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PERCEPTION AND ATTITUDE TOWARDS MENOPAUSE IN THE CLIMACTERIUM PHASE: EXAMPLE OF EASTERN BLACK SEA REGION IN TURKEY

Çağla YİĞİTBAŞ[1]

ABSTRACT

The aim of this study is to reveal the perceptions and attitudes of women in the centre of a province in the Black Sea region of Turkey towards menopause and their symptoms with regards to their socio-demographic properties.

The participants were determined by the snowball sampling method. Data were collected according to the face to face interview method through house visits. The data form used consists of the descriptive qualities, Menopause Rating Scale and Scale of Attitude towards Menopause. Data were evaluated by a statistics package program, parametric and non-parametric tests were conducted, correlation analyses were applied, and the significance limit was accepted to be $p<0.05$.

It was observed that the menopause symptoms and scores of participants were below average. It was determined that seeing oneself physiologically weak and having no knowledge about menopause were high in the attitude score; having a chronic disease, having no knowledge about menopause and using any medicine and HRT for complaints were high in the menopause symptoms evaluation score; living in a rural region, having a chronic disease and having no knowledge about menopause were high in the psychological symptom dimension which was statistically significant.

The approach of the participants in the climacteric phase is mainly positive with low levels of symptoms. The evaluation of the menopause symptoms is related to the menopause attitude.

Keywords: Climacterium, phase, menopause, perception, attitude.

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[1]Assist. Prof. Dr., Çağla YİGİTBAŞ, Giresun University, Faculty of Health Sciences, Public Health Department Giresun, Turkey. caglayigitbas@hotmail.com

Orcid Number: https://orcid.org/0000-0002-3789-1156

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1. INTRODUCTION

Women have many remarkable changes throughout their lives such as menarche, sexual initiation, pregnancy and menopause. Among these stages it is worth highlighting the climacteric period, which is characterized by a long transition period between the reproductive (menacme) and the not reproductive (agedness). The climacteric phase, regardless of irregular menstrual cycles and observable endocrine changes, comprises the period between 40 to 65 years old, subdividing in: pre-menopause (commonly beginning after 40 years old), perimenopause (starting about 2 years before the last period and going to one year after it) and post-menopause (initiate one year after the last period)(Sozeri Varma et al., 2006; Koc and Saglam, 2008; Melo and Costa, 2018). Calculations indicate that the number of women in menopause will reach 1.2 billion in 2030. In a developed country, almost every woman reach to the period of menopause and spend one-third of their lives in the climacteric phase (Zıvdır and Sohbet, 2017). Menopause is one of most an important phase women‟s life (Rossouw et al., 2002) and it is associated with biological, psychological and somatic changes affecting women's Health and well-being, as well as the capacity to adapt to a new role (Tamaria et al., 2013). While menopause as a physiological event has been essentially unchanged over a long time, attitudes and expectations have changed considerably and differ in various cultures (Olofsson and Collins, 2000). Its harmful effects are associated with psychological problems including stress, anxiety, depression, sexual function sexual arousal, sexual fantasies, sexual desire, night sweats, hot flushes, vasomotor symptoms, breast and skin atrophy, muscular, cardiovascular system diseases, skeletal problems, and senile vaginitis (Freitas et al., 2015; Arbab et al., 2018).

Menopause is a highly individualized phenomenon; complaints of menopause are not universal and vary among cultures.For example, although most women in India have no complaints about menopausal symptoms, except irregular menstruation, most women in Western cultures commonly experience hot flashes and night sweats. Attitudes and perceptions toward menopause have also been acknowledged to greatly influence menopausal experiences. Women with negative attitudes toward menopause, in general, have more complaints of symptoms.Western culture often deemsmenopause as an end and a ‘‘disease’’ to be treated, whereas other cultures, like that of the Mayans, perceivemenopause as a symbolismof freedom, an elevation of status, and respect. Given that differences in menopausal experiences between cultures have been well established, it is necessary to examine the menopausal experiences of women within the same culture to inform the development of culture-specific management methods (Shorey et al., 2018).

According to the 2017 data of the Turkish Statistical Institute (TSI), 25.63% of the women in Turkey are in the climacteric phase (TSI; 2018). According to 2015 data, the life expectancy in Turkey was 78 for the whole population with 75.3 years for men and 80.7 years for women which indicates an increase compared to previous years (Ilcıoglu et al., 2017). With the increase of life expectancy of women, the number of women in the climacteric phase also increased, and this phase began to cover around 1/3 of the lives of women. The average age of menopause for women in Turkey is 49 age (TDHS, 2008) while this ratio is 51 for women in the United States, 48 in Italy, 46 in Egypt and 44 in Iran (Sis Celik and Pasinlioglu, 2014). In

this phase, the effect of socio-cultural factors should also be taken into consideration. In this phase, women may have concerns about ageing, experience psychological changes with the loss of fertility, have the perception of losing social and symbolic gainings and have the feeling of inadequacy concerning sexual identity. A study conducted in Turkey reported 62.8% of having health issues based on menopause (Abay and Kaplan, 2015), while another study determined that 77.5% of women didn't have any behaviour for seeking health assistance due to the problems based on the process. This was associated with the traditional ways of thinking and conservative behavioural habits of women in Turkey (Ozgur et al., 2010). Women in Turkey are mainly Muslim and in Islam, having no menstrual bleeding is associated with positive considerations including cleanliness and maturity and considered to be an advantage concerning religious rituals and prayers (Metintas et al., 2010).

Besides, it is reported in the literature that the severity of the menopause based symptoms and the levels of women being affected vary by societies and according to experiences (Uludag, 2014). In a study, it was reported that the menopause found somatic and psychological complaints in women from Tunisia are more than the French women (Ferrand et al., 2013).The positions of women in the family, their duties and responsibilities, and even the perceptions of their husbands towards the menopause period are significant in Turkish society. Studies in Turkey report that women have positive and negative views concerning the approach to the menopause period (Koc and Saglam, 2008; Ozgur et al., 2010).

The objective of this study to determine the sociodemographic properties that affect the menopause perceptions, symptoms and attitudes of women in the climacteric phase living in the centre of a province in the Black Sea region of Turkey.

2. MATERIAL AND METHODS

This study is quantitative. The data of the descriptive and cross-sectional study was collected between February 2017 and April 2017 from the women living in the centre of a province in the Eastern Blacksea Region in the age group of 45 to 65 years. The women in the specified age group were reached by the snowball sampling method within the scope of the content of an education program carried out as a field study. With house visits, data were collected from the women in the climacteric phase who accepted the interview. In accordance with Helsinki criteria, the researchers provided information about the content, purpose, importance, and scope of the study through the informed consent form attached to the questionnaire. After obtaining required permissions, The survey form with questions about the socio-demographic qualities and measuring the symptoms and menopause attitude prepared by the researcher was applied to the voluntary participants (120 people). Data were collected by the face to face method by five students in the last year of the faculty of health faithfully to the original of the survey, the students having standard education on data collection. The students were informed about the climacterium period. The participants were willing to learn the climacteric period. Therefore, after the study, the students who collected the data made two house visits to the participants about the climacteric phase, menopause problems, coping with these problems and increasing life quality.

The independent variables of the study consist of the socio-demographic qualities and menopause perceptions of the participants while the dependent variables consist of the Menopause Rating Scale (MRS) [including the subscales of Somatic Complaints (SC), Psychological Complaints (PC), Urogenital Complaints (UC)] and the Attitude For Menopause Scale (AFMS)].

Menopause Rating Scale (MRS): It was developed by Schneider et al., in 1992 in German to measure the severity of menopausal symptoms and adapted to English in 1996. MRS was adapted to Turkish in 2005 by Gürkan. The Likert type scale consists of total 11 items including menopausal complaints with the following choices for each item: “0= none”, “1= mild”, “2= moderate", "3= severe" and "4= very severe". Scores for each item are used to calculate the total score of the scale. The lowest score from the scale is 0, and the highest score is 44. There is no cutoff score on the scale. The increase in the total score from the scale indicates the increase in the severity of the complaints that are experienced. The scale consists of three subscales, i.e. Somatic Complaints (SC), Psychological Complaints (PC) and Urogenital Complaints (UC). The Cronbach α reliability coefficient was reported to be .84 for MRS .79 for SC, .65 for PC and .72 for UC. The Cronbach α reliability coefficient for this study was .87 for MRS, .58 for PC, .85 for PC and .74 for UC.

1. SC: It consists of the 1st and 2nd items on the scale. The scores are between 0-8.
2. PC: They are the items 3, 4, 5, 6, 7 and 11 in the scale. The scores are between 0-24.
3. UC: It consists of the items 8, 9 and 10 in the scale. The scores are between 0-12.

Attitude for Menopause Scale (AFMS): The scale developed by Uçanok in 1994 is a 5 point Likert type scale consisting of positive and negative statements on the menopause life and after that. The subjects are requested to mark the suitable choice next to each statement including "0-strongly disagree", "1-disagree", "2-no idea", "3-agree" and "4-strongly agree". The scale includes two positive statements (statements 1 and 18) and 18 negative statements (statements 2-17, 19 and 20). In negative statements, scoring is reverse. The lowest score from the scale is 0, and the highest score is 80. The high scores from the scale indicate a positive attitude towards menopause and low scores indicate a negative attitude. Higher scores than the average (40) indicate that the attitude is more positive. The coefficient of consistency for the whole scale is .86, and the same score was found to be .84 for the present study.

The analysis of the data obtained from the study was conducted with the statistics package program and the percentage distribution, Student t-test, Mann Whitney U test, Kruskal Wallis test,andOne-wayANOVA tests were used in the evaluation. The significance limit was accepted to be $p<0.05$.

3. RESULTS

The score averages of the participants on the quantitative data are 50.10±3.75 (45-65) for age and 45.84±3.45 (35-55) for the menopausal age. The score average in MRS is 19.25±8.82 (0-44) and 3.60±1.93 (0-8) for SC, 12.10±5.52 (0-24) for PC and 3.55±2.89 (0-12) for UC. The scoring average for AFMS is found to be 44.96±10.63 (26-72).6.7% of the participants are not

literate, %17.5 of them are were literate but did not go to school, %39.2 of them are primary school graduates, %16.7 of them are middle school, %12.5 of them are high school, %39.2 of them are primary school graduates graduates and 7.5% are university graduates. The ratio of housewives is 75.8% while 4.2% of the participants are health employee. The ratio of married participants is 79.2%. The ratio of the participants without a child is 1.7%. The ratio of the participants who spend most of their lives in a province is 60%. The ratio of the participants with a large family is 22.5%, while 5.0% has a fragmented family while the rest has a core family type. 1.7% of the participants stated that they don't find themselves to be physically strong while 79.2 % of them stated that they participate in the family decisions, 10.0 % stated that they smoke, 0.8% stated that they use alcohol and 30.0% of them stated that they have a chronic disease.

78.3% of the participants stated they are in the menopause phase, 40.0% of them stated they have knowledge about the menopause process, 27.1 % of them stated they did not/would not tell anyone about their menopausal problems, 22.4% of them stated that they explained/would explain their problems to a health personnel, 15.0% of them stated that they used/would use if necessary some medications to cope with the symptoms of the process, 15.0% of them stated that they received Hormone Replacement Treatment (HRT), 70.6% stated that they used this treatment for a period more than 4 months.

In the study, 78.3% of the women stated that they found the menopause to be a normal process, 61.7 be the beginning of feeling old, 30.0% a process of maturity, 43.3% end of female characteristics, 38.7% a reduction/end of sexuality, 64.2% end of fertility and 4.2% a disease.

The MRS, SC, PC and UC scores of the participants were not found to be significant concerning age, marital status, family type, finding oneself physiologically strong, having a child, participating in the family decisions, perception on the economic status, smoking and alcohol consumption ($p>0.05$).

Table1. Distribution of the AFMS, MRS and SC, PC and UC Score Averages of the Participants According to Some of Their Characteristics (N=120)

			AFMS	MRS	SC	PC	UC
Somecharacteristics		**n**	**Mean± SD**	**Mean± SD**	**MeanRank**	**Mean± SD**	**MeanRank**
Place where the majority of life is spent	**Province**	73	45.13±11.46	17.78±8.91	56.29	11.10±5.48[a]	56.66
	County	27	46.03±10.38	22.11±8.50	67.70	13.88±5.09[a]	67.98
	Village	20	42.90±7.53	20.80±8.10	62.95	13.30±5.64	64.40
	Test Value		F=0.52; p=0.59	F=2.82; p=0.06	KW=2.38; p=0.30	F=3.17; **p=0.04**	KW=2.42; p=0.29
Oneselfphysiologicallystrong	**Very**	32	43.64±10.52[a]	18.12±9.05	58.28	11.25±5.65	57.17
	Quite	55	42.81±10.20	18.90±8.32	59.99	12.23±5.31	56.31
	Little	24	52.04±10.40[a]	21.45±10.58	64.02	12.75±6.52	76.04
	None	9	43.77±6.86	19.55±5.59	62.11	12.55±3.53	56.50
	Test Value		**F=4.93; p=0.003**	F= 0.69; p=0.55	KW=0.41; p=0.93	F=0.38; p=0.76	KW=6.10; p=0.10
Havingchronicillness	**Yes**	36	47.52±10.29	23.00±9.94	74.06	14.13±6.15	72.79
	No	84	43.85±10.64	17.65±7.83	54.69	11.22±5.02	55.23
	Test Value		t=1.74; p=0.08	t=3.15; **p=0.002**	U=1024.00; p=0.005	t=2.71; **p=0.008**	U=1069.50; p=0.011
Knowing menopause	**Yes**	48	41.91±11.21[a]	17.33±9.15[a]	56.64	10.56±5.52[a]	58.35
	Partially	53	46.81±9.68[a]	21.43±7.83[a]	66.75	13.77±4.70[a]	61.73
	No	19	47.26±10.09	18.05±9.68	52.84	11.31±6.56	62.50
	Test Value		F=3.36; **p=0.03**	F=3.02; **p=0.05**	KW=3.31; p=0.85	F=4.76; **p=0.01**	KW=0.3; p=0.85
Druguse for menopausalcomplaints (n=108)	**Yes**	23	47.86±10.99	23.56±8.55	63.63	14.26±4.99	61.93
	No	85	44.89±10.13	19.76±7.89	52.03	12.42±5.18	52.49
	Test Value		t=1.22; p=0.22	t=2.01; **p=0.04**	U=767.50; p=0.11	t=1.52 p=0.13	U=806,50; p=0.19
HRT (n=107)	**Yes**	16	49.43±11.61	24.43±8.97	65.06	15.12±5.27	65.94
	No	91	44.79±10.05	20.01±7.82	52.05	12.49±5.04	51.90
	Test Value		t=1.66; p=0.06	t=2.04; **p=0.04**	U=551.00; p=0.12	t=1.91; p=0.05	t=537.00; p=0.09

AFMS: Attitude For Menopause Scale. MRS: Menopause Rating Scale, SC: Somatic Complaints, PC: Psychological Complaints, UC: Urogenital Complaints (UC). [a,b]*GroupsaccordingtoTukey HSD test results.*

As shown in Table 1, a significant difference was found between the MRS scores and the variables of having a chronic disease, having knowledge about menopause and using medications about the menopausal complaints ($p<0.05$). In the post hoc analysis about the difference in the variable for knowing menopause, it was determined that the difference was between those with knowledge and those with partial knowledge ($p>0.05$).

In this study, a difference was found between the PS subdimension and the variables of the place where the majority of life is spent, having a chronic disease and having knowledge about menopause ($p<0.05$). In the post hoc analysis after the difference found between the education level and PC subdimension, the difference was found to be caused by those who are not literate and who are graduates of the primary school and university ($p>0.05$). The variable of the place where the majority of life is spent caused a difference concerning the PC subdimension and the post hoc analysis showed that the difference was caused by the participants who live in the province and a district ($p>0.05$).

In addition, the variables of age, education, marital status, having a child, family type, place where most of your lifeis spent, participating in the family decisions, finding oneself psychologically strong, perception on the economic condition of the family, smoking,and alcohol consumption were not found to be significant with respect to the AFMS scores in the present study ($p>0.05$).

As shown in Table 1, the variables of finding oneself physiologically strong and having knowledge about menopause were found to be significant concerning the AFMS scores ($p<0.05$). The post hoc analysis for finding oneself psychologically strong regarding the AFMS indicated that the difference was between the groups with answers "very" and "little" ($p<0.05$).

As shown in Graphics 1, heart disease was stated to be none and slight by the participants being the two highest ratios. Again as the highest ratios, the menopause symptoms stated to be none consisted of the urination problems and vaginal dryness; the mild symptoms consisted of grief, physical and mental fatigue, sexual problems, joint and muscle diseases; moderate symptoms consisted of sleep problems and anxiety; severe symptoms included hot flush and nervous temperament. No signs were stated to be very severe.

Graphics 1. Ratios of the Menopause Symptoms/Complaints of the Participants (N=120)

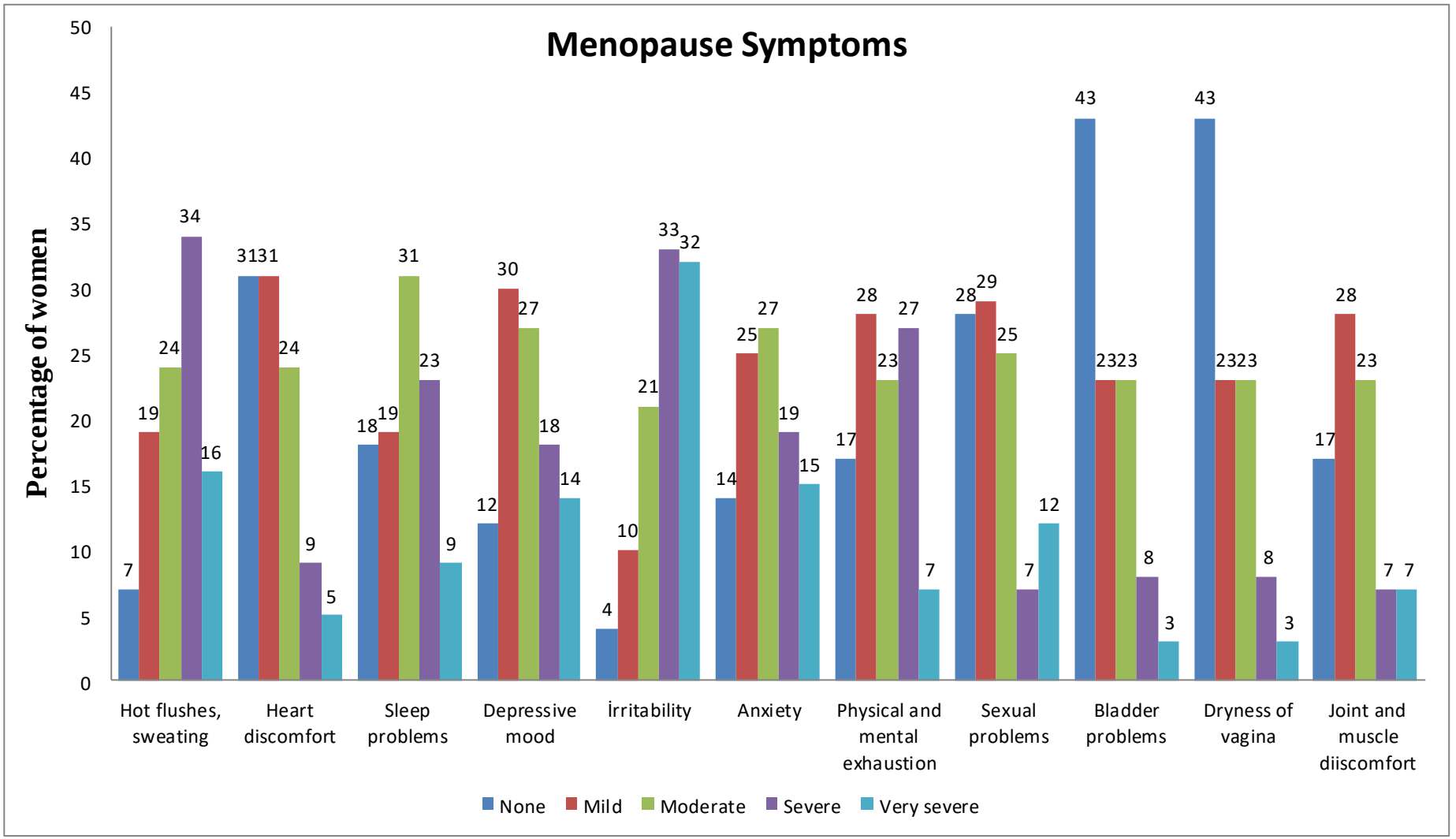

Table 2. Distribution of the MRS and AFMS Score Averages of the Participants According to their Menopause Perceptions (N=120)

Menopause			MRS	AFMS
		n	Mean± SD	Mean± SD
It's a normal process	**Yes**	94	18.60±8.82	44.43±10.96
	No	26	21.61±8.60	46.88±9.26
	Test Value		t=-1.54; p=.12	t=-1.04; p=.30
It makes me feel old.	**Yes**	74	20.28±8.88	48.01±9.73
	No	46	17.60±8.58	39.95±10.21
	Test Value		t=1.62; p=.10	t=4.29; **p=.001**
It makes me more mature.	**Yes**	36	16.50±8.87	44.86±12.08
	No	84	20.44±8.59	45.01±10.01
	Test Value		t=-2.28; **p=.02**	t=-.07; p=.94
It is a loss of femininity.	**Yes**	52	20.96±8.58	50.09±9.50
	No	68	17.95±8.85	41.02±9.70
	Test Value		t=1.86; p=.06	t=5.11; **p=.001**
It is a(n) decrease/end of sexuality.	**Yes**	46	21.89±9.75	49.39±9.08
	No	73	17.68±7.99	42.36±10.54
	Test Value		t=2.58; **p=.01**	t=3.72; **p=.001**
It is the end of the fertility.	**Yes**	77	19.87±8.57	45.93±10.39
	No	43	18.16±9.26	43.20±10.82
	Test Value		t=1.01; p=.31	t=1.35; p=.17
It is like an illness.	**Yes**	5	23.00±4.74	50.69±4.50
	No	115	19.09±8.94	44.71±10.71
	Test Value		t=.96; p=.33	t=1.22; p=.22

MRS: *Menopause Rating Scale; AFMS: Attitude For Menopause Scale*

MRS score average was found to be higher among those who don't consider menopause to be maturity and those who consider it to be reduction/end of sexuality. AFMS score average was found to be high among those who consider menopause to be the feeling to be old, loss of female characteristics and reduction/end of sexuality (Table 2).

In the study, a positive and weak relation was found between MRS and all dimensions of this scale as well as between the age of the participant and the AFMS score. Besides, a similar relationship was found between AFMS, MDSD and the sub-dimensions while there was no relation between the age of the participant entering menopause and any of the scales (Table 3).

Table 3.The Relation between the AFMS and MRS, SC, PC and UC Scores and the Age and the Age Entering Menopause (N=120)

Characteristics		AFMS[a]	MRS[a]	SC[b]	PC[a]	UC[b]
Age	**r**	0.210*	0.350**	0.321**	0.345**	0.216**
	p	**0.02**	**0.001**	**0.001**	**0.001**	**0.01**
Age Entering Menopause	**r**	0.153	0.039	0.166	0.048	-0.08
	p	0.13	0.70	0.10	0.63	0.41
AFMS	**r**	1	0.372**	0.293**	0.351**	0.235**
	p	-	**0.001**	**0.001**	**0.001**	**0.01**

[a]Pearson correlation analysis, [b]Spearman Correlation analysis, [*]Level of significance

4. DISCUSSION

The menopause perception, menopause symptoms and the attitude on these symptoms are an important issue of woman health that needs to be taken into consideration concerning offering and providing health services (Koyuncu et al., 2015).

In the present study, the average age of women in entering menopause was found to be 45.84±3.45 (35-55), and 78.3% of the participants consisted of individuals who entered menopause. The ratio of those who know about menopause is 40% while 27.1% of women don't tell anyone about their menopausal problems. 21.3% of the participants stated that they use symptomatic medications for their menopausal problems. The ratio of the participants receiving HRT is 15.0%. The average age for entering menopause was stated to be 45.1±1.52 in the study of Koc and Saglam, 47.74± 2.15 in the study of Ozgur et al., and 47.7± 4.5 in the study of Uludag et al (Koc and Saglam, 2008; Ozgur et al., 2010; Uludag et al., 2014). In the 2008 data of Turkey Population and Health Research (TPHR), the menopause age average of women in Turkey was stated to be 49 while the 2013 data indicated that the percentage of women in menopause increased by age from 1% in the beginning of the 30s to 49% in the ages of 48 to 49 (TPHR, 2008; Ozer and Gozukara, 2016). The ratio of women receiving HRT is 19.8% in the study of Koc and Saglam; 14% in the study of Uludag et al. and 4% in the study of Ozer and Gozukara (Koc and Saglam, 2008; Uludag et al., 2014; Ozer and Gozukara, 2016). The ratio differences were considered to be related to the region of the study. The study with the lowest ratio is the South-eastern Region of Turkey which is rather lower than the desired level concerning the socio-cultural health perception (Koc and Saglam, 2008; Uludag et al., 2014; Ozer and Gozukara, 2016). The study by Irmak Vural and Balcı Yangın on the comparison of Turkish and German women, the ratio of receiving HRT was found to be 23.1% in Turkish women and 31.3% in German women. The ratio of receiving information about menopause was found to be close in both groups (Irmak Vural and Balcı Yangın, 2016).

78.3% of the women stated that they found the menopause to be a normal process, 61.7 be the beginning of feeling old, 30.0% a process of maturity, 43.3% end of female characteristics, 38.7% a reduction/end of sexuality, 64.2% end of fertility and 4.2% a disease. The study by Koc and Saglam reported that the approach of the 57% of women towards the concerned phase is negative while the study of Ozer and Gozukara indicated that the 96.7% of the participants have positive feelings (not giving birth and end of menstruation) (Koc and Saglam, 2008; Ozer and Gozukara, 2016). In the study by Sis Celik and Pasinlioglu, 35.0% of women stated menopause to be a normal process, 60.8% to be the beginning of feeling old and 41.8% to be the end of fertility. The same study didn't find any difference between the MRS score averages and views about menopause of the women (Sis Celik and Pasinlioglu, 2015). The study by Irmak Vural and Balcı Yangın found that the menopause perceptions of the Turkish women were more positive than the German women (Irmak Vural and Balcı Yangın, 2016). Studies comparing the women in the Eastern and Western cultures indicated that Eastern women considered menopause to be a normal process and had more positive attitudes (Koc and Saglam, 2008). A study in China reported that the women had a more

positive approach towards menopause (Li et al., 2016). It is reported that the American Latin women defined menopause to be "Cambio de Vida", i.e. a natural condition that one has to experience without any intervention while the Irish women considered the process an annoying and unexpected condition (Hall et al., 2007). Chinese women consider the process to be a particular phase of life (Astbury-Ward, 2003). 65% of the German women have a positive view about menopause (Kowalcek et al., 2005). In Asian countries, menopause is accepted to be the beginning of freedom (Irmak Vural and Balcı Yangın, 2016).

38.7% of the participants in the study stated that they considered menopause to be the reduction/end of sexuality. Those with this perception had high score averages in both MRS and AFMS ($p<0.05$; Table 2). Studies in Turkey reported the loss of sexual drive in the pre-, peri-and postmenopausal periods to be respectively 35%, 55% and 60% (Demirel Bozkurt and Sevil, 2016). Similarly, in the study of Sözeri Varma et al., problems in sexual satisfaction were determined with menopause and this was explained as "it becomes clear that the reproduction function of individuals ends with the impact of cultural references as the years in menopause increase and the process means staying away from sexuality for some women" (Sozeri Varma et al., 2006).

The score averages of the scores used in this study are 19.25 ± 8.82 in MRS, 3.60 ± 1.93 in SC, 12.10 ± 5.52 in PC and 3.55 ± 2.89 in UC. The study by Sis Celik and Pasinlioglu (2014) revealed higher score averages in all of these values (MRS: 22.67 ± 8.06, SC: 4.19±2.08, PC: 13.12±4.59, UC: 5.35±3.09) (Sis Celik and Pasinlioglu). In the study by Uludag et al., (MRS score average is 16.3±8.9 (0-38) and lower than the value in the present study (Uludag et al., 2014). The reason for this is considered to be cultural differences, and the culture of the individuals is emphasised in the literature to be important with regards to menopause perception (Abay and Kaplan, 2015).

It was reported that the participant in the study didn't have urination problems and vaginal dryness complaints; had mild complaints of physical and mental fatigue; moderate sexual, joint and muscle problems and severe sleep issues and anxiety. None of the problems was reported to be very severe (Figure 1). The study by Sis Celik and Pasinlioglu reported sleep problems, nervous temperament, anxiety, sexual problems, urination problems and symptoms of vaginal dryness to be mostly in moderate levels (Sis Celik and Pasinlioglu, 2014). The difference of results is linked to the difference of receiving HRT by the participants while it is also reported in the literature that menopause symptoms were lower in the use of HRT (Ozcan and Oskay, 2013).

The study found the difference between the PC subscale and the education level, place where the most of life is spent, having a chronic disease and having knowledge about menopause ($p<0.05$). PC score average was found to be lower in the people with low education levels and who spend most of their lives in urban regions. Lower PC values in urban women are associated with the fact that they receive treatment due to their menopause based problems. The score averages of the participants in the PC dimension in this study were found to be close to half due to the menopause phase. The study by Yüksel Kocak reported that 6.9% of the women in the menopause phase received psychological support (Yüksel Kocak, 2017). In the study by Zıvdır and Sohbet, it was reported that 6.6% of women had psychological problems due to menopause and 87.8% had both physical and psychological problems, the

feelings of guilt and embarrassment due to menopause were reported to be higher than the average and the ratio of the women who stated that their respectability was reduced because of menopause to be 10% (Zıvdır and Sohbet, 2017). In the study by Bayraktar and Ucanok, they viewed the menopause perception through the perspective of the place where the majority of the lives of the participants is spent (living in the east/west) and emphasized higher tendency of the women living in the east to consider the process to be a natural mechanism (Bayraktar and Ucanok, 2002).

Concerning the scores of the MRS and subgroups, the variables including age, marital status, family type, finding themselves psychologically strong, having a child, participating in family decisions, perception about the economic condition of the family, smoking and alcohol consumption ($p>0.05$). Similar to the present study, the study by Sis Çelik and Pasinlioğlu found no difference between the MRS score averages and the variables of age, education level, employment status, family type and receiving HRT (Sis Celik and Pasinlioglu, 2014) while the study by Uludağ et al. found no difference concerning age and education level (Uludag et al. 2014).

Similarly, the variables including age, education, marital status, having a child, family type, place where the majority of life is spent, participation in the family decisions, finding oneself psychologically strong, perception on the economic condition of the family, smoking and alcohol consumption were not found to be significant with respect to the AFMS scores ($p>0.05$). Differently, from the present study, it is stated in the literature that the high education level and older age have a positive effect on the attitude towards menopause while the socio-economic qualities are significant in negative symptoms (Koc and Saglam, 2008).

5. CONCLUSION AND RECOMMENDATIONS

Women in the study having generally positive attitudes toward menopause and with low levels of symptoms. It was seen that they didn't have very severe menopause symptoms. Age, marital status, family type, finding oneself physiologically strong, finding oneself psychologically strong, having a child, participation in the family decisions, perception on the economic condition of the family, smoking, and alcohol consumption were not found to be significant with respect to the menopause symptoms. The development of culturally tailored programs for women, specifically on menopause, can be incorporated with existing primary health care to provide specific care and equip such women with adequate information and coping strategies to increase their preparedness for menopause and maintain a high quality of life.

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