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MENOPAUSE, MIDDLE AGE, AND THE SOCIAL WORKER

by

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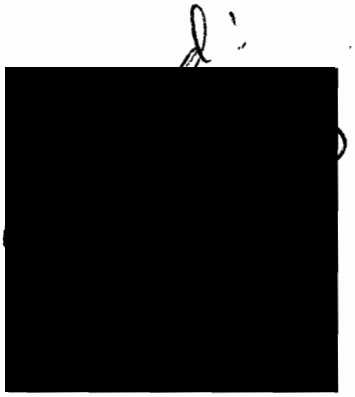
A study submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SOCIAL WORK



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CHAPTER I

INTRODUCTION

There has existed throughout history a fear among a high proportion of women that at the time of menopause there is a danger of extreme emotional instability and even insanity. This fear has persisted not only because of ubiquitous and degrading attitudes regarding woman's loss of fertility, but also to a great extent because of a culturally determined lack of knowledge and research in this area. While fear connected with menopause is by no means unfounded, it can certainly be a less traumatic time for women if they are fully informed regarding the typical symptoms, and if they follow this up with a manner of living that will contribute to emotional stability (Tucker, 1966:125).

I shall attempt to show in this writing that menopause is often a phenomenon of crucial importance to the social worker in most kinds of diagnosis and treatment for women in the appropriate age bracket and for women's interaction with others during the menopausal years. Many of the matters that I am writing about are phenomena that are of course still being studied and are not scientific facts; but enough has been learned to make it imperative to be much

more sensitive to these patterns than we have in the past. Hence, in one sense, I would hope that this paper is to some degree a brief manual for social workers.

The central thesis of this paper is that the social work profession needs to know much more about menopause and its concomitants in order to enhance diagnosis and treatment. Unfortunately, the woeful lack of research and consequent paucity of data on the subject require a heavy reliance upon intuitively plausible statements in support of larger propositions about many of the strategic relationships advanced in the course of the argument. When these propositions and statements are taken as a whole, the paper is also an outline of essential research topics.

The major topics that the paper will treat are:

1. The major ideological and institutional biases to be overcome by the social worker in order to raise his or her sensitivity to possible menopausal influences on clients' conditions.
2. The prominent physiological changes characteristic of menopausal experience.
3. Significant influences of menopause upon the condition of women clients in the middle years (forty to fifty-five years of age).
4. The client characteristics the social worker needs to know in order to detect the possible presence of menopausal

influences in a given case.

5. What the profession can do to become better equipped in this neglected area.

While menopause in the strict sense means cessation of the menses, a biological phenomenon which indiates that the reproduction function of the woman has come to an end, the term is generally and quite properly used in a much broader sense. This broader meaning is often referred to as the "change of life" which indicates the years before and after menopause. The medical term is the climacteric or climacterium (Tucker, 1966:127). Knowledge about the "change of life" is especially pertinent for the social work profession. It includes not only the symptoms that indicate the decline and cessation of the menses but also the personality and behavioral changes that women experience preceding, accompanying, and following the cessation of the menses.

For the individual the menopause may occur early or late relative to the average chronology. The range of the climacterium, encompassing pre-menopause, menopause and post menopause, has been recorded to extend over a period of a quarter of a century, from ages thirty-five to sixty (Neugarten, 1967:45). It is estimated that thirty-two million women over forty are on the edge of menopause, in its midst, or have passed through. One in twenty women go through menopause in their thirties. In rare cases women have been

known to experience menopause as early as age twenty-five (Lake, 1965:85). Exceptionally early menopause (under age forty), is attributed to obesity (Amundson and Diers, 1970:79-86). The cessation of the menses by no means marks the end of the involution, or retrograde, process. It is only a part of a protracted complex change having as important components disturbances of the glandular, circulatory, nervous, and psychic systems.

Because the word menopause in common usage has the broader meaning climacterium, it will be used in that sense in this paper.

While there are three types of menopause -- natural, artificial (or surgical), and premature -- the discussion here will be confined largely to natural menopause. Artificial menopause, which results from hysterectomy with removal of ovaries, is also pertinent insofar as in the absence of hormonal treatment the symptoms of natural menopause can occur. Discussion of premature menopause is excluded because it falls outside the age group under consideration.

For some the menopause is not feared. Indeed, it may be welcome for the reason that it finally eliminates apprehensiveness about a late pregnancy and enhances the ever dire thoughts the women may have about lost attractiveness. In fact, a woman's physical attractiveness is in all probability not immediately impaired. The end of the monthly "curse" provides a sense of relief.

For many the menopausal experience is so gradual and mild that it causes little concern. The almost exclusive treatment of the problem aspects of menopause in this discussion does not necessarily imply that the majority of middle-aged women experience most of the incapacities treated here. However, it is almost certain that most do experience some of them.

CHAPTER II

SOCIAL ATTITUDES TOWARDS THE MENOPAUSAL WOMAN THROUGH HISTORY

In our effort to understand why menopause is such a blind spot to the medical profession and an area of ignorance in the practice of social work, we should no doubt take note of the injurious folklore which has been transmitted, albeit in somewhat diluted form, through Western culture even up to contemporary times.

It is significant to note that there is a relative neglect of the menopause (and its anticipation) in the literature on the psychology of women. Many comprehensive books on women and sex differences do not deal with it at all, despite the fact, and the concomitants, of the relatively early end of female fertility versus male fertility.

Throughout history the age at which menopause is supposed to occur is usually forty-five or fifty. Aristotle wrote... "for the most part, age fifty marks the end of woman's reproductive activity." Avicenna, a famous Arab physician of the eleventh century pointed out, "There are women whose menstruation lapses quickly to end in their thirty-fifth or fortieth year, but there are others in whom it

lasts until they reach age fifty." Classical sources generally state an age range of forty to fifty, with a maximum of sixty years cited (Amundson and Di rs, 1970: 79-86).

There are a number of reasons put forward for this limit on fertility experienced by women. One advantage of the limitation was that the ova, if stored too long, have no chance to be fertilized. The ova tend to deteriorate over the years, as is shown by the higher rate of mongolism in babies born to older women due to defective chromosomes in the aged female egg. The male sperm in contrast is freshly manufactured throughout life, and is therefore not subject to this deterioration. Another important inference from nature's processes is that the onset of infertility at a not too advanced age ensured that children would not be born to a mother who would not likely live long enough to rear them. Unfortunately, like many such "inferences from nature," this does not reckon with the extension of life-span achieved through social progress (Cooper, 1975: 64-65).

In the historical past in some societies the older woman who was free of childbearing, however, had to accept the fiction that she was old and had ceased to be sexually interesting. It marked the end of her life as a desirable woman since she could no longer bear sons, and her value as a wife was thus very much diminished (Cooper, 1975: 65).

In many older cultures, a man might go through a number of

wives in a lifetime. He could go on enjoying sexual relationships and fathering children right into old age. He did not even have to be concerned about retaining a youthful appearance -- in earlier times this was not a necessary part of male attraction as it was (and still is), on the part of women. That double standard of aging can still be seen to a large extent in the attitudes toward menopause and also in the contrast in the way society views the aging process in men and women (Cooper, 1975:66).

Menopause was traditionally seen as a negative state of being -- that is, marked by the absence of "issue of blood." Yet on the other hand, blood was associated in the primitive mind with injuries and death. Hence menstruation itself was tarnished with much adverse mystical folklore. These contrasting myths trapped women in a painful double bind. Menstruation became the subject of strict taboos in every culture. Remnants of taboos are still present to some extent in our culture as suggested by the euphemism still popularly extant: "the curse."

Pliny stated in his Natural History that menstruating women had disastrous effects on quite ordinary things: They turned wine sour and made seeds sterile. This view is still held in some wine-making lands. Additionally, they were believed to cause grass and garden plants to wither and fruit to fall from any tree beneath which they sat (Cooper, 1975:66).

Menstruating women in ancient times were so much objects of disdain that in many cultures there were rules that forbade any contact with them. In some parts of the world they were kept apart in special living quarters which were some distance from the village. In Mosaic law, a woman had to be separated from the rest of the village during the time of menstruation as it was thought that anything she touched became contaminated. It was widely held that menstruation was a form of purging, by which women were relieved of impurities and excess blood. This blood flow was believed to be poisonous. In France, menstruating women were not allowed to work in sugar refineries as it was believed that their presence turned sugar black. The women in Indochina were not allowed to work in the opium industry for it was thought that menstruation would turn opium bitter.

Strangely enough, the cessation of menstruation was still considered bad. The woman was freed from one set of taboos only to become the object of another set. The double bind insisted that post-menopausal women were no longer getting rid of their "evil poisons." These poisons therefore were considered to be building up inside them as they no longer were able to produce a new life. Either way, the woman was not a useful, desirable person.

In connection with this ancient folklore, Robert G. Richardson makes a lucid point:

> We must ask why an event of such significance to the individual woman passed almost without notice sociologically, anthropologically and medically. And the answer thrown back from the silent past is that menopause was a negative event of no importance in the life of the community. So when a woman's usefulness ended, she ceased to be a woman. (Richardson, 1975:69).

A solution for this neglected and misrepresented problem of the ages is to a great extent a medical responsibility. As material progress and modern medical science have prolonged life greatly, they have for the first time in history brought menopause and old age into existence for the overwhelming majority of women. Most women live a third of their lives after menopause. Therefore the problems of what we now term middle age, as well as the degenerative aging process, are more pressing today than any time throughout history (Atchley, 1972:10). Hence, we confront an historically rather new set of social problems with a backdrop of deep-rooted, injurious myths and frightening folklore, many elements of which are very much a part of our contemporary collective unconscious.

CHAPTER III

PHYSIOLOGICAL CHANGES IN MENOPAUSE

Menopause is a result of the gradual decline in the number of ova (or eggs). The ovaries develop these female sex cells. They also manufacture two sex hormones: estrogen and progesterone. Estrogen stimulates the development of the breasts and determines body contours, fat distribution, quality of voice, and the character of the skeleton and hair. Every female is born with an abundance of ova which number in the several hundred thousand. However, only about four hundred of these actually mature. Once these are gone, fertility ceases. As the ovaries start to close down during menopause, the production of the two important female sex hormones, estrogen and progesterone decline. This results in a shortening of the menses, followed by an irregular menstrual pattern that eventually ends the monthly cycle. At the same time this is the beginning of glandular imbalance and the related menopause symptoms. Additionally, it is the beginning of changes in the body that take place in the post-menopausal years due to lack of circulating estrogen. The body receives decreasing amounts of estrogen and progesterone from the ovaries over an extended period of time, although

other body tissues continue to produce small amounts of estrogen for about ten years after ovarian function ceases (Galloway, 1975: 1006-1011).

In post-menopausal years the ovaries become small and shriveled, the lining of the womb atrophic and the vaginal skin thin and more vulnerable to infection. The vagina itself narrows and the external skin becomes thin and less sexually responsive, due to atrophy of mucous membranes. Changes in the vaginal epithelium may also bring about other discomforts such as discharge, itching, burning, and pain during intercourse (Cooper, 1975: 16-20). In some older women, declining estrogen levels cause the growth of facial hair; occasionally too, the voice is affected, becoming low and gruff like the masculine. The facial hair and lowering of voice is brought about because of the continued presence of the male hormone androgen, which remains stable throughout life. When the female hormone, estrogen, decreases, the amount of androgen the woman possesses has a more pronounced effect (Nugent, 1976: 42).

The inadequate amount of estrogen affects other parts of the body as well. The mucous membrane of the bladder is adversely affected by pelvic atrophy. This thinning of the bladder neck contributes to incontinence or a frequent need to urinate in older women. These degenerative changes occur elsewhere due to lack of estrogen. The loss of subcutaneous fat brings about wrinkling of

the skin as it becomes inelastic; breasts become flabby and nipples flatten out and become nonerectile (August, 1956:92).

Osteoporosis, which is brought about by a rise in bone resorption that leads to thin and brittle bones, is not solely a product of menopause itself, according to Robert E. Greenblatt. He states, however, that it typically accompanies and follows menopause. He advocates the use of estrogen replacement treatment in combating this deficiency:

> While osteoporosis may be considered part of the general aging process, bone demineralization is significantly accelerated in the absence of estrogens. Though estrogens do not restore calcium to the bone, they apparently arrest demineralization. (Greenblatt, 1974:225)

A summary report on Menopause and Aging at a national meeting in Hot Springs, Arkansas in 1971, concluded that the reduction of bone mass affects women in the menopausal years to such an extent that up to twenty-five percent of all women over age sixty have spinal compression fractures, and that the risk of hip fracture is twenty percent if a woman lives to age ninety. This reduction in bone mass also manifests itself in a deformity of the spine, popularly called, "dowager's hump," that so many elderly women experience. The report further avers that eighty percent of all hip fracture patients have preexisting osteoporosis. Hip fracture is the most debilitating aspect of brittle bones as one-sixth of all hip fracture

patients die within three months of injury (Ryan and Gibson, 1971: 7-8). Furthermore, for those who live there is usually some degree of deterioration in total life adjustment.

Some indicators of the effects of menopause for aging women as contrasted with men is the fact that studies show spinal osteoporosis is about four times as common in women as in men and hip fractures about two and one-half times as common in women (Ryan and Gibson, 1972: 59-66).

The effects of estrogen deficiency on women certainly go far beyond the purely physical, and particularly to the psychological. Indeed, the effect of estrogen deficiency on the psyche is more pronounced in menopausal women than in many other deficiency conditions. Due to the fact that traditionally the medical field is more concerned with pathology than normality, the menopausal years have been woefully neglected by it. Also, there are differing views on the so-called normality of aging. However, perhaps in no phase of life is the line between what is normal and therefore acceptable to the individual and what is pathological and therefore unacceptable, thinner than here. Unfortunately, we do not know the degree of severity that can be called "normal" with respect to menopausal disturbance. Hence, it is impossible to appraise with any precision the extent to which the normal case can complicate other, non-menopausal problems of the client. Until this kind of

information becomes available through research to the profession, the social worker, unfortunately, will have to feel his/her way on a case-by-case basis.

Because of the strong link with the pituitary gland, estrogen levels can directly affect emotional stability. There is nothing unusual about many women feeling depressed and irritable just before menstruation, when hormone levels drop; this same kind of reaction, of course, can occur, and more chronically, during menopause.

There are at least twenty-one generally recognized symptoms of menopause (Cooper, 1975: 31). A reasonably comprehensive list of symptoms, drawn in part from the Blatt Menopausal Index and from a study by Neugarten and Kraines (Neugarten and Kraines, 1965: 270), would include:

Physiological

Hot and cold flushes
Extreme reactions to heat and cold
Dry, itchy skin
Back pain
Fatigue
Dizziness
Headaches
Numbness and tingling
Arthralgia (Neuralgic pain in the joints)
Desquamative gingivitis (Inflamation and peeling of the gums)
Myalgia (Muscle pains)
Night sweats
Incontinence (Loss of bladder control)
Palpitations
Gastrointestinal disturbances
Constipation, diarrhea

Dry mucous membranes
Flooding
Weight gain
Breast pains
Blind spots before the eyes

Psychological

Insomnia
Emotional instability
Distorted perception
Nervousness
Inability to concentrate
Crying spells
Feeling of suffocation
Depression
Heightened irritability
Excitability
Moodiness
Negative attitude toward the world
Paranoia
Diminished self confidence
Memory losses
Withdrawal

Some or all of these are estimated to be experienced by eighty-five percent of all women. At the onset of menopause, some of the more common symptoms are fatigue, headache, irritability, palpitations, dizziness, and depression. These mark the beginning of disturbances brought about by hormone and related pituitary imbalance. The pituitary gland is a master gland at the base of the skull. This gland maintains the proper balance between all the various hormones in the bloodstream. When the hormonal imbalance occurs, the pituitary gland continues to bombard the ovaries with follicle stimulating hormones. However, the ovaries are no longer able to respond.

When this occurs there is no known, compensatory, equilibrating reaction set in motion (Cooper, 1975:27, 29).

However, though a very large percentage of women experience some significant overt disturbance or serious disequilibrium at the onset of menopause, in the absence of some specific ailment, few bring these problems to a physician (Neugarten, 1967:48). The culture has instructed these women that they are supposed to expect and accept menopausal suffering.

According to O. Spurgeon English, a variety of symptoms may occur several years in advance of the actual change in glandular activity, and these symptoms may also persist long after menstruation ceases (italics mine). English states:

> Medical writers have never clearly formulated a distinct symptomatology which they relate specifically to the climacterium, but include along with hot and cold flushes such disorders as irritability, moodiness, depression, insomnia, indigestion, constipation, agitation, restlessness, and a negative attitude toward the world, often colored with feelings of being imposed upon and exploited by others (English, 1954:139).

Gail Sheehy points out that menopause tends to creep up on women. Because of the lack of knowledge on the part of many women regarding menopause, they tend to think that as long as they are menstruating regularly they are not yet in the menopausal period. However, even though their menstrual flow may appear normal in

their forties, a chemical measurement will usually show wide swings in their hormonal level (Sheehy, 1976:396). This can bring on some or all of the symptomatology of the menopause, even though the woman has monthly evidence that she is still fertile and may even become pregnant.

Many women also experience surgical menopause called hysterectomy. Hysterectomy is a medical term for removal of the uterus. The need for a hysterectomy may be the presence of a tumor or a variety of other conditions which make this operation desirable. The decision to remove the ovaries (the female sex glands that secrete estrogen and progestrone), depends on whether those organs are disordered in some way. The term artificial menopause applies only to that type of hysterectomy in which the ovaries are also removed.

Since removal of the ovaries induces menopause, the administration of missing hormones either in pill form or by shots will probably be required. A physician will not include the removal of the ovaries without strong reasons. Most common of these reasons are existence of cysts, incapsulated collections of fluid glandular material, which sometimes grow large in size and cause great discomfort. The ovaries may also be affected with tumors which make removal necessary. Since ovaries supply the body with the important female sex gland secretions, elimination of the uterus alone will not

disturb the onset of natural menopause (Nugent, 1976:68).

If a client exhibits significant menopausal symptoms the social worker needs to judge whether the menopausal disturbance implied by the symptom(s) is aggravating the other difficulties of the client. If such is found to be the case, the menopausal disability should be treated if possible, Furthermore, it would seem desirable for the client to be informed that her non-menopausal problems are being exacerbated by menopause, and therefore may not be as serious as they appear to her. This recognition should facilitate therapy.

Of course there are some symptoms of menopause that are perhaps too mild to be treated. Also, some clients (patients) may not respond to treatments that are presently available. Furthermore, social workers must recognize that in making referrals they may frequently encounter physicians who take an indifferent, fatalistic attitude toward menopause. In such cases the social worker may be able to elicit and give positive encouragement to family support. If the family is unenlightened on menopause, the social worker may make a positive contribution of an educational nature.

CHAPTER IV

OVERVIEW OF CONNECTIONS BETWEEN PHYSIOLOGICAL, PSYCHOLOGICAL, AND SOCIAL CHANGES

Attempts to delineate the many symptoms which are characteristic of the menopause have brought about a great deal of terminological debate due to the fact that symptoms occur at different times for different women. For, as stated earlier, some women experience menopausal symptoms before the actual cessation of the menses; for others they coincide with the cessation of the menses; yet for others they do not appear until several years later.

There appear to be two major points of view regarding the nature and significance of menopause. Most research has been guided by the endocrine factor theory, which attributes menopausal symtoms largely to the disturbance in hormone balance. In contrast, the emotional factor theory emphasizes the personality background of the woman (Neugarten, 1967:50). Clearly these two viewpoints may be synthesized, for they are not mutually exclusive. The emotional factor theory avers that generally only those women who had emotional problems earlier in their lives will suffer psychological trauma during menopause.

A significant number of women turn to therapists for psychological counseling during this epoch of stress in their lives. Many

of these women are totally unaware of the fact that certain emotional problems they are experiencing may be directly or indirectly connected with menopause. More often they ask themselves, "What's wrong with me? Why can I no longer cope?"

Hanna Klaus, who leans toward the emotional factor theory in describing the emotional aspects of menopause, sees menopausal symptoms as prepuberty in reverse. Just as there was initial uncertainty regarding the feminine role in puberty, the same ambiguity is recapitulated in menopause due to the fear of insufficient femininity. Furthermore, pre-menstrual tension tends to increase in the pre-menopausal phase of menopause, raising problems particularly for women with young children at that time, and to a lesser extent for women in professional work (Klaus, 1974: 1187).

Martinez Prados enriches the same point:

> In the life span of women there are two age periods in particular in which she needs all of her emotional resources so that the ego may adapt itself to the new life situation which is brought about by two major biological changes. These two life processes are puberty and menopause (Prados, 1967: 233).

While mid-life is a period when women are adjusting to changes in body image as well as changes in body functioning, transformations in psychological self-image may also occur along with menopause. Social networks are experiencing far-reaching structural changes as

children leave home, parents are often suffering from aging disabilities, and life interests are shifting. Women are often re-evaluating their basic mode of life during this period. While these concomitants of middle age are certainly not all to be attributed to menopause, they may occur during the extended menopausal period, and combinations of changes in structure and function, together with family crises, can significantly alter women's reactions to the menopausal changes. These factors are fundamental to a central thesis of this paper. Menopause does come at a bad time in a woman's life. In addition to the disruptions emanating from glandular disturbance, she has reached the stage in life in which she may equate loss of menstruation with loss of attractiveness, health and self esteem, even though her physical appearance has not deteriorated. She may also experience one or another variety of role reorientation. If a woman has children in adolescence at this time, for example, it can be a heavy emotional burden. As Klaus puts it:

> It seems to be a dirty trick on the part of nature that the mother's menopause and diminished self confidence coincides with her children's needs, which are so often expressed by a rejection of parental values (Klaus, 1974: 1187).

At this time for the woman who is married the husband is likely to be highly involved in his work or career and may lack sensitivity to the stressful problems of transition his wife is

experiencing. Society at large acknowledges some of the difficulties but frequently evaluates them as a consequence of the woman's "neurotic tendencies" or "selfish traits." Additionally, while family members can be understanding, there appears to be no specific social support systems around the menopausal woman such as is so evident around the pregnant woman and the new mother (Neugarten, 1967:46).

The emotional liability that occurs during pregnancy when hormonal levels also change rapidly is usually received with sympathy and understanding by those close to her and by society in general, whereas women experiencing menopausal symptoms are frequently expected to have "a stiff upper lip," to endure in silence, and to control their emotions. The fifty-year-old woman may, to her husband's dismay, be laughing one minute and crying the next. Because of this acute sensitivity and these rapid mood swings, such a woman may wonder if she is "going crazy." An often repeated "old wives' tale" is that women suddenly go crazy during menopause and some women fear that such is actually what is happening to them (Galloway, 1975:1008). These women desperately need assurances from their family, their physician, and their counselor that this is normal and possibly linked to a combination of hormonal imbalance and changes in their personal lives.

One of the more disturbing aspects of the problems faced by the middle-aged woman is found in the widespread case of the person

who has fully given of herself to the demands placed upon her as wife, mother and homemaker. Since this woman must sustain many different roles during the long busy years of family life, she may, by the time she reaches middle age and confronts the problems of partial role losses, become stressfully perplexed about her very identity. Often, when looking at the range of possible new opportunities in interpersonal relations or in social life, or in possible professional endeavors, this middle-aged woman is unable either to muster the necessary self confidence, or to find from others the encouragement she needs to actually explore the range of choices that can provide her with the means to discover her true self. This problem of self-discovery may be especially difficult for her, after having been embroiled in years of domestic and marital responsibility. She may, unfortunately, come to believe there is no identifiable personality to be discovered or liberated (Frank, 1956: 114). While individuals always lose roles throughout their lifetime, it is more difficult to envision and to actually build new roles to replace the old ones when one is middle aged (Bart, 1975: 12).

The menopause as experienced by some women may appear to them as a devastating blow to their femininity as they conceive it. As this marks the end of their ability to bear children, even though they may not wish them, the thought that child-bearing is no longer a choice may bring about severe depression as a reaction to this

loss (Galloway, 1975:1009). Historically, this has probably been the single most deep-rooted menopausal reaction, for child bearing has ever been considered the unique function of women. The social worker should also bear in mind that the religious background of the client could affect the degree of disturbance experienced by the client as the result of no longer being able to bear children.

Because of this loss of femininity-from-fertility it is not unusual for a woman to go through a protracted grief reaction at the time of menopause. This is particularly the case if motherhood has been, as traditionally dictated, a vital source of self esteem over the years; or if her youth and femininity, also as conventionally required, were a major source of self esteem. Thus, for the menopausal woman who has been confined to a too narrow range of traditional roles, menopausal depression may result, as menopause dramatically marks the transition from a reproductive to a non-reproductive role. Stanley Lesse and James Mathers revealingly note that the depression syndrome is found largely among the middle aged and is found in twice as many women as men. They attribute this higher incidence among women primarily to menopause (Lesse and Mathers, 1968:535-543).

Thus it is important for middle-aged women to know what is happening to their bodies, and to be aware of the possible physio-chemical cause of their bodily symptoms and feelings. The most

distressing thing for these women in their role as social work clients is not knowing what to expect. Neugarten points out that it is the unanticipated life event which is likely to be the most traumatic. She concludes that a psychology of the life cycle is not so much a psychology of crisis behavior as it is a psychology of timing (Neugarten, 1976:18). Thus education about menopause may increase self confidence and supply the informed woman with the inner strength to anticipate and therefore to cope more effectively with stresses and dysfunctional changes at this time.

Most research indicates that for a large number of women during menopause, meeting even the routine day-to-day tasks in their lives becomes more difficult. As long as a woman is able to relate her difficulties to familiar situations, and respond to them in the way she has handled them in past adult life, she is fairly secure. Too often at this time, however, changes in her physiology, together with external conflict, activate responses that she may not be able to reconcile with her established ego ideal. As a result, her ego alien emotional responses now threaten her. Thus, any disappointment in self accomplishment brings about acute feelings of inferiority and self accusation, which is an almost certain path to severe depression. When under even moderate stress, this woman may well experience the failure of her usual ego defenses and thus become desperate because of her inability to cope with routine activities. Most important,

as hormonal secretion diminishes, the ego's integrative capacity itself (like that of some women in the pre-menstrual stage), may become dissipated (Benedek, 1950:16).

Sherwin Kaufman properly emphasizes in his book, The Ageless Woman, that depression and associated loss of ego strength are likely to be related to both psychic and somatic influences. It is therefore significant that some women with both depression and estrogen deficiency experience a great relief with estrogen replacement treatment. For other women, however, the depression remains despite estrogen replacement therapy. Depression in its role as a symptom has various causes. When it is unrelated to an existing estrogen deficiency, it is not surprising that replacement treatment fails to alleviate the symptoms (Kaufman, 1969:90).

It therefore needs to be emphasized that individual reactions during menopause can vary widely according to the life situation of the woman involved. One very significant thing that has been found in interviewing women in the middle years, however, is that menopause is a subject they do not discuss with one another and may hesitate to discuss even with a counselor. Yet most women also indicate that given the opportunity they would like more information (Neugarten, 1967:67).

Social workers should be careful not to apply mechanically either the research results reviewed here, or the interconnections

suggested above between the physiological, psychological, and social factors. Social workers should also be careful to recognize that the psychological concomitants of menopause may well be connected primarily with extra-menopausal influences. They should also recognize that menopausal disturbances can be, and often are, used as an excuse by the client for not facing up to other problems and responsibilities. Additionally, an exaggerated appraisal of menopausal symptoms of the client by the social worker can adversely affect diagnosis.

Finally, it is also quite clear that the social concomitants of menopause are quite likely to exist independently of the physiological menopausal nexus. Diagnostic mistakes are therefore very possible in these matters. The point, however, is that the physiological and psychological components of the menopausal syndrome should always be looked for in order to determine if they are to a substantive degree operative in the particular case.

CHAPTER V

THE MENOPAUSAL LIFE STAGE CHARACTERISTICS

The menopausal syndrome in itself could create a social work clientele of quite small magnitude. But the combination of the menopausal syndrome and the numerous other problems that beset important sub-groups within the middle age category constitutes a significant phenomenon with which social workers today need to be concerned.

The need for knowledge of the menopausal syndrome by the social worker derives from its possible interaction with the social aspects of the middle-aged female client's problems. And that interaction could be significant. As indicated earlier, during the middle years a woman experiences many role changes. It is now appropriate to examine these in more detail. She often has to adjust to the fact that her children are leaving home at approximately this time (the so-called "empty nest" experience). For many women this can be a distressing emotional experience in itself. Some women are widowed in middle age. The divorce rate for women in the middle years is also rising at a rapid rate. If the client should be either an

empty-nest woman or a displaced homemaker (either through widowhood or divorce), the specific problems associated with such conditions could be exacerbated by menopausal disturbances, both physiological and emotional. The "withering circle of roles," in itself, may leave them feeling useless and functionless (Lopata, 1966: 14), even without considering the menopausal factor.

The divorced woman who is no longer young, who has grown children or children in the household in late teenage revolt, sometimes faces problems that are unique and severe. It is estimated that almost a third of all divorced American women are in the middle or menopausal years (Statistical Abstract, 1976: 37). There are a number of interpretations advanced for this. Among them is that people often hold off on divorce until the children reach an age of self reliance (teens or beyond), when they are thought to be less stunned by their parents' breakup.

Another interpretation is that marital dissolution takes time, often many years of "progressive dissensions" to unfold (Stroup, 1966: 529). That process is neither self-contained nor does it usually proceed at a steady pace. Dissolution is slowed down by all the societal and family pressures making for the continuation of the marriage, in addition to the cementing forces internal to the man-wife relationship that continue to operate as long as hope persists.

Gail Sheehy has another interpretation, congenial to the first

two, for the delay of marital crises until mid-life. She points out that it is not necessarily the twenty years or so of living together that causes so much marital stress at the mid-life stage, but rather the effect of our youth worshiping culture with its false expectations that the roles which served well in the first half of life should carry over to the second. Sheehy stresses that the second half of life must have its own significance in and of itself. Otherwise it will be little more than a pathetic imitation of the first (Sheehy, 1976:287). The couple, if they remain a couple, must redefine their relationship in mid-life. This means a series of often painful readjustments must be made over a period of years. For the woman this may mean cultivating talents that were set aside during busy child rearing years and becoming disturbingly assertive of her own concerns rather than merely a party to someone else's.

Regardless of the causes for the high rate of divorce and of marital stress during mid-life, these women do experience an additional burden of change and adjustment, as compared to the single woman, along with learning to cope with the traumatic aspects of menopause. For the quality of a woman's marriage or personal life is thought to determine to a high degree the extent of the mental disturbance she will experience as a result of menopause.

Often these women turn to therapists in their painful struggle to adjust to these various losses in mid-life. It is important that the

menopausal factor be looked for and given due consideration at all times when counseling women experiencing mid-life crises.

The widowed woman experiences many of the same grief reactions of the divorced. While she does not have to cope with the social and personal rejection feelings that newly divorced women often experience, she does, surprisingly enough, lose status with the loss of a spouse and must redefine her role as a widow and a single woman (Lind, 1975: 3-6). Many self-concept changes may occur during the adjustment to widowhood, just as they do in the critical transition period following divorce. One or all may bring about a heightened grief reaction which may be compounded by menopause. The period of suffering is the adjustment involved in learning to live with the loss. These experiences could be described as phases of adjustment, for there is no clearly defined time sequence. The widow may move in and out of these phases over indistinct periods of time. It is important, however, to understand them as distinct phases of adjustment in order to understand fully the complexity and the period spanned by normal grief reaction.

For both the widow and the divorcée in the middle years the adjustment process is likely to be compounded if they have children leaving home at about this time or have through previous departure already lost one of their established roles. For many women this may be at worst a distressing emotional experience, and at the best

a disturbing experience in role realignment. The women in these cases face the loss of two roles, that of mother and that of wife. Two cornerstones of their personal community can crumble (Henry, 1974: 433-34). Thus, they face the highly complex task of securing for themselves satisfactory role substitutions for both of those lost while concurrently attempting to cope with the occurrence of possibly traumatic menopausal changes, the mastering of which Helene Deutsh considers to be "one of the most difficult tasks of a woman's life."

In recent times the problem of alcoholism in women is being recognized and studied. Statistics as to the number of middle-aged women who are addicted are unreliable because of the "closet drinker" syndrome. However, a study by Joan Curlee on "Alcoholism and the Empty Nest Syndrome," makes some informative points. She states that a "trauma" probably triggered alcoholism in the majority of middle-aged women examined in her study. This trauma was related in some way to their roles as wives and/or mothers. Furthermore, it appeared that most of these women had exhibited reasonably stable personalities until a particular problem arose. These women had previously not given any indication either to themselves or others that drinking might be a problem for them. One thing they had in common, however, was that they were unusually dependent upon their husbands and/or children for their identity and their sense of worth (Curlee, 1969: 167).

While the subject of menopause was not dealt with in any depth in this study, the question that should be asked in connection with its results is what weight menopause may have played in the extreme emotional reactions to particular trauma that these previously stable women exhibited. Curlee's neglect of this aspect is typical.

The progression of alcoholism in women tends to be much more rapid than in men. Whereas in men it usually takes many years of drinking to become an alcoholic, with women this addiction can become pronounced within a year or two or, in some cases, in a matter of months (Curlee, 1969:165-168).

The reason for this rapid addiction to alcohol in women is not clear, but there are some possible factors suggested in the Curlee study. Without doubt, psychological factors play some part. At the same time, it is also thought that perhaps some aspects of the physical make-up of women of this age group make them more susceptible to alcohol and somehow alter their reaction to it. Here again, the fact that these women are in the menopausal years, and no doubt experiencing physiological changes, suggests that menopause could have an affect on their reaction to alcohol. At the least, the likely connection suggests a desirable avenue for counselors to explore.

Several psychological problems clearly present themselves.

Once drinking became excessive, it contributed further to a decline in self esteem. Since heavy drinking was not a part of the previous way of life in the Curlee study, it seems most likely that these alcoholic women shared the general tendency of society to look down upon drunken women. For example, within the total group studied, those who felt their husbands no longer needed them now indicated that they believed their husbands felt contempt for them. Thus a vicious cycle continued and gained momentum. The women felt useless and unnecessary, but added to this was the feeling that they were both weak and degraded.

If a social worker has one of the growing army of middle-aged female alcoholics as a client, the entire nexus of disturbances discussed here should be looked into when making a diagnosis of the causes and therefore the appropriate treatment. We know that alcoholism is basically a symptom. Studies repeatedly show that women drink excessively precisely in order to relieve more virulent kinds of emotional upset that are typically in the middle years, with the combination of severe hormone imbalances and role losses frequently occurring during that period of life.

As has been put forth by Sheehy "identity crisis" is not something that occurs only in adolescence and is solved for all time, but rather can occur at many life stages. For middle-aged women it may be associated with menopause, loss of husbands, children leaving

home, occupational-goal crisis, or a combination of the four. The crucial point that was made in the Curlee study was that these alcoholic women appeared to have formed an identity that sufficed as long as the external reference points such as husband, children, remained relatively intact. However, when these external references were somehow disrupted, the established identity was not strong enough to survive. None of the women in this study appeared any longer to be a clearly defined individual in her own right.

The acquisition of self identity is difficult at age sixteen, but it may be devastating if the task is again confronted during menopause in middle age. Much more attention on the part of counselors needs to be devoted to the problems which result when a person in her early years creates identity by defining herself in terms of others, and then in later years finds that her relationships with those significant others are substantially altered. Women obviously need to find early paths to self identity that will hold them in good stead when facing unanticipated changes in later life situations. As Pauline Bart points out, "If a woman's worth comes from her own interests and accomplishments, she is less vulnerable to breakdown when significant others leave" (Bart, 1970: 70). In this respect, the never-married, single, middle-aged woman who has long been in the labor market or a profession has a distinct advantage. Unfortunately, studies of menopause for this category of women do not seem to

be available.

During the middle years many women either return to or first enter the labor market. This is sometimes done out of necessity for livelihood if widowed or divorced, for supplemental income if still married, or as a way of seeking identity outside the home after the children are gone. The identity of these women may have been narrowly constrained or stifled during the busy child rearing years. The problems of new entry or re-entry into the work force in such cases are innumerable, even if the woman once had some earlier training. Not the least of these concerns is training for employment and adaptability to this new environment. It is possible that decades of homemaking can even stultify the mind insofar as its capacity to adapt to the job market is concerned. If in addition the woman is plagued with debilitating menopausal symptoms that affect her ability to concentrate and her self confidence, then her capacity to endure the work regimen may be reduced. There is a tenuous balance between the individual's psychic economy and the social milieu to which she has to adapt. Social and interpersonal forces external to the individual influence psychological states. On the other hand, successful coping with the job market can have positive therapeutic effects that social workers should encourage.

With respect to both new entry and re-entry employment, economic and psychological barriers overlap. The older woman is

often not hired because of employer's sexist image of women, an image that frequently leads them to employ a woman only if she performs a decorative function along with her ordinary duties. While there has been a gradual change in recent times regarding attitudes in the hiring of middle-aged and older women as compared to a decade ago, there is still subtle discrimination in this area. Ivan Nye's study of 2,000 working mothers, for example, showed they are likely to work at lower status jobs than young women (Rossi, 1974: 454).

It is well known that "youth utility," an emphasis upon the presumed superior qualities of youth, physical beauty and newness is considered one of four dominant themes pervading the American value system (Ludwig and Eichhorn, 1967:50-64). Enjoying the physical attractiveness of youth counts much more in a woman's life than a man's, and being physically attractive for the woman means looking young. From adolescence, women in our society are bombarded by the media, their peers and their parents to keep their faces smooth and young looking and their bodies trim and sexually attractive. Men on the other hand can entertain more flexible expectations in this regard. While they too, feel a certain amount of pressure to appear young, it is by no means as exacting as with a woman (Sontag, 1972:34). A man does not worry to an equal degree when he loses the smooth unlined skin of a boy, for it is possible for

him to go from one form of attractiveness to another. Lines on his face, gray in his hair give him a more "distinguished," even "charismatic" appearance. Furthermore, men apparently experience nothing corresponding to menopause. In the case of women, Jules Henry states that because of emphasis on youth, beauty, and romantic love, the woman deprived of these three very important components (as is sometimes the case after the onset of menopause), has no place to go but down (Henry, 1974:438).

The middle-aged, menopausal woman entering the job market therefore has to endure a double standard society maintains regarding the aging process. While both men and women suffer from age discrimination in our youth-oriented culture, this discrimination is much more prevalent and intense for older women. Our society is more willing to accept the aging process in men just as it is more tolerant of the sexual infidelities of husbands and free-wheeling bachelors (Sontag, 1972:33-34). These double standards, when placed upon the menopausal woman by the job market and society at large may place added burdens upon her physical and psycholgical state of being, burdens that surely must be taken into consideration when the social worker is helping her to work through the day-to-day stresses of a new job situation.

CHAPTER VI

THE SOCIAL WORKER AND EDUCATION IN MENOPAUSE

Mental health is not easy to define. The same is true of mental illness. Nor is there a distinct borderline between them at all times and under all conditions. Most people vacillate in a continuum lying between the two. This vacillation happens to a far greater degree during the hormonal changes of adolescence and climacterium.

All social work agencies most probably have clients who are directly or indirectly affected by the menopause. This also includes women well past middle age who may be scarred by earlier phases of the menopausal experience. Menopause influences many kinds of social work problems including alcoholism; neurosis; absenteeism from work; way of relating to spouse, children, and friends; apathy; withdrawal; depression; and insomnia. This connection makes it doubly important to consider menopause as a factor in treatment, and prior to that, as a factor in diagnosis.

The prevailing response toward menopause among many middle-aged women seems to be that of projection. A considerable

number of women (especially among the well educated) appear to feel that menopause symptoms occur only in women who are emotionally fragile. They happen only to "other women" (Neugarten, 1967: 67). There also appears to be a great deal of denial regarding the emotional effects because they are not "socially acceptable." Concealment is widespread. Often when these women are questioned their inihibitions prompt them to give only socially acceptable answers (Neugarten, Wood, Kraines, and Loomis, 1968:47). It is important for counselors, in reaching out to these women, to recognize this projection as a defense and a behavior pattern that therefore needs to be respected. It is desirable to go along with such defenses and to move gradually into the area of the particular woman's view of, and possible fears connected with, the menopausal syndrome. Suppression by clients makes counseling doubly hard for a social worker whose clients are in the menopausal years. The social worker must be alert, not only to the unaware client, but also to the many conscious and unconscious "smoke screens" (such as concealing or hiding menopausal symptoms for fear of appearing "crazy") that are put forth by women who are experiencing emotional distress in this transition period of their lives.

Robert Wilson in his book Feminine Forever states that there is a certain amount of negativism in women during menopause. He then goes on to say, however, that whatever the manifestations and

whatever the social setting, what he calls "menopausal negativism" is a disability that can be treated if recognized early enough. He emphasizes that treatment requires a combination of estrogen therapy and psychological aid. The hormone restores the woman physically, but it is also essential to renew her sense of values, her level of motivation, and her self esteem. The understanding and cooperation of her husband and family during her psychological recovery is important to the success of the estrogen replacement therapy (Wilson, 1966:99-106).

The social worker may of course have clients who do not have this family support that is so desperately needed. In these cases the role of the social worker is doubly important in giving the woman supportive and insight therapy and in revealing the many possible causes of her negativism, depression, and anxiety. The social worker needs to point out the many possible changes which her body may be experiencing that contribute in part to her emotional distress.

Unfortunately, all too often negativism is not considered by physicians to be a condition demanding medical help. It is widely regarded simply as a "natural" symptom of aging, and neither family nor physicians may be aware of the possibility of effective treatment. This failure on the part of a segment of the medical profession is no doubt connected with ancient attitudes as well as with the lack of research in this area.

The social worker should be wary of the widely held misconception that the menopausal symptoms are "all in the head" and that they are almost exclusively a mental problem. According to Wilson, who leans to the other extreme, this is a myth that flagrantly confuses cause and effect. He states there is nothing "mental" about menopause except some of its consequences (Wilson, 1966:104-105). Furthermore, he writes that its origins are clearly and overwhelmingly physical; and that it is high time that this fact be recognized by the medical profession, the public, and the therapists who counsel some of these women.

Wilson gives as an example of the overwhelming physical basis of the menopause a woman going to a physician with definite physical symptoms -- hot flushes, fatigue, dry mucous membranes, disturbed vision, and aching joints. Too often her physician will tell her she is just emotionally upset and will send her home with tranquilizers. He states that this is like telling a person with a broken leg that his trouble and his pain are purely imaginary. Yet such blind, irrational view of menopause persists widely as the basis of standard medical practice. Physicians and therapists who see menopause for what it is, a treatable deficiency condition, are still in the minority. Therefore, one must emphasize again and again that by hormonal treatment plus counseling, it is possible for the menopausal woman to live a rich and fulfilling life without being

shattered by debilitating menopausal symptoms (Wilson, 1966:54).

Many women social workers today are in their middle years themselves and may be experiencing some of the menopausal symptoms. For this particular age group of social workers who are counseling women who are experiencing mid-life crises, contact with such clients may involve opening up their own internal conflicts. It is sometimes easier for such social workers to keep these middle-aged women at a distance in order to be protected from their own discomforts. The need for self awareness regarding responses on the part of the counselor in these "prime" years is important when working with middle-aged female clients.

A great deal of exploration on the part of the counselor is necessary in order to determine the client's individual strengths, weaknesses, and resources. A history of how previous losses were handled can be helpful.

Estrogen given in addition to counseling appears to yield very good results in bringing about a feeling of well being (Wilson, 1966: 104). Estrogen has been scientifically proven to relieve hot flushes and improve atrophic vaginitis. It is also believed by many physicians to relieve insomnia and prevent or delay the onset of osteoporosis along with many other symptoms brought about by this deficiency condition. The question of whether prolonged estrogen therapy can be physiologically harmful is still being studied. Some

studies show a link between prolonged estrogen therapy and cancer (Consumer Reports, 1976:642-645). Clearly, current limitation in our knowledge of menopause indicates that studies on menopause and the degenerative changes which accompany it are most needed in biomedical research. In addition to the fear on the part of some that estrogen may be linked with some forms of cancer there is, amazingly enough, the hackneyed "interfering with nature" concept embraced by some physicians. Their feeling seems to be that sooner or later all women suffer from shriveling ovaries and declining estrogen is therefore a "natural" part of aging. Apparently an indeterminate proportion of physicians subscribe to the myth that "whatever is natural is right" (Wilson, 1966:52-53).

Cooper also attacks this myth and points out that other aspects of aging, such as decaying teeth or failing eye sight, are likewise natural aging processes, yet they do not go untreated in our culture (Cooper, 1975:61). She further speculates that if it were men who faced a physical menopause with atrophy of their sex organs in middle age, the male-dominated medical profession would long ago have done something about it. In that case, there would be far less talk about it being "natural" and therefore right.

Women experiencing menopausal symptoms will in all liklihood not be referred to social workers by physicians. But the essential point is that middle aged and older women clients of social workers

may suffer aggravation of their problems because of that experience. The social worker needs to be educated and attuned to this connection, and to adjust his/her diagnosis and treatment accordingly. Furthermore, such clients should by all means, whenever the menopausal aspects appear significant, be referred to a physician, hopefully known to be knowledgeable and sympathetic, for possible hormonal or other appropriate treatment.

Historical attitudes and omission from the formal curriculum have probably endowed the social worker with a weak sensitivity toward menopausal aspects of clients' problems. Insensitivity by segments of the medical profession reflects these same attitudes.

One of the reasons for this insensitivity by many physicians is the medical school curriculum:

> ... the most important factor accounting for the diagnostic "blind spot" concerning menopause lies in the limitations of medical training. In his four years in medical school, a student has to assimilate a vast mass of information. Perhaps no more than a single thirty-minute lecture is devoted to menopause during a doctor's entire medical education. This neglect of the subject appears quite justified in the traditional view of menopause as a normal part of aging (Wilson, 1966:35).

There is a wide range of menopausal mental disturbances which may be manifested differently with different persons. These disturbances may show themselves in mild forms, such as absent-mindedness or irritability, or they may take the form of severe

neurosis, so that normal personal adjustments become extremely difficult. They may take the form of extreme passivity, disinterest, or withdrawal (Deutsch, 1945:484-485). There is a high propensity for some women to escape from the associated mental anguish by turning to such self-prescribed escape routes as alcohol or sleeping pills (Wilson, 1966:95).

A degenerative transformation may take place in a matter of a few years. A woman who may have previously been a pleasant, cheerful person may turn into a sharp-tongued, abrasive crank. This kind of personality change brings on not only personal suffering but also suffering for the family and for others close to her, such as friends, neighbors, and many people with whom she comes into daily contact. The severity of such menopausal symptoms depends in part upon the client's social status, native intelligence, education, and personal achievements (Wilson, 1966:99).

In many instances, friends and family may not clearly understand what is happening, and partly because of their lack of understanding they will recoil from such a client. They may even become hostile. Of course, this can only react back upon the client and make matters worse. The distinctly menopausal contribution to this cumulative interaction process as it affects the client needs to be discovered and weighed, by the social worker, if proper treatment is to be pursued.

If the social worker decides that menopause is probably a significant element in the problem nexus, she should first get from the client a history of previous physical and psychological ailments. He/she should also get information from the client about her current physician, seeking to find out if her physician has been treating her for menopausal disturbances. If not, the social worker should urge her to have a medical check of her present estrogen level. This sometimes requires the social worker to make direct contact with the client's physician. If this medical check indicates a deficiency of estrogen and the physician prescribes treatment to alleviate this deficiency, the social worker then has a basis on which to work with the client on whatever problems she may be having that may be exacerbated by menopause. It is important to point out to the client which problems are possibly menopausal as distinct from other problems. Once this distinction has been clearly revealed for the client, the use of customary, appropriate therapy should be facilitated.

The social worker very much needs to understand first, the capacity of menopausal disturbances to weaken the coping capacity with respect to the problems of middle age. Secondly, the social worker needs to understand that the menopausal disturbances may even be the dominant factor. In numerous cases adequate treatment of the menopausal difficulties alone could so release the client's own

inner resources that she could cope with her other problems herself. Indeed, I strongly suspect that future research will reveal many more cases than we recognize today in which social workers are seeking for erroneous causes of symptoms that are primarily menopausally generated.

Recognition of the above two basic sets of relationships is essential if the social worker is to appraise properly both the direction to be taken by therapy and the degree of progress the client is making. Corollary to this is a third requirement that the social worker possess sufficient technical knowledge to diagnose and treat, or refer for treatment, the menopausal aspect of the client's problem complex. This clearly calls for the inclusion of knowledge about menopause in the training of social workers.

The social worker should also point out to the client that there are certain positive aspects of menopause. The coincidence of menopause and departure of grown children releases the middle-aged woman for new leisure time activities or possibly rewarding employment. Sexual life can be enhanced when there is no longer a fear of pregnancy. The discomforts of menstruation are things of the past. A woman is not suddenly old at the time of the cessation of the menses. A menopausal woman can be reminded of the existence of thousands of older women who care for themselves properly and remain interested and enthusiastic in their new stage of life (Sheehy, 1976: 345-346).

CHAPTER VII

CONCLUSION

Menopause comes about because of the decline of the production of the two important female sex hormones estrogen and progesterone. This results in an irregular menstrual pattern which eventually ends with the cessation of the menses. Women also experience a glandular imbalance at this time. According to some medical sources a variety of symptoms may occur several years in advance of this glandular imbalance. Although a woman's flow may be normal in her forties, a chemical measurement will often show wide swings in sex hormones. This can bring on all or some of the symptoms of menopause even though the woman has evidence that she is still fertile.

Two menopausal symptoms are recognized by all members of the medical profession. The first is hot flushes, which are described as a very sudden sensation of overwhelming warmth starting at the waist or chest and spreading upward to the face and neck. The etiology of this disturbance is still unknown. The other accepted symptom is vaginal atrophy, which comes about because of estrogen deficiency. Because of this deficiency the vaginal epithelium

eventually becomes thin and dry due to the atrophy of mucous membrane. Both of these symptoms always respond to estrogen therapy -- this is accepted by the medical field at large.

In this paper I have emphasized estrogen deficiency much more than I have the two generally acknowledged symptoms. The reason for this emphasis is that my studies have convinced me that a wide range of emotional disturbances of direct concern to the social worker, are functionally connected with fluctuations in estrogen levels and estrogen deficiency.

When there is a sharp drop in the production of estrogen, a woman's hormonal balance is thrown wildly out of kilter. Glands producing other hormones (the pituitary), the adrenals and the thyroid are affected. It is particularly through connections linking estrogen secretion with the pituitary gland and the adjacent hypothalamus (directing the autonomic nervous system), that estrogen deficiency produces the emotional disturbances which are hallmarks of the menopause (Wilson, 1966: 74-76). Furthermore, it has been well established that the administration of estrogen hormone can correct a number of extreme menopausal symptoms (Lake, 1965: 158-160).

There are generally two points of view regarding menopausal symptoms that have caused considerable controversy in the medical field. First, the endocrine factor theory, which attributes

menopausal symptoms to the disturbance in the hormone balance, and second, the emotional factor theory which attributes the character and extent of the emotional disturbances to the general personality background of the woman. This controversy continues in the medical field and now revolves around the issue as to whether the psychological changes experienced by women at this time are precipitated by hormonal imbalance or are, given the individual's personality, a result of the aging process and the adjustments that are part of changes in mid life.

Some of the menopausal symptoms which a part of the medical profession question as being brought about by hormonal changes are irritability, mood fluctuations, depression, insomnia, indigestion, constipation, agitation, restlessness, inability to concentrate, fatigue, and a generally negative attitude toward the world. One or more of these symptoms are, however, estimated to be experienced to some degree by eighty-five percent of all menopausal women. The disturbing aspect of this is that most women do not bring the symptoms to the attention of a physician unless connected with something more specific in nature. This makes it difficult in actuality to pinpoint an accurate percentage of women experiencing these symptoms.

Estrogen replacement therapy may improve a menopausal woman's psychological state as well as alleviate many or all of her physical symptoms. This would seem to lend plausibility to the

estrogen deficiency theory. Unfortunately, there is some question as to estrogen's long-term side effects. For example, the relation of estrogen treatment to possible cancer development is being studied.

A number of recent studies indicate that women who take estrogen are much more likely to develop endometrial cancer than are non-users (Consumer Reports, 1976:642). Obviously women who have had hysterectomies would not be subject to this danger. No other firm evidence of long run adverse effects, physiological or psychological, have been discovered.

Aside from the insufficient research effort in this area and the differing views regarding the cause of menopausal symptoms and the efficacy of estrogen replacement therapy by the medical profession, it is a fact that many women turn to counselors during this stressful time in their lives. These women may be totally unaware that the emotional problems that have beset them are connected with menopause. It is important that the social worker be attuned to this possibility at all times when counseling, not only women in the middle years, but also in counseling families and adolescents, because in both the latter categories the menopausal woman may be influencing their problems. Hence counseling can alleviate their problems also.

As the menopausal client does not have the social support

system around her that is witnessed with pregnant women and new mothers, who also experience emotional fluctuations because of hormonal changes, it is important for the social worker who is seeing her to be supportive and to give assurances that it may well be linked to menopausal disturbances. The social worker must also be alert to the fact that projection may be used by such a client, once she is aware of a possible menopausal connection, because of the stigma customarily attached to menopause.

The extent to which menopause may affect a woman is connected not only to her background personality but also to her current life situation. If a woman is divorced, widowed, or feeling the loss of recently departed children, experiencing marital problems, or some other trauma in her life, then the menopausal disturbance most probably will be more severe. And this in turn will aggravate the non-menopausal difficulties.

In this connection it has been discussed above that women may face a number of traumatic losses occurring simultaneously with the menopausal experience: loss of husbands, children, parents, and the loss of the choice to bear children. The social worker should be sensitive to the possibility of this conjuncture.

Historically the menopause has been viewed as a negative state of being. Much of this presumed morbidity has been passed down to the present. Published research in this area of menopausal

disturbance and its repercussions on personality and behavior has been woefully inadequate.

With respect to research on the physiological aspects, further study is needed before all physicians, or even a majority, will be in agreement on what ages and in which ways women will experience disturbances from lack of estrogen as well as whether to treat them or how. John L. Bakke, at the University of Washington Medical School in Seattle, states: "There will be continued uncertainty for many years because no one has set up the very expensive prolonged human experiments to remove all doubt." (Lake, 1965:164)

Research effort, along with a sympathetic sensitivity to menopausal imbalances, is at last beginning to be undertaken. These changes reflect the jump in life span and the spread of our humanistic feelings about other people. While the expansion of research effort is primarily a task for biology, the medical profession and psychology, the social work profession can also make a contribution, particularly at the level of the delivery of social work services, to the middle-aged female client and to all those with whom that client is in personal contact. To accomplish that task, the social worker needs more education about menopause as it is presently understood, and needs to acquire a new perceptiveness regarding the possible presence of menopausal influences in the set of problems found among many middle-age women.

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