 1).

To analyze the relationship between the scores of each dimension, the distribution of data was studied using the Kolmogorov-Smirnov test. It was identified that the 4 dimensions did not meet the normality criteria ($p<0.05$). For this reason, Spearman's correlation coefficient was used to analyze the relationship between the representative dimensions of menopause. A significant correlation was found between the identity dimension and the negative consequences dimension (p=0.000). Correlation was also observed between the identity dimension and the control, awareness and causes dimension. Likewise, there was correlation between the positive consequences dimension and the negative consequences dimension (p=0.002).

The comparative analysis showed that the results in the identity dimension for women who seek medical help are lower compared to those who do not, this difference being significant (p=0.003). In the positive consequences and negative consequences dimensions, women who seek medical help showed a higher mean value ($p<0.05$), without finding significant differences in the control, awareness and causes dimension (Figure 2). On the other hand, in the identity dimension, women who use hormone therapy for menopause presented a higher mean value than women who do not use it (p=0.039). However, the other dimensions showed no significant differences (Figure 3).

DISCUSSION

It has now been confirmed that social and cultural influences significantly affect how women perceive

TABLE 1: Representations of menopause distributed by questions and dimensions.

Dimensions and questions	$\bar{X}$	SD
Identity dimension		
Identity means. Having hot flashes and/or night sweats.	3.9	1.0
Menopause means. Having changes in appearance and body parts.	3.5	1.1
Menopause triggers new diseases.	3.3	1.1
Menopause causes you to gain weight.	3.1	1.1
Menopause means. Having pain in your bones, muscles, and joints.	3.5	1.1
Menopause means. Having poor sleep quality.	3.3	1.1
Menopause means. Having sexual changes (vaginal dryness, sexual desire).	3.8	1.0
Menopause means. Feeling more tired.	3.4	1.1
Menopause means. Having mood changes (anxious, irritable, depressed).	3.8	1.0
Positive consequences dimension		
The consequence of menopause means. Having more freedom to plan activities without worries.	3.0	1.0
The consequence of menopause means. Feeling physically better.	2.6	0.9
The consequence of menopause means. Feeling better psychologically.	2.7	0.9
The consequence of menopause means. Having more sexual freedom.	2.8	1.0
Negative consequences dimension		
The consequence of menopause means. Getting sick easily.	3.0	1.1
The consequence of menopause could. Interfering with my work duties.	2.8	1.1
The consequence of menopause means. Having a poor quality of life.	2.4	1.0
The consequence of menopause means. Interfering with my family life.	2.7	1.1
Control, awareness and causes dimension		
Menopause is a natural phase of a woman's life.	4.3	0.9
Menopause is the end of the reproductive phase.	4.2	0.8
If I cannot control my menopausal symptoms, I can seek medical support.	4.2	0.8
Lifestyle (diet, physical activity) can influence my menopausal symptoms.	3.7	1.0
Menopause is caused by hormonal changes.	4.2	0.8

SD: Standard deviation.

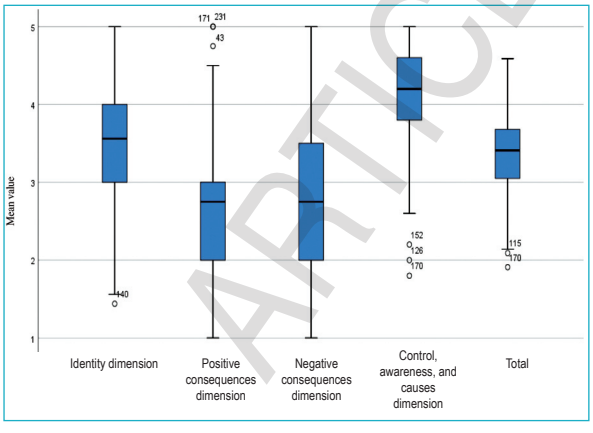

FIGURE 1: Results of menopause representations by dimensions.

and manage their symptoms during menopause. These problems are culturally constructed, taking into account negative stereotypes, attitudes towards aging and women's social roles. Research has shown that negative attitudes towards menopause are related to the presence and severity of menopausal symptoms, which manifest as discomfort and can affect the family environment.[20]

The results show that most women do not use hormone therapy and do not seek medical help for symptom management, due to several barriers such as low educational level, limited knowledge about menopause-related health, and that menopause is not considered a priority.[21] Factors such as availability and difficulty in accessing health services, economic problems, the high cost of hormone therapy, as well as its contraindications that limit its use, have been ratified by research conducted with European and Australian women. In these studies, it was reported that only 5% had sufficient knowledge about hormone therapy and none of them knew about the various therapies available.[22]

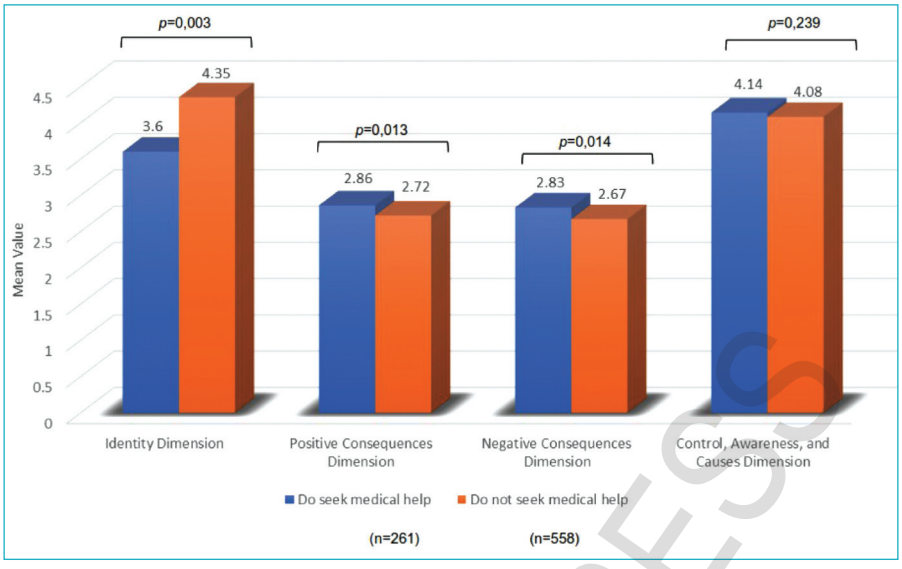

FIGURE 2: Analysis of results according to women seeking medical help and representations of menopause by dimensions.

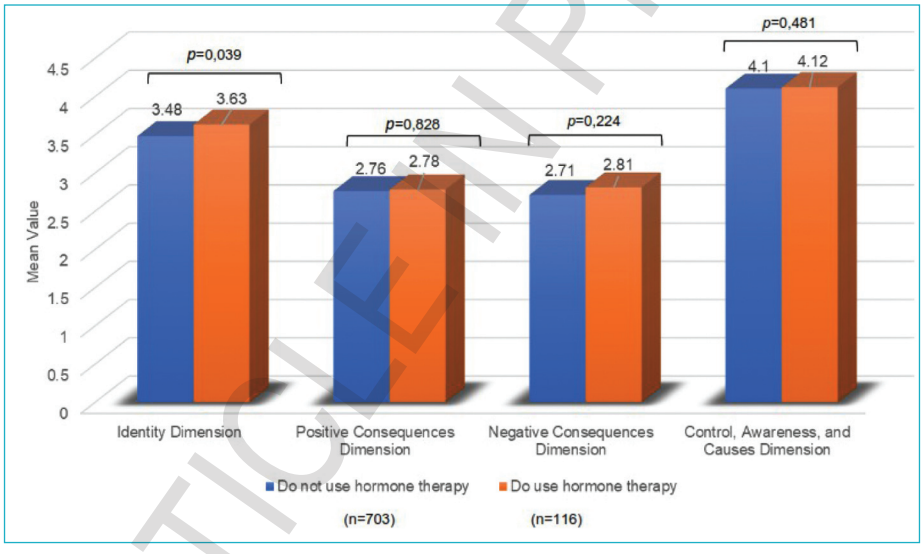

FIGURE 3: Analysis of results according to women using hormone therapy for menopause and representations of menopause by dimensions.

According to the self-regulation model, in the identity dimension, symptoms such as hot flashes, night sweats, vaginal dryness and changes in sexuality are associated with menopause. These findings are corroborated by research with European and North American women, where it is indicated that 80% of women reported the presence of hot flashes and night sweats at some point during menopause, and that these have a negative influence on the performance of their professional work or domestic activities.[23,24] Likewise, research with Asian and Western women has reported a higher incidence of vasomotor and urogenital symptoms, which may vary with other populations due to social factors, lifestyles and culture, as in the case of Malaysian women.[25]

Regarding the positive consequences, the results do not seem to coincide with Hunter and O'Dea's model, which states that the cessation of menstruation and the end of reproductive capacity are associated with greater sexual freedom.[15] The way middle-aged women cope with menopause may indicate an adaptation to the changes, which subsequently manifest as feelings of

satisfaction and increased self-esteem, allowing women to fulfill various family and work responsibilities.[26,27] Brown et al. findings indicate that postmenopausal women have more positive representations, demonstrating that women's personal experience during the menopausal transition may offer a positive view of this phase, and not be as unfavorable as one might think when experiencing changes during premenopause.[17]

The self-regulation model applied to menopause emphasizes that aging is associated with various physiological changes and an increased risk of getting sick easily, which can interfere with work life. Despite this, the results have shown indifference with respect to getting sick easily. This aspect is relevant since women work in different areas of the economic and productive process until postmenopause.[28] It is important to note that the term "healthy menopause" incorporates disease and disability, regardless of comorbidities. However, it has been shown that the prevalence of multiple chronic diseases increases in middle-aged women in a short period of time.[29] Although many women go through menopause with few problems, approximately 30% report bothersome symptoms that affect their quality of life.[30,31] Our results have shown that women disagreed that the deterioration of quality of life is caused by menopause.

The results corresponding to the control, awareness and causes dimension have ratified that menopause is considered as the final phase of reproductive life and that the need to accept it in a natural way will facilitate its adaptation.[28] Sakson-Obada and Wycisk emphasized the importance of accepting the presence of menopausal symptoms, as they are associated with the ability to cope with emotions and physical state, such as fatigue.[32] Other results have shown that women perceive menopause as a stage in the normal aging process.[1] These findings are consistent with other research from collective cultures, such as Vietnam and Iran, where aging has a positive meaning.[33]

The women agreed to seek help to manage their symptoms. Although women often feel isolated and show reluctance to seek medical help, they express dissatisfaction with the care received and consider the information and support to be insufficient.[23,34] Mohamad Ishak et al. noted that none of the women who participated in their research sought information and medical help for the management of menopausal symptoms. These results could be attributed to a lack of knowledge about hormone therapy.[25] Whereas European women are more likely to seek medical help and use hormone therapy.[35]

In terms of limitations, the instrument used explores cognitive representations of menopause, but does not capture emotional representations. Negative cultural stereotypes about menopause in Peruvian women, combined with possible feelings of shame when expressing their menopause-related emotions, could be influencing. Also, most of the participants did not use hormone therapy for menopause, women who do not know how to read and write were excluded, which could have influenced the presence of unintentional bias and the type of sampling used precludes generalizing the results.

CONCLUSION

Social and cultural influences, as well as negative stereotypes and attitudes towards aging, influence a higher prevalence in the dimension of control, awareness and causes (mean value 4.1±0.57). Thus, women perceive menopause as a natural phase of their life and show disagreement with the idea that menopause means a decrease in quality of life. This change of attitude on the part of the women should be considered as a significant contribution.

Source of Finance

During this study, no financial or spiritual support was received neither from any pharmaceutical company that has a direct connection with the research subject, nor from a company that provides or produces medical instruments and materials which may negatively affect the evaluation process of this study.

Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

Idea/Concept: *Juan Matzumura Kasano;* ***Design:*** *Hugo Gutierrez Crespo, Juan Matzumura Kasano;* ***Control/Supervision:*** *Juan Matzumura Kasano;* ***Data Collection and/or Processing:*** *Diana*

Maris Yuncar Fajardo; ***Analysis and/or Interpretation:*** *Raul Alberto Ruiz Arias, Juan Matzumura Kasano;* ***Literature Review:*** *Hugo Gutierrez Crespo;* ***Writing the Article:*** *Hugo Gutierrez Crespo;* ***Critical Review:*** *Juan Matzumura Kasano;* ***References and Fundings:*** *Hugo Gutierrez Crespo;* ***Materials:*** *Hugo Gutierrez Crespo, Juan Matzumura Kasano.*

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