Help-seeking Behavior in Taiwanese Woman with Menopause-related Mood Symptoms

Mei-Chun Hsiao[1,3], MD; Pi-Hui Chiang[4], MS; Chia-Yih Liu[1,2], MD; Yi-Hsiung Lin[1], MD

Background: Typical menopause-related symptoms sometimes mimic cardiovascular illnesses or other physical problems. It is essential to understand the help-seeking behaviors of menopausal women.

Methods: A total of 181 subjects were recruited from our menopause-related mood clinic. A questionnaire which included patient data and help-seeking questions was used. All help-seeking information was documented in chronological order up to register in the menopause-related mood clinic.

Results: The average latency from the onset of menopausal symptoms to seeking evaluation at our specialty clinic was 16.8 ± 27.7 months. The first contact was a gynecologist (28.2%), general practitioner (15.5%), cardiologist (6.1%), and psychiatrist (6.1%). The most common contacts were gynecologists (37.0%), followed by general practitioners (28.2%), psychiatrists (16.0%), and cardiologists (11.6%).

Conclusions: Gynecologists, general practitioners, cardiologists, and general psychiatrists are all potential gatekeepers for menopausal women. It is important to increase the public's understanding of menopause and improve cooperation between the various providers of women's mental health to cut medical insurance costs and improve the quality of care.

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Key words: menopause, symptoms, treatment, help-seeking, psychiatrists

Menopausal women experience both physical symptoms and changes in mood due to fluctuations in estrogen levels.[1] Many menopausal women seek a variety of health care services to alleviate their symptoms.

Consulting professional help is a decision-making process consisting of four stages (Fig. 1).[2] First is the perception of symptoms, where biological, individual, and social factors are catalyzed. The pathway from internal information to somatic and emotional sensations is influenced by external information as well as by selective attention to body, both referring to the sociocultural context. Whether these sensations are attributed to symptoms of somatic or emotional distress, or to a normal response to environmental conditions, largely depends on the subjective meaning of these sensations.[3] In a study on help-seeking behaviors of Chinese Americans, those with anxiety or depressive symptoms were remarkably less likely to seek professional help than those with somatized symptoms.[4]

Sometimes vasomotor symptoms are mistaken

From the [1]Department of Psychiatry; [2]Neuroscience Research Center, Chang Gung Memorial Hospital, Taipei, Chang Gung University College of Medicine, Taoyuan, Taiwan; [3]Department of Tradition Chinese Medicine, College of Medicine, Chang Gung University, Taoyuan, Taiwan; [4]Family Education Graduate School, Chiayi University, Chiayi, Taiwan.

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Correspondence to: Dr. Mei-Chun Hsiao, Department of Psychiatry, Chang Gung Memorial Hospital. 5, Fusing St., Gueishan Township, Taoyuan County 333, Taiwan (R.O.C.) Tel.: 886-3-3281200 ext. 2439 Fax: 886-3-3280267; E-mail: norase@cgmh.org.tw

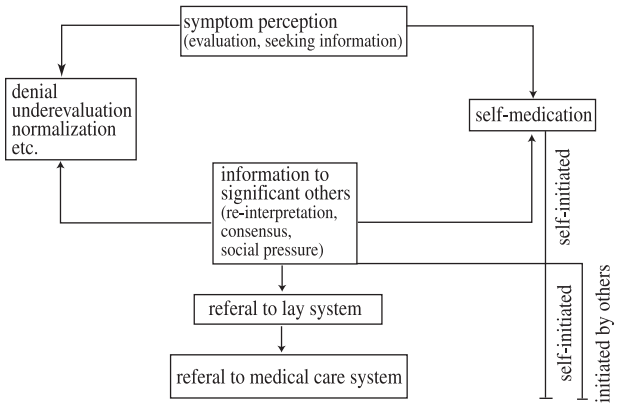

Fig. 1 Stages of help-seeking (adapted from Moller-Leimkuhler, 2002[2])

for panic disorders[5] or other serious medical illnesses.[6,7] Therefore, menopausal women may spend considerable time and incur significant costs in the pursuit of an appropriate medical clinic from which to receive treatment. Some studies have reported that the number of health care consultations increase in women during the menopause transition[8,9] and this places an enormous burden on the health care system. For a more efficient health care system, it is therefore important to understand the nature of help-seeking behaviors among these menopausal women.

The current study investigated the help-seeking behaviors of women with menopause-related symptoms who were currently patients at a specialty menopause-related mood clinic in Taiwan. The aims of this study were as follows: (1) to determine the number of professional contacts made for menopausal symptoms, (2) to record the time that elapsed from the onset of symptoms to the first professional contact, (3) to identify the gatekeepers involved in menopausal health care, and (4) to characterize patients' help-seeking behaviors with respect to different medical specialists. In so doing, we hope to lower health care costs and shorten the duration of time women have distiessing menopausal symptoms.

METHODS

Subjects

The study was conducted as part of the women's mental health program of Chang Gung Medical Center. A total of 223 women sought treatment for menopause-related symptoms at our specialty mood clinic between July 2003 and June 2004. Two senior psychiatrists affiliated with the women's mental health program were in charge of the specialty clinic, and two senior gynecologists were consulted when women reported gynecological problems or had hormone therapy issues. All participants who were recruited provided written informed consent. Most of the subjects were self-referred from local advertisements and the clinic's internet homepage (72.2%). The remainder of the subjects were referred by their primary care physicians (11.2%), general psychiatrists (9.8%) or gynecologists (6.7%).

Assessment

Each subject completed a questionnaire at their initial visit to the specialty mood clinic that elicited patient data, height and weight, personal and family histories, medical and gynecological histories, and current menstrual pattern. It was required that the participant's chief complaints included at least one moderate-to-severe or two mild symptoms from the menopause rating scale (MRS).[10]

Information about the course leading to definitive care was collected through another questionnaire during an interview with a senior mental health professional. All help-seeking information, including the interval between the onset of symptoms and the initial contact with a medical professional and a comprehensive list of the medical professionals that the subject contacted, were documented in chronological order up to the time of the menopause-related mood clinic visit.

Following completion of the questionnaires, the participants were asked to complete two self-rating scales: (1) the MRS to evaluate the severity and characteristics of subject's classic menopausal symptoms and (2) the hospital anxiety and depression scale (HADS),[11] to evaluate the subject's emotional status. Finally, we determined the subject's blood levels of estradiol and follicle-stimulating hormone (FSH) to further define their menopausal stage.

The MRS is a self-rating scale for the assessment of menopausal complaints. It has been proved to have good applicability and reliability. It consists of 11 symptom items. Each symptom item is rated on a 5-point scale, (none, mild, moderate, marked, and severe) and is scored from 0 (none) to 4 points (severe symptoms). The total score of the MRS

ranges between 0 (asymptomatic) and 44 (highest degree of complaints).

The HADS was developed to assess anxiety and depression in patients with physical diseases. It consists of seven items for anxiety (HADS-A) and seven for depression (HADS-D). Each item is scored by the patient on a four point scale (0-3) so possible scores range from 0 to 21 for anxiety and 0 to 21 for depression.

Menopausal stage

In the current study, we defined three menopausal stages:[12] (1) premenopause, characterized by an irregular menstrual pattern and a FSH < 25 IU/L, (2) perimenopause, with an irregular menstrual pattern and a FSH ≥ 25 IU/L, and (3) menopause, > 12 cycles of amenorrhea and a FSH ≥ 25 IU/L.

Definition of help-seeking behaviors

We used three points and two stages to describe the help-seeking process. The three points were, (1) the onset, when menopausal symptoms were first recognized. (2) the time of contact, when the subject had her first professional medical consultation, and (3) the time of treatment, when the subject enrolled in the specialty mood clinic. The two stages were: (1) contact delay (CD), the interval of time between the onset of symptoms and the time of professional contact and (2) treatment delay (TD), the interval of time between the onset of symptoms and the time when treatment was initiated. Help-seeking behaviors were evaluated by the following: (1) CD and TD, (2) the number of professional contacts made before enrollment in the specialty mood clinic, and (3) the first professional contacted and the number of professionals contacted prior to enrollment in the specialty mood clinic.

Statistical analysis

Patient data, including age, body mass index (BMI), living situation, marital status, years of education, number of children, employment status, menopausal stage, hormone therapy use, and self-rating scales, were reported using descriptive statistics.

The chi-square test was used to analyze categorical variables. One-way ANOVA and the post-hoc Scheffé test were used to analyze continuous measures. A p-value < 0.05 was considered statistically significant. Statistical analyses were performed using the Statistical Package for the Social Sciences for Windows, version 10.0 (SPSS, Inc., Chicago, IL, U.S.A.).

RESULTS

Patient data

A total of 181 subjects completed the questionnaires, for a response rate of 81%. The majority of subjects in the study were married (85.1%) and not employed outside the home (48.6%), with a mean age of 49.8 ± 5.9 years. The subjects had a mean 8.4 ± 4.4 years of education. Table 1 shows the patient data and scores on MRS and HADS. The MRS and HADS were completed by 165 and 170 of the subjects, respectively.

Table 2 shows patient and gynecological data.

Table 1. Patient Data (N = 181) and MRS and HADS Scores

Variables	Mean ± SD	Range
Age (years)	49.8 ± 5.9	(39.0 – 67.0)
Body height (cm)	156.3 ± 4.5	(145.0 – 177.0)
Body weight (kg)	57.0 ± 7.5	(36.0 – 85.0)
BMI	23.3 ± 3.0	(14.4 – 34.0)
Years of education	8.4 ± 4.4	(0 – 18.0)
Numbers of children	2.6 ± 1.3	(0 – 6)
Estradiol (μg/dL)	58.1 ± 65.0	(1.8 – 351.8)
FSH (IU/L)	39.5 ± 35.5	(1.7 – 199.7)
MRS scores		
Total	16.19 ± 7.93	(1 – 14)
Psychological	7.11 ± 3.68	(0 – 16)
Somatovegetative	5.83 ± 3.15	(0 – 16)
Urogenital	3.30 ± 2.90	(0 – 12)
HADS scores		
Total	19.37 ± 8.77	(0 – 41)
Anxiety	10.19 ± 4.57	(0 – 23)
Depression	9.22 ± 4.65	(0 – 20)

Abbreviations: BMI: Body mass index; FSH: Follicle-stimulating hormone; MRS: Menopause rating scale; HADS: Hospital anxiety and depression scale.

Table 2. Patient Data and Gynecological History (N = 181)

Variables	Frequency (%)
Marital status	
Married	84.5
Single	4.4
Widowed/Separated/Divorced	10.6
Occupation	
Married, not employed outside of home	48.6
Full-time, employed outside of home	28.2
Part-time, employed outside of home	1.7
Unmarried, not employed outside of home	21.5
Living situation	
Metropolis	43.1
Urban	54.1
Rural	2.8
Gynecologic history	
Yes	34.8
No	65.2
Hysterectomy	
Yes	14.9
No	85.1
Menopausal stage	
Premenopause	38.1
Perimenopause	14.9
Menopause	47.0

Help-seeking behaviors

The mean CD and TD were 2.3 ± 13.7 and 16.8 ± 27.7 months, respectively. The mean number of contacts before registration in the specialty mood clinic was 1.1 ± 1.2.

The first professionals contacted were gynecologists (28.2%), general practitioners (15.5%), cardiologists (6.1%), and psychiatrists (6.1%). If all the health professionals that had been contacted before the index visit were considered, the most common professionals contacted were gynecologists (37.0%), followed by general practitioners (28.2%), psychiatrists (16.0%), and cardiologists (11.6%). There were no statistically significant differences in help-seeking behaviors and the characteristics of the women; specifically, there were no differences in age, BMI, years of education, number of children, marital status, occupation, living situation, estradiol and FSH levels, gynecological or pelvic surgical histories, or menopausal stage.

MRS and HADS and medical specialties

Interestingly, we found that subjects who had visited a gynecologic clinic had higher MRS somatovegetative scores (6.48 ± 3.08) than those who had never visited a gynecologic clinic (5.44 ± 3.15; $p < 0.05$); however, there were no statistical differences in the other dimensions of the MRS, HADS, and other medical specialties. We also found no statistically significant differences when comparing MRS and HADS scores with help-seeking behavior, including CD, TD, and the number of professional contacts.

DISCUSSION

The course to care

The current study was a novel attempt to determine which healthcare professional symptomatic menopausal women first visit for treatment. In our study, when women were aware of their physical symptoms related to menopausal transition, they visited a gynecologic clinic, especially those with a high somatovegetative score on the MRS. But sometimes, menopausal symptoms are nonspecific and vague. For example, in the case of musculoskeletal symptoms, palpitations, or polyuria, women did not know where to seek assistance, so they frequently visited general practitioners first. Moreover, we found that menopausal women with cardiovascular symptoms visited cardiologists first and women with mood symptoms visited psychiatrists directly. Also, a portion of Taiwanese women sought the help of traditional Chinese medicine practitioners as their first contact.

We did not find statistical differences between the MRS and HADS scores and other demographic data elicited in this study, possibly because the sample size was not large enough or not all women completed the self-rating MRS and HADS. It was noted during the interview that many menopausal women, especially those with a high anxiety-tone, had no patience or tolerance to respond to a series of questions. This may have served as a limitation in the

collection of more data in our study as well.

We also found that the CD was much shorter than the TD. We suspect this finding may be due to women with severe anxiety who had multiple somatic discomforts seeking medical assistance sooner.

Comparison with other studies

Montero et al.[13] reported that the typical 45-to-55 year old women seeking gynecological care for climacteric complaints was married and a housewife, and had children older than 14 years. Our inability to verify these differences may be due to different methods and research design and the different characteristics of family and social support systems in a different culture. Barlow et al.[14] reported that more women with hysterectomies had more than one consultation to discuss issues related to the climacteric than women without hysterectomies. Morse et al.[15] also noted that those being treated for menopausal symptoms were more likely to have undergone surgical menopause, defined as amenorrhea due to surgical removal of the uterus and/or ovaries. The lack of a statistically significant difference in our study between help-seeking behaviors and a hysterectomy may have been due to the limitation of the sample size.

Clinical implications

In 1992, the maximum number of women seeking consultation for menopausal symptoms in the United States was 15%.[16] In Australia, 86% of the 45-55 year old women in a 9-year study by Guthrie et al consulted a physician about menopausal symptoms.[8] We believe that the number of professional healthcare consultations in Taiwan may also be increasing in women during the menopause transition, and this will put a burden on the health insurance system. Subsequent to the recent media report of the Women's Health Initiative,[17] women have been more anxious about the indications for and use of hormone therapy. Some women visit a medical clinic only for information and counseling.[8] In Taiwan, women hope to find a caring and understanding physician who will carefully explain any health-related issues to them.[18] So, it is important to raise the awareness of menopausal symptoms and associated information about hormone therapy to the public and all primary care physicians. We also agree with the suggestion by Garnett et al. who encouraged general practitioners to take more responsibility in their care of menopausal women.[19] We further identified the possible gatekeepers in our study as gynecologists, general practitioners, cardiologists, and general psychiatrists. Establishing a stronger referral system or a combined menopausal clinic with different medical specialties should therefore be seriously considered in Taiwan.

Greater cooperation in the multidisciplinary care of women's mental health could help menopausal women and the medical insurance system reduce unnecessary medical costs. Further studies are needed with a larger sample size to identify different patient characteristics in different cultures and in other medical specialties.

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REFERENCES

1. Archer JS. NAMS/Solvay Resident Essay Award. Relationship between estrogen, serotonin, and depression. Menopause 1999;6:71-8.
2. Moller-Leimkuhler AM. Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. J Affect Disord 2002;71:1-9.
3. Shields SA, Mallory ME, Simon A. The Body Awareness Questionnaire: reliability and validity. J Pers Assess 1989;53:802-15.
4. Kung WW, Lu PC. How symptom manifestations affect help seeking for mental health problems among Chinese Americans. J Nerv Ment Dis 2008;196:46-54.
5. Pacchierotti C, Castrogiovanni A, Cavicchioli C, Luisi S, Morgante G, De Leo V, Petraglia F, Castrogiovanni P. Panic disorder in menopause: a case control study. Maturitas 2004;48:147-54.
6. Guthrie JR, Smith AM, Dennerstein L, Morse C. Physical activity and the menopause experience: a cross-sectional study. Maturitas 1995;20:71-80.
7. Jokinen K, Rautava P, Makinen J, Ojanlatva A, Sundell J, Helenius H. Experience of climateric symptoms among 42-46 and 52-56-year-old women. Maturitas 2003; 46:199-205.
8. Guthrie JR, Dennerstein L, Taffe JR, Donnelly V. Health care-seeking for menopausal problems. Climacteric 2003;6:112-7.

9. Porter M, Penney GC, Russell D, Russell E, Templeton A. A population based survey of women's experience of the menopause. Br J Obstet Gynaecol 1996;103:1025-8.
10. Schneider HP, Heinemann LA, Rosemeier HP, Potthoff P, Behre HM. The Menopause Rating Scale (MRS): reliability of scores of menopausal complaints. Climacteric 2000;3:59-64.
11. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. Acta Psychiatr Scand 1983;67:361-70.
12. Randolph JF Jr, Sowers M, Bondarenko IV, Harlow SD, Luborsky JL, Little RJ. Change in estradiol and follicle-stimulating hormone across the early menopausal transition: effects of ethnicity and age. J Clin Endocrinol Metab 2004;89:1555-61.
13. Montero I, Ruiz I, Hernandez I. Social functioning as a significant factor in women's help-seeking behaviour during the climacteric period. Soc Psychiatry Psychiatr Epidemiol 1993;28:178-83.
14. Barlow DH, Brockie JA, Rees CM. Study of general practice consultations and menopausal problems. BMJ 1991;302:274-6.
15. Morse CA, Smith A, Dennerstein L, Green A, Hopper J, Burger H. The treatment-seeking woman at menopause. Maturitas 1994;18:161-73.
16. McKinlay SM, Brambilla DJ, Posner JG. The normal menopause transition. Maturitas 1992;14:103-15.
17. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women. JAMA 2002;288:321-33.
18. Tsao LI. Relieving discomforts: the help-seeking experiences of Chinese perimenopausal women in Taiwan. J Adv Nurs 2002;39:580-8.
19. Garnett T, Mitchell A, Studd J. Patterns of referral to a menopause clinic. J Roy Soc Med 1991;84:128-30.

某台灣更年期身心門診婦女之求醫行爲探討

蕭美君[1,3] 姜丕慧[4] 劉嘉逸[1,2] 林義雄[1]

背 景： 更年期身心症狀眾多，有時又疑似心臟血管疾病之症狀表現。一般大眾婦女因欠缺足夠瞭解，會有不同求醫行爲呈現。本研究主要在探討某台灣更年期身心門診初診婦女，之前因身心不適之求醫途徑及行爲。

方 法： 181 名婦女接受個別問卷調查，包含所有相關人口學資料、疾病史、家族史及關於更年期不適之仔細求助途徑及求醫行爲前後過程調查。並給與醫院焦慮及憂鬱量表，評估焦慮及憂鬱分項分數。

結 果： 個案出現更年期症狀到首次求助平均時間爲 16.8 ± 27.7 個月。前五項首次求醫科別分別爲：婦科 (28.2%)，一般科診所 (15.5%)，心臟科 (6.1%)，及精神科醫師 (6.1%)。最常求助對象之多寡次序爲婦科 (37.0%)，一般科診所 (28.2%) 精神科 (16.0%)，及心臟科醫師 (11.6%)。以上次序與年齡、教育程度、過去疾病史 (含婦科、精神科、心臟科)、婚姻狀態、及子宮切除等等相關人口學及過去疾病史，無明顯統計關聯性。與量表評估之憂慮及焦慮嚴重程度也沒有明顯統計關聯。而造訪過婦產科門診的個案比從未看過婦產科門診之個案在更年期量表之身體生理 (somatovegetative) 分項分數有較高的分數 (即較多較明顯之症狀)。

結 論： 本研究指出婦科、一般科、心臟科、及精神科醫師都是可能的更年期身心不適的健康守門員。增進大眾對更年期之認識與衛教是重要且必須的；而促進各科際不同醫療人員之合作，可以降低婦女因過度或不當求醫造成之醫療費用與資源花費，並增進更年期婦女之照護品質。

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關鍵詞： 更年期，症狀，治療，求助行爲，精神科醫師

長庚紀念醫院 台北院區 [1]精神科，[2]神經醫學研究中心；長庚大學 醫學院 [3]中醫系；[4]國立嘉義大學 家庭教育研究所
受文日期：民國96年7月19日；接受刊載：民國97年7月14日
通訊作者：蕭美君醫師，長庚紀念醫院 精神科。桃園縣333龜山鄉復興街五號。Tel.: (03)3281200轉2439;
Fax: (03)3280267; E-mail: norase@cgmh.org.tw