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“Symptom-Specific or Holistic”: Menopausal Symptom Management

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Abstract

Our purpose in this study was to identify differences in menopausal symptom management among four major ethnic groups in the U.S. This was a secondary analysis of the qualitative data from a larger Internet-based study. We analyzed data from 90 middle-aged women in the U.S using thematic analysis. We extracted four themes during the data analysis process: (a) “seeking formal or informal advice,” (b) “medication as the first or final choice,” (c) “symptom-specific or holistic,” and (d) “avoiding or pursuing specific foods.” Health care providers need to develop menopausal symptom management programs while considering ethnic differences in menopausal symptom management.

Researchers reported that the choice of management strategies for menopausal symptoms highly depended on the perceived causes and meanings of menopausal symptoms, and suggested that there would be ethnic differences in menopausal symptom management process (Im, Meleis, & Lee, 1999; Lock, 1986; Sengupta, 2003). In order to identify ethnic differences in menopausal symptom management among four major ethnic groups in the U.S. (non-Hispanic Whites, Hispanics, non-Hispanic African Americans, and non-Hispanic Asians), we conducted a secondary analysis of the qualitative data from a larger study on ethnic differences in menopausal symptoms. The findings of the larger study can be found elsewhere (Im, Lee, Chee, Brown, & Dormire, 2010a; Im, Lee, Chee, Dormire, & Brown, 2010b). In this secondary analysis, we expected to provide in-depth practical information on midlife women’s ethnic-specific attitudes toward menopausal symptom management and their actual symptom management strategies. The information would be helpful for health care providers from various disciplines that take care of multi-ethnic groups of midlife women in ever-changing and diversifying global communities.

Researchers found ethnic differences in menopausal symptom management, especially in the use of hormone replacement therapy (HRT) (Friedman-Koss, Crespo, Bellantoni, & Andersen, 2002; Shelton, Lees, & Groff, 2002; Strickland & Dunbar, 2000; Weng et al., 2001). White midlife women were more likely than African American midlife women to be offered and to take HRT (Friedman-Koss et al., 2002; Shelton et al., 2002; Strickland &

Dunbar, 2000; Weng et al., 2001). White midlife women were also more likely to use HRT than Hispanic women (Ganesan, Teklehaimanot, & Norris, 2000; Newell, Markides, Ray, & Freeman, 2001). Also, White women were more likely to be prescribed and to use HRT than Asians (Brown et al., 1999). In a national study in the U.S. (NHANES, 2003), researchers also confirmed ethnic differences in the use of HRT; White women were much more likely to use HRT than either non-Hispanic African American or Mexican American women.

The use of complementary and alternative medicine (CAM) also tended to be ethnic specific as well. Asians were more likely to take high dietary soy products (Anderson, Anthony, Cline, & Washburn, 1999; Adlercreutz, Hamalanen, Gorbach, & Goldin, 1992; Newton, Buist, Keenan, Anderson, & LaCroix, 2002). Asians, especially Chinese women, were more likely to use acupuncture and dong quai, a Chinese herb traditionally prescribed as a tonic for women (Hirata, Swiersz, Zell, Small, & Ettinger, 1997). Native Americans also tended to use red clover, a Native American herb (Foster & Tyler, 1999). However, researchers also reported that baseline CAM use (the usage of CAM before menopausal transition) was the major predictor of subsequent CAM use in menopausal transition (Bair et al., 2002).

As mentioned above, in several qualitative studies, researchers reported that the choice of management strategies for menopausal symptoms highly depended on the perceived causes and meanings of the menopausal symptoms. For example, Korean women chose not to manage their symptoms because they perceived that the symptoms came from normal aging processes, and did not place any meanings on them (Im, Meleis, & Lee, 1999). Also, Japanese women did not place great importance on menopausal symptoms and simply lived with them (Lock, 1986). Indian women went untreated or used unproven alternative therapies for their menopausal symptoms because of lack of awareness and unavailability or increasing cost of medical and social support systems (Sengupta, 2003). Although evidence for ethnic differences in menopausal symptom management was reported in these studies, the usages of the management strategies or the influences of women's ethnic specific attitudes on the choice of management strategies have rarely been compared among multiethnic groups in the U.S.

As we used the feminist approach by Im (2007) in the original study, we took a feminist perspective for this secondary analysis. According to feminists, inadequate management of menopausal symptoms results not only from pure biology, but also from women's continuous interactions with their environments and from biases reflecting the ways they and their health care providers view the world (Im & Meleis, 2000). Thus, we assumed that inadequate management of some menopausal symptoms could result from the differences in cultural attitudes toward menopausal symptoms. In addition, we also tried to prioritize the women's own views and experiences, and viewed ethnicity as a significant characteristic that influenced the menopausal symptom management process.

Methods

Again, this was a secondary analysis of the qualitative data from a larger national Internet study. The Institutional Review Board of the institution where the researchers were affiliated approved the study.

Settings and Participants

The larger study was conducted through both Internet communities (ICs) for middle-aged women (ICMWs) and Internet communities/groups for ethnic minorities (ICEMs; ICs for ethnic-specific churches, organizations, forums, health care centers, and professional groups) in the U.S. These two settings were useful to recruit midlife women, especially ethnic minorities, in existing studies (Barrera, Glasgow, McKay, Boles, & Feil, 2002; Gilliss

et al., 2001). More detailed information on the settings can be found elsewhere (Im et al., 2010a).

Through the settings, we recruited 512 women (160 N-H Whites, 120 Hispanics, 121 N-H African Americans, and 111 N-H Asians) for the Internet survey, a part of the original study. Among the Internet survey participants, we recruited 90 for four ethnic-specific online forums, which was adequate for this secondary analysis of the qualitative online forum data. Usually, 6–12 participants are ideal for a qualitative focus group discussion including a qualitative online forum (Stevens, 1996). All the participants were middle-aged women in the U.S. who could read and write English, who were online, whose self-reported ethnic identity was Hispanic, non-Hispanic (N-H) White, N-H African American, or N-H Asian, and who were early peri-menopausal, late peri-menopausal, or post-menopausal. Here, *middle-age* refers to the period of life from age 40 to age 60 when women go through physiological changes associated with the cessation of menstruation. Also, *being online* means that the women are familiar with the Internet as a medium of communication and have regular access to e-mail and the web. Women under 40 years and over 60 years were excluded because most women would experience menopause around the age of 50, ranging from 40 to 60 years old (USDHHS, 2001). We used only English because it was practically unfeasible to use multiple languages in a multi-ethnic study. We chose the four ethnic groups because they were the most common ethnic groups in the U.S. (USCB, 2000). Finally, we included only those who were early peri-, late-peri, or post-menopausal to obtain vivid descriptions of menopausal symptom experience. In Tables 1 and 2, we summarize background characteristics and perceived health and menopausal status of the participants.

Online Forum Topics

For the online forums, we used seven online forum topics on menopausal symptom experience and ethnic-specific contexts surrounding women's menopausal experience. For each topic, we included a main question and 5–8 sub-questions. Five experts in menopause and two experts in qualitative research methods reviewed and approved these topics and questions in previous studies (Im et al., 2010b). More detailed information on the online forum topics is available elsewhere (Im et al., 2010b).

Data Collection Procedures

For the original study, we developed a project website while following the Health Insurance Portability and Accountability Act (HIPAA) and the joint SysAdmin, Audit, Network, Security Institute (SANS)/FBI recommendations. In the project website, we included an informed consent sheet, Internet survey questions, and ethnic-specific online forum sites. At the participants' first visit at the project website, they were asked to review the "informed consent sheet" and to click the "I agree to participate" button to give their consent to participate. After getting their consents and checking them against the inclusion criteria and quota requirements, they were linked to the Internet survey site. At the completion of the Internet survey, they were asked to participate in an additional online forum. Only those who checked "yes" were contacted by email at the initiation of the online forums. At the initiation of the online forums, the participants were given their initial usernames and passwords that they should use to login to the online forum sites. At their first visit at the online forum sites, the participants were asked to introduce themselves and encouraged to engage in the discussion on the topics. Each month, two to three new topics were posted, and the participants were asked to post messages at their convenience. Then, at the end of the 5th month, the women were asked to add any topics that they wanted to discuss with other participants; the participants added only 1–2 topics related to menopause for each ethnic-specific online forum. In the final month, the women discussed the added topics.

Data Management and Analysis

For this secondary analysis, we analyzed the data from the online forums using thematic analysis (Boyatzis, 1998). We assigned serial ID numbers to the data, and eliminated any identity information attached to the data. Then, we printed out the data as transcripts from the online forum sites, and read and re-read the transcripts thoroughly for line-by-line coding. We summarized the codes in a coding book, and conducted categorization using the coding book. Then, we extracted the themes representing differences in factors influencing menopausal symptom management among the four ethnic groups by mapping associative links among the categories and formulating relationships. During the analysis process, we considered and examined possible effects of variable ethnic-specific contextual factors including health status, socioeconomic circumstances, family responses and roles, stability of their daily lives, and social support networks. In addition, we used an interactive process that involved reading and re-reading text to produce more abstract and refined ideas about domains of interest in order to identify themes common to and different across the ethnic groups.

To ensure rigor of the analysis, we used the standards of rigor in feminist research by Hall and Stevens (1991). To ensure dependability of this analysis, we examined the methodological and analytic decision trails created by the analysts during the course of the study itself. We wrote a chronological research diary, memos, and field notes to ensure reflexivity. For credibility and relevance of the study, we posted the developing analytic categories on the website, and the participants were asked to provide their feedback on the analysis. Also, we continuously questioned research methods, goals, research questions, design, scope, analysis, conclusions, and impact of the study within the social and political environment in order to assure adequacy of the study. Finally, we held monthly group meetings in order to ensure the quality of data collection and analysis.

Findings

We extracted four themes reflecting differences in menopausal symptom management among the four major ethnic groups: (a) “seeking formal or informal advice,” (b) “medication as the first or final choice,” (c) “symptom-specific or holistic,” and (d) “avoiding or pursuing specific foods.” Each theme is described in detail as follows.

Seeking Formal or Informal Advice

A prominent difference in menopausal symptom management among the four ethnic groups was the way of seeking information on menopausal symptom management. Most White women went to see their medical doctors as soon as they started to have menopausal symptoms. Or, they tried to seek advice from their medical doctors to manage their menopausal symptoms because they thought menopausal symptoms were a serious health issue that would affect their life for a long time. Some women mentioned that they wanted their doctors to give them more information so that they could make a decision on how to manage the symptoms, though they complained that most doctors were not as supportive or trustworthy as the women would like. Two White women said;

“My culture views menopause as more serious than a stomach ache, headache, or tooth ache because it is something that you experience for a long time instead of something that only effects you for a limited time. I think that my culture is more expressive verbally than other cultures...I feel that other cultures also have great support systems but they might not have an easier time getting the support they need from doctors. I feel that in my culture, a women experiencing menopause looks very stressed and tired because that is the way I look and feel at this moment in time.” [White]

“I have unberable [unbearable] hot flashes. At their worst, they are several times an hour and to the point of causing nausea. I’m also a major witch! The patch works great, still have some symptoms, but much more manageable [manageable] I’ve not been without insurance in many years, so that’s not been an issue. I would just be happy to have a doc listen to me! So many times I’ve seen a doc and they cut me off mid-sentence, jump to conclusions, and just plain ignore me. I also would like a doc to give me my options, and the pros and cons of each...and encour[a]ge me to make the decision...not tell me what to do!” [White]

Similarly, some Hispanic women said that they went to doctors’ offices to deal with their menopausal symptoms because they had no one to talk to about how they should manage their symptoms. Based on their cultural perspectives, they said that they felt embarrassed to talk about their symptoms with family and friends and felt that they had to deal with the symptoms patiently until they could not endure them any longer. Therefore, they thought that they needed doctors’ advice to overcome a cultural disadvantage. Two Hispanic women mentioned:

“I believe that in my office too a good many of woman are going through menopause but I am too embarrassed to ask them how they feel and how they cope with their symptoms...I also believe that there is a generation gap when menopause is discussed in my family. No one wants to talk about or gets very embarrassed when it is brought up and that is the main reason why I go to my doctor for advice because she knows all the techniques to deal with this horrible phase in my life.” [Hispanic]

“I tend to get a lot of migraines these days which really set me back. I suppose not being having a lot of information has left me at a disadvantage of what to expect. It [In] that respect, our culture has put itself behind. We can share more with each and not feeling that we’re going crazy when we have these setbacks...I find it is difficult to talk about my symptoms and that it is because of my culture. However, if I want to get better, I need to overcome this obstacle or I’m only hurting myself and those around me. I have a great doctor who is helping through most of my issues.” [Hispanic]

On the contrary, many ethnic minority women believed that the elderly was a primary information source on how to manage their menopause symptoms because they had experienced menopause. They also mentioned that they got advice from their close friends who went through similar issues. Prominently, Asian women thought that they did not need to get help or information from others because they considered menopause as a normal aging process. Two Asian women wrote:

“Menopause wasn’t openly discussed in my culture so we would not go about expressing it to anyone other than perhaps the doctor. When any member of the family was having particular troubles caused by menopause or periods, every ones would just understand and help them out. I wouldn’t really say that I have difficulties expressing my menopausal symptoms. It’s just a way of life and it’s the way things happen with my family and other families in the society I grew up. We just mind our business and don’t stop to complain. We just move on in hopes that it would all go away some day.” [Asian]

“I do talk about what all i go through with my clos[e] friend [and] seek her advice. Like its easy to give advice to other[s] but when it comes to your own implementation we can’t. I discuss all what I go through with my close friend by mutually supporting each other in time of distress.” [Asian]

Some women, yet, said that they tried to get information independently because they wanted to deal with their menopausal symptoms without bothering others. They tried to search for information on the Internet or in journals/newspapers but needed more reliable information to use. Two ethnic minority women mentioned:

“I do talk about what all i go through with my clos[e] friend [and] seek her advice. Like its [it’s] easy to give advice to other[s] but when it comes to your own implementation we can’t. I discuss all what I go through with my close friend by mutually supporting each other in time of distress.” [Asian American]

“As Black women, we tend not to complain about our own physical difficulties, but always put our families and others first...I wish there was more information available concerning ways to relieve symptoms, results of extensive surveys, etc. The only way to find out anything is to search and search. And usually what you find is not from any type of documented study, or is out of date.” [African American]

Medication as the First or Final Choice

An observable difference in menopausal symptom management between White women and ethnic minority women was: while white women preferred to take a variety of different medications to alleviate their symptoms, ethnic minority women did not prefer to take medications to handle their menopausal symptoms. White women stated that, when they felt their first menopausal symptoms, they chose medication as the first strategy to manage their symptoms. When their symptoms were alleviated, they would stop taking the medication. However, they also mentioned that if their symptoms worsened, they would choose to get back on the treatment. Meanwhile, ethnic minority women said that they avoided taking medicine to manage their menopausal symptoms. Instead, they tried to find alternative methods to control their symptoms. If their alternative treatment trials were not effective in subsiding unfavorable menopausal symptoms, they would then consider medication as a final choice. One White American woman mentioned:

“Anyway my 1st hot flash was about 16 months ago plus night sweats. I used Hgh [human growth hormone] spray for 26 month cycles and the symptoms stopped. But then they returned so I started taking Remifemin [herbal menopause supplement]. It seemed not to work so I started using progesterone cream. I was back to normal til[I] I ran out of Remifemin. ... If my symptoms get worse I will go back to using progesterone cream, or try something else.” [White]

One Asian woman said:

“I don’t like medicine, so I try to do another way first, for example, sleeping, massage, [and] water bath ets [etc]. If it doesn’t work, I take the medicine. If we cannot avoid, we should deal with it directly. Menopausal symptom is not one event, so women have the time to prepare [for] it. Gradually we can adjust to the unavoidable thing.” [Asian]

Most women preferred using any ethnically originated natural/herbal remedies. They all had the opinion that natural/herbal remedies helped to alleviate their menopausal symptoms, assisted with sleep patterns, or provided relief from fatigue. However, there was a difference in their perspectives on natural/herbal treatments between Whites and ethnic minorities. White women favored herbal supplements as medicinal pills whereas ethnic minority women had a tendency to use them as teas, such as chamomile, angelica, and Chinese tea. One white participant mentioned:

“I took a Mannatech supplement called Plus which relied heavily on wild yam. It eased me though the worst of the symptoms. I have also had success with Nature Herbs “Change-O-Life”.” [White]

One Hispanic participant said:

“I wonder what it could be, I try ginseng, vitamins, green tea, it just seems I am always tired [tired]. Maybe someone here has a recommendation! ... Wild Yam, angelica, ten treasures Chinese tea, are some of the things I have picked up from some of my herbalist friends.” [Hispanic]

Symptom-specific or Holistic

White women preferred symptom-focused management strategies or treatments for menopausal symptoms, which were usually anticipated to have immediate effects. On the contrary, ethnic minority participants favored holistic strategies that would help relieve menopausal symptoms by making their entire body feel better. White women mentioned that they tried a variety of specific treatment methods for their individual symptoms. The methods that they commonly used were those that gave immediate responses/effects to control specific individual symptoms; namely, cooling treatments (fan, ice cream, or cotton layers) for hot flashes, and analgesic methods for a headache. On the other hand, ethnic minority women pursued holistic approaches to handle their symptoms because they believed that the symptoms came from aging process. They intended to overcome their menopausal symptoms by making their general condition better with natural foods, exercise, yoga, massage, or meditation. One white participant stated:

“I just get hot, and my head gets damp, they only last about 5–10 minutes. I haven’t been bothered with night sweats. I don’t take anything because the symptoms haven’t been anything I thought to complain about. ... Take tylenol for Headaches, dress in layers for hot flashes/cold spells. Have a fan by the bed for night sweats. Considering shot gun for husband on days that annoyance level is high!” [White]

Two ethnic minorities mentioned:

“More management, less treatment. Exercise, good nutrition and involving myself in activities that take my attention away from my own nagging discomforts... But more lifestyle strategies... Barring someone getting unusual symptoms (which would even create doubts in the minds of those who have been through it all before), I think there needs to be a very holistic approach to this problem of handling menopause symptoms.” [Asian]

“I attend a menopausal class; which consist of mostly emotional verbiage, and take part in yoga sessions three times per week... I prefer the holistic approach in addition to relaxation techniques such as deep breathing, consuming organic foods, exercise, yoga, trying my best to stay in a positive conscious state which will promote an overall healthy well being.” [African American]

As a holistic approach, ethnic minority women also thought that it would be possible to cope with their physical symptoms by controlling their minds. Thus, they tried to control their minds or have positive views along with using some alternative methods to overcome their symptoms. Some ethnic minority women wrote that they kept themselves busy or enjoyed a pastime to change their focal point to concentrate on something other than their symptoms. Two ethnic minorities mentioned:

“I am still using natural methods, But I am open to conventional methods when and if I need to... natural remedies, such as herbal, jogging, meditation, trying to have a positive outlook with whatever is put in front of me.” [Hispanic]

“We don’t focus as much on the symptoms. We keep busy with our lives and usually refrain from complaining too much about any minor issues we’re experiencing... We manage by staying active and not focusing too much attention on little problems. If the problem is severe, then we may address it. We only resort to medical help if we REALLY know we need it... I try to manage on my own and with a positive outlook.” [Asian]

Avoiding or Pursuing Specific Foods

All women across the ethnic groups thought that foods would be one of the most important influencing factors on menopause symptoms. However, there were specific differences in their approaches to foods in managing their symptoms; White women tended to avoid specific foods to prevent or control their menopause symptoms whereas ethnic minority women tended to pursue healthy foods to improve their general health. White women said that they learned how to manage their symptoms through experience. They believed that their menopausal symptoms became severe or specific symptoms were triggered when they consumed specific foods such as spicy foods, caffeine, junk foods, carbohydrates, and alcohol. Therefore, they tried to avoid these specific foods to prevent or control their symptoms. Two white women said:

“I did have them quite frequently when first entering into menopause, however the daytime hot flashes have now subsided (I call them mini heat waves) I have noticed at certain times if I eat hot spicy food it may trigger a flash... The only changes I have made because of menopause (and they are minor changes) I have cut back on my intake of caff[ei]nated products, have changed the type of night clothes I wear to sleep in because of the terrible night sweats I have and to dress in layers when I go to work. This enables me to remove clothing when I experience a hot flash. It seems since I have cut back on caffeine my headaches are not as frequent.” [White]

“I’m pretty much staying away from the spic[i]er foods because of the hot flashes. Sometimes coffee will do it to me as well. As far as the insomnia, I also will take naps if I’m completely exhaus[t]ed. I try not to, so I’ll be t[ir]ed when I go to bed, but sometimes I can’t help it. Stress, I find, has a major [cause]/effect on my symptoms. ... My hot flashes get really bad when I’m stressed. I had to give a presentation to about 150 people last month... the closer it got to me talking, the more often the hot flashes were happening. Once I finally finished my presentation, I was fine. I didn’t drink much before, but I stay clear of alcohol now too. My hot flashes get much worse if I drink.” [White]

Ethnic minority women mentioned that they learned to manage gynecological issues from their elderly and they thought menopause was not a sickness, but just a life stage. Specifically, they believed that their diet would be a factor that could modify the aging process, and some healthy foods such as soy, and natural vitamins were effective in improving their general health, subsequently controlling their menopausal symptoms. Therefore, they pursued healthy foods to prevent from aggravating or triggering menopause symptoms. One Asian woman mentioned:

“In the culture I grew up, life stages were not based on how your estrogen and progesterone and prolactin went up and down. The life stages were defined by your responsibility levels within a family. You were first a daughter, then a wife and daughter-in-law, then a mother, then maybe a mother-in-law. At each stage we observed our elders. Each life stage involved family support and duties. We observed older women guiding younger women regarding gynaec [gynecological] issues. Diets were modified as age advanced. A lot of minor menopausal “symptoms” could be handle [d] by a sensible diet.” [Asian]

Discussion

In this analysis, we found ethnic differences in menopausal symptom management among four major ethnic groups of midlife women in the U.S. The third theme of “symptom-specific or holistic” could be the overriding theme of the major themes on ethnic differences in menopausal symptom management that we found in this analysis. White women tended to focus on specific symptoms by seeking help through formal health care systems while ethnic minorities tended to approach their menopausal symptoms holistically while seeking help through their family members and friends. Subsequently, White women used medication as the first step of managing their menopausal symptoms while ethnic minorities tended to use medication as the final choice. White women preferred avoiding specific foods that might cause specific symptoms, and ethnic minority women pursued specific healthy foods to holistically improve their general health through which they could manage their menopausal symptoms.

The first theme of “seeking formal or informal advice” has been reported in the literature on White women’s HRT usages. As mentioned above, until recently, hormone replacement therapy (HRT) has been the most frequently researched and prescribed management strategy for menopausal symptoms (NHANES, 2003). Despite potential adverse effects, White women have been reported to take HRT more often than ethnic minority women (Friedman-Koss et al., 2002; Ganesan et al., 2000; Newell et al., 2001; Shelton et al., 2002; Strickland & Dunbar, 2000; Weng et al., 2001). In the theme of “seeking formal or informal advice,” we also found this tendency of White women’s seeking medical help for menopausal symptoms. Also, this theme has been reported in the literature on menopausal experience of ethnic minority women: ethnic minority women have been reported to get help through informal networks of only same-race, same-sex friends (Dillaway, Byrnes, Miller, & Rehan, 2008). For example, Asian women tended to view any symptom from menopause as natural part of being a woman, and the first people that the Asian women asked for help when they had menopausal symptoms were their mothers or older women relatives (Berg & Lipson, 1999; Bottorff et al., 2001). Indeed, Berg and Lipson (1999) reported that midlife Filipina Americans primarily obtained the menopausal information from female relatives and friends. Also, in a different study (Bottorff et al., 2001), immigrant South Asian women were reported to learn everything related to health concerns from their own mothers.

In the second theme of “medication as the first or final choice,” we identified new information related to ethnic differences in menopausal symptom management; Whites tended to take medication as the first choice while ethnic minorities tended to take medications as the final choice. There have been a number of studies on effects of medications on menopausal symptoms (Barton et al., 2002; Berendsen, 2000; Guttuso, Kurlan, McDermott, & Kieburtz, 2003; Loprinzi et al., 2002; Shanafelt, Barton, Adjei, & Loprinzi, 2002; Stearns et al., 2000; Weitzner, Moncello, Jacobsen, & Minton, 2002). Yet, very little is known about ethnic differences in actual usages of these medications to manage menopausal symptoms.

The third theme of “symptom-specific or holistic” is somewhat consistent with the literature on ethnic minorities’ use of the complementary and alternative medicine (CAM), but also could be new information to the current literature. Researchers reported that midlife women began to use CAM to manage their menopausal symptoms more than ever before, and the most frequently used CAM therapies for menopausal symptoms were herbal remedies, chiropractic, meditation, acupuncture, dietary supplements (e.g., vitamin E), and foods containing phytoestrogens (Kronenberg & Fugh-Berman, 2002; Newton et al., 2002; Thompson, Robb, Serrano, & Cheung, 1991). However, researchers rarely reported women’s ethnic-specific approaches to menopausal symptom management as in the third

theme; Whites tended to use symptom-specific approaches while ethnic minorities tended to use holistic approaches.

The final theme of “avoiding or pursuing specific foods” has been reported in existing studies, and is also new to the current literature. The finding that ethnic minorities pursued specific foods during their menopausal transition is consistent with the literature. As noted above, high dietary intake of soy products was reported in Japan, China, and Korea, and it was reported as a reason for the lower prevalence of menopausal symptoms in those countries (Anderson et al., 1999; Adlercreutz et al., 1992; Newton et al., 2002). Dong quai, a Chinese herb traditionally prescribed as a tonic for women, was frequently used by Chinese Americans for menopausal symptom management (Hirata et al., 1997). Red clover, a Native American herb, was frequently used among Native Americans (Foster & Tyler, 1999). However, in existing studies, it has rarely been reported that White midlife women avoid specific foods to control or prevent their menopausal symptoms.

In this analysis, we had several limitations because of its inherent nature of a secondary analysis study. First of all, there was no control of the data collection; the data came from the original study, and there was no way to get more data to confirm or double-check the questions from this secondary analysis. Second, because the original study was an Internet study, the participants tended to be a select group of midlife women. Third, all the data analysts except one researcher were not the original data collectors and/or analysts. Thus, we totally depended on the transcripts and written records from the original data collectors and analysts. Fourth, the data on menopausal symptom management from the original study tended to be limited because the original study focused on menopausal symptom experience rather than menopausal symptom management. Finally, this was a qualitative secondary analysis that did not allow the researchers to control other personal data such as education, job, and access to information (e.g., from the internet or other sources) in its exploration on ethnic differences in menopausal symptom management.

Conclusion

In this secondary analysis, we found differences in menopausal symptom management among four major ethnic groups. Based on the findings, we suggest the following for future research and health care practices with ethnically diverse groups of midlife women in the U.S. These suggestions could be also applicable to researchers and health care practitioners across the nations who take care of multi-ethnic groups of midlife women. First of all, we found that White women in the U.S. sought help for menopausal symptom management through formal health care systems while ethnic minority women in the U.S. sought help through informal channels of resources. Thus, researchers and health care providers need to create interventions and/or mechanisms to deliver information related to menopausal symptoms management while considering this specific ethnic difference in women’s preferences for information channels. Second, researchers and health care providers need to be aware of ethnic differences in the usage of medications for menopausal symptom management as in the theme of “medication as the first or final choice.” Third, we found that Whites in the U.S. tended to use symptom-specific management strategies while ethnic minorities in the U.S. aimed to take holistic approaches to improve their general health, subsequently managing their menopausal symptoms. Therefore, researchers and health care providers need to consider this tendency of symptom management in their development of interventions for menopausal symptom management. Finally, in development of menopausal symptom management programs, researchers and health care providers need to consider tabooed foods and preferred foods for menopausal symptom management as indicated in the theme of “avoiding or pursuing specific foods.”

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Table 1

Background characteristics of the participants (N=90)

Characteristics	Hispanic (N=27) n (%)	NH African American (N=27) n (%)	NH Asian (N=13) n (%)	NH White (N=23) n (%)	Total (N=90) n (%)
Age (years, Mean $\pm$ SD)	50.0 $\pm$ 4.8	49.1 $\pm$ 5.2	50.7 $\pm$ 5.6	50.2 $\pm$ 5.9	49.1 $\pm$ 5.3
<i>Education</i>					
High school	5(18.5)	2(7.4)	3(23.1)	4(17.4)	14(15.6)
College	17(63.0)	19(70.3)	6(46.2)	17(73.9)	59(65.6)
Graduate degree	5(18.5)	6(22.2)	4(30.7)	2(8.7)	17(18.9)
<i>Religion</i>					
Protestant	1(3.7)	10(37.0)	3(23.1)	5(21.7)	19(21.1)
Catholic	15(55.6)	6(22.2)	2(15.4)	10(43.5)	33(36.7)
Others	4(14.8)	9(33.3)	7(53.8)	6(26.1)	26(28.9)
No religion	7(25.9)	2(7.4)	1(7.7)	2(8.7)	12(13.3)
<i>Marital status</i>					
Married/partnered	18(66.7)	14(51.9)	12(92.3)	14(60.9)	58(64.4)
Non-married/partnered	9(33.3)	13(48.1)	1(7.7)	9(39.1)	32(35.6)
<i>Employment</i>					
Yes	21(77.8)	23(85.2)	9(69.2)	19(82.6)	72(80.0)
No	6(22.2)	4(14.8)	4(30.8)	4(17.4)	18(20.0)
<i>Income level (difficulty paying for basics)</i>					
Very hard	8(29.6)	6(22.2)	0(0.0)	4(17.4)	18(20.0)
Somewhat hard	10(37.0)	10(37.0)	7(53.8)	9(39.1)	36(40.0)
Not hard	9(33.3)	11(40.7)	6(46.2)	10(43.5)	36(40.0)
<i>No. of children</i>					
None	2(7.4)	3(11.1)	0(0.0)	5(21.7)	10(11.1)
1-2	19(70.4)	15(55.6)	8(61.5)	14(60.9)	56(62.2)
3-5	5(18.5)	9(33.3)	5(38.5)	3(13.0)	22(24.4)
More than 5	1(3.7)	0(0.0)	0(0.0)	1(4.3)	2(2.2)
<i>Country of birth</i>					
U.S.	25(92.6)	26(96.3)	2(15.4)	22(95.7)	75(83.3)
Outside U.S.	2(7.4)	1(3.7)	11(84.6)	1(4.3)	15(16.7)

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Characteristics	Hispanic (N=27) n (%)	NH African American (N=27) n (%)	NH Asian (N=13) n (%)	NH White (N=23) n (%)	Total (N=90) n (%)
Length of stay in U.S.(yrs/(Mean±SD))	27.5±42.4	NA	13.6±10.9	NA	NA

*
1= none of the time ~ 4= most of the time
**
1= awful ~ 6= excellent

Table 2

Perceived health and menopausal status of the participants (N=90)

Characteristics	Hispanic (N=27) n (%)	NH African American (N=27) n (%)	NH Asian (N=13) n (%)	NH White (N=23) n (%)	Total (N=90) n (%)
<i>General health* (1-5)(Mean±SD)</i>	3.5±1.1	3.6±0.8	3.8±0.6	3.4±1.2	3.6±1.0
<i>BMI(kg/m²) (Mean±SD)</i>	28.3±6.9	29.8±7.5	26.8±4.0	33.4±11.9	29.7±8.6
<i>Category of BMI</i>					
Normal (< 24.9)	11(40.7)	9(33.3)	5(38.5)	8(34.8)	33(36.7)
Overweight (25-29.9)	8(29.6)	7(25.9)	6(46.2)	3(13.0)	24(26.7)
Obese (≥ 30)	7(25.9)	11(40.7)	2(15.4)	12(52.2)	32(35.6)
Missing	1(3.7)	0(0.0)	0(0.0)	0(0.0)	1(1.1)
<i>Menopausal status</i>					
Premenopause	2(7.4)	1(3.7)	2(15.4)	3(13.0)	8(8.9)
Early perimenopause	10(37.0)	14(51.9)	4(30.8)	9(39.1)	37(41.1)
Late perimenopause	8(29.6)	6(22.2)	2(15.4)	5(21.7)	21(23.3)
Postmenopause	7(25.9)	6(22.2)	5(38.5)	6(26.1)	24(26.7)

*
1=very unhealthy ~ 5=very healthy