International Journal of Nursing
December 2016, Vol. 3, No. 2, pp. 69-78
ISSN 2373-7662 (Print) 2373-7670 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/ijn.v3n2a10
URL: https://doi.org/DOI: 10.15640/ijn.v3n2a10

Women's Menopause-Related Complaints and Coping Strategies: Manisa Sample

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Abstract

The purpose of the study was to identify health problems suffered by menopausal women and alternative coping methods used by them. The study is a descriptive cross-sectional one. The population of the study comprised 45-59-year-old women enrolled in the third family health center in Manisa (n = 629). The minimum sample size was calculated using 50% of prevalence and 4% margin of error at the 95% confidence interval and was found to be 239.In the study, the Socio-Demographic Questionnaire, Coping with Menopausal Symptoms Questionnaire and Menopause Rating Scale were used. To analyze the data, descriptive statistics and the chi-square test were used. The women's mean age was 51.7 ± 3.9. Of the participating women, 94.6% went through the menopause, 50.6% were knowledgeable about the menopausal period, 41.4% learned about menopause from friends or other people around and 72.8% never receive any menopause-related drug therapy. Alternative treatment methods used by women suffering menopause symptoms were as follows: having sage tea for hot flashes and sweating (35.6%), having herbal tea for nervousness (44.4%), eating almonds, hazelnuts, walnuts, apricots and raisins for physical and mental fatigue (53.1%). It was found that menopausal women suffered a lot of physical and psychological problems and used several alternative methods for coping

Keywords: Menopause, women, complementary therapy

1. Introduction

One of the natural changes experienced by middle-aged women is menopause (Dökmen, 2009). As defined by the relevant committee of the World Health Organization (WHO), menopause is "the permanent cessation of menstruation due to the loss of ovarian follicular activity" (Özkan, 2008). Menopause is characterized with the reduction in estrogen and progesterone levels and may cause such symptoms as hot flushes, night sweats, vaginal dryness, sexual apathy, sleep disturbances, uneasiness, depression, anxiety, nervousness, headaches, forgetfulness and fatigue (Greene, 1998; Stadberg, et al. 2000; Kronenberg and Berman, 2002; Huffman, et al. 2005; National institutes of health, 2005; Borrelli and Ernst, 2010).

With the increase in the life expectancy, a woman spends almost a third of her life in menopause (Poomalar and Arounassalame 2013). Menopause is a current issue, and is becoming increasingly a matter of interest. Nursing approaches consist of supportive opinions, careful assessment and training. Nurses should fulfill their educational roles by enlightening women about premenopausal and postmenopausal symptoms and providing guidance (Şirin, 1995). To eliminate or at least to alleviate the symptoms of menopause, women and healthcare professionals should know which complementary and alternative medical treatments are the safest and most effective (National institutes of health, 2005).

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Non-representative surveys in many countries have suggested that there is a high use of complementary and alternative medicine (CAM) (MacLennan, et al. 2006). While some women never receive any hormone replacement therapy (HRT), some discontinue their treatment.

The reason why women are reluctant to receive HRT during the postmenopausal period is that it is unnatural and is of various complications (Glazier and Bowman, 2001). Efforts to prevent postmenopausal diseases and to raise awareness of these diseases in women are greatly affected by cultural differences. In the literature, studies conducted on physical and biological changes during menopause in different ethnic groups are not many (Özkan, 2008). Women often prefer treatment methods consistent with their culture (Amanak, et al. 2013). These methods include acupuncture, yoga, relaxation, exercise, herbal therapy, traditional therapy, vitamin, mineral or nutritional supplements, phytoestrogens, homeopathy, chiropractic, and aromatherapy (MacLennan, et al. 2006; Glazier and Bowman, 2001; Amanak, et al. 2013; Kang, et al. 2002). Therefore, these should be taken into account while healthcare is planned (Özkan, 2008).

This study was planned to create a database for healthcare services by identifying menopause-related health problems of women living in Manisa and the alternative methods they use to overcome these problems.

2. Materials And Methods

The study was designed as a cross-sectional descriptive study. Research data were collected between September 2013 and December 2013. The study population comprised 45-59-year-old women (N = 629) followed by the third family health center in Manisa. To estimate the sample size, the following values were used: 50% prevalence, and 5% margin of error at 95% confidence interval, and the smallest sample size was determined to be 239. In the first stage of sample selection, the number of individuals to be included in the sample was determined in proportion to the 45-59-year-old population followed by each of the eight family physicians working in the third Family Health Center. In the second stage individuals were randomly determined from household identification cards.

In the study, the socio-demographic questionnaire, coping with menopause symptoms questionnaire and Menopause Rating Scale were used.

The socio-demographic questionnaire consists of items questioning such characteristics of the participants as age, education, employment status, marital status etc.

The "coping with menopause symptoms" questionnaire questions self-, medical and alternative coping methods used by women to cope with the symptoms of menopause. This questionnaire was prepared by the researchers through a literature review.

The Menopause Rating Scale (MRS) was developed by Heinemann et al. and is composed of 11 items related to menopausal complaints. Each item is scored from 0 to 4 (0: no complaints, 1: mild symptoms, 2: moderate symptoms and 3: severe symptoms and 4: very severe symptoms). (ya da "0: not present, 1: mild, 2: moderate and 3: severe and 4: very severe).

The Likert-type scale has three sub-scales: somatic, psychological and urogenital complaints (Heinemann, et al. 2003). The validity and reliability of the Turkish version of the scale was performed by Gürkan (2005). Higher total scores obtained from the scale refer to the increase in the severity of the complaints and adversely-affected quality of life. While the internal consistency coefficient for the whole scale was determined as 0.84 in Gürkan's study (Gürkan, 2005), it was 0.81 in this present study.

The data obtained from the study were assessed using the SPSS 15.0 program. While descriptive statistics were used for the statistical analysis, the Chi-square test was used to compare scores obtained from the Menopause Rating Scale in terms of the socio-demographic characteristics.

Table 1: Some of the Socio-demographic Characteristics of the participants

Characteristic	N	%
Age		
45-49	82	34.3
50-54	91	38.1
55-59	66	27.6
Age distribution	51.7±3.9(45-59)	
Education		
Illiterate	105	43.9
Primary school	114	47.2
Junior high school	18	7.5
Senior high school	2	0.8
Marital Status		
Married	227	94.6
Single / widow / divorced	12	5.4
Social Security		
for self-employed workers and farmers	36	15.1
for private and public sector workers	111	46.4
for civil servants	36	15.1
for those who are not members of any of the above and cannot afford medical expenses (Green card)	31	13.0
No social security	25	10.5
Family type		
Nuclear	143	59.8
Extended	94	39.3
Broken	2	0.8
Perception of income		
Income equal to expenses	163	68.2
Income less than expenses	70	29.3
Income more than expenses	6	2.5
Total	239	100.0

Data analysis of the 239 women in terms of their socio-demographic characteristics revealed that of them, 47.2% were primary school graduates, 94.6% were married, 46.4% had for private and public sector workers type social security, 59.8% had a nuclear family and % 68.2 had income equal to expenses, and that their mean age was 51.7 ± 3.9 years.

Table 2: Menopause and Health Status Characteristics of the Participants

Characteristic	N	%
Entering the menopause		
Yes	227	94.6
No	12	5.4
Age distribution at entering the menopause	45.6±3.7(33-56)	
HRT usage		
Yes	26	10.9
Yes but discontinued	39	16.3
Never	174	72.8
Source of information about menopause		
Not knowledgeable	118	49.4
Friends	99	41.4
Health care providers	12	5.0
Mass media	9	3.8
She has a health-related profession	1	0.4
Chronic Diseases		
None	116	48.5
Hypertension	72	30.1
Diabetes	27	11.3
Goiter	6	2.5
Asthma	4	1.7
Heart Failure	8	3.3
Rheumatic diseases	6	2.5
Disability Status		
No	229	95.8
Yes *	10	4.2
Contagious disease		
No	237	99.2
Yes **	2	0.8
Smoking Status		
Still smoking	20	8.4
Never	199	83.3
Smoked but quit	20	8.4
Total	**239**	**100.0**

Walking, hearing*; hepatitis **

It was determined that of the women, 94.6% entered the menopause, 72.8% never took medication, 50.6% were knowledgeable about the menopausal period, 41.4% obtained this information from friends or people around them, 48.5% had no chronic disease, 95.8% had no disability, 99.2%, had no communicable diseases and 83.3% were not smokers.

Table 3: Comparison of the Scores the Women obtained from the Menopause Rating Scale in terms of some of their Socio-demographic Characteristics

Characteristics	N	Subscales of the Menopause Rating Scale			Total
		Psychological	Somatic	Urogenital	
Age					
≤50	121	6.2±3.2	7.4±3.1	2.5±2.0	16.2±7.4
≥50	118	4.8±3.1	6.9±2.9	2.1±2.1	13.9±7.0
*p		p<0.05	p>0.05	p>0.05	p<0.05
Education					
Illiterate	105	6.1±3.2	7.9±3.1	2.7±2.1	16.8±7.3
Primary school or above	134	5.0±3.1	6.6±2.8	2.0±2.0	13.7±7.0
*p		p<0.05	p<0.05	p<0.05	p<0.05
Employment status					
Employed	27	5.9±4.0	6.8±3.6	1.9±1.8	14.4±8.9
Unemployed	212	5.5±3.1	7.2±3.0	2.4±2.1	15.1±7.1
**p		p>0.05	p>0.05	p>0.05	p>0.05
Marital status					
Married	226	5.6±3.1	7.2±3.0	2.4±2.0	15.4±7.2
Not married	13	2.9±3.0	5.6±2.7	1.0±1.7	9.5±6.8
**p		p<0.05	p<0.05	p<0.05	p<0.05
Spouse					
Alive	188	6.0±3.2	7.6±3.0	2.6±2.0	16.3±7.1
Dead	39	4.2±2.7	5.7±2.8	1.3±1.7	11.3±6.1
*p		p<0.05	p<0.05	p<0.05	p<0.05
Social security					
Yes	214	5.8±3.1	7.3±2.9	2.5±2.0	15.7±7.0
No	25	2.9±2.6	5.7±3.7	1.0±1.5	9.6±7.2
**p		p<0.05	p<0.05	p<0.05	p<0.05
Perception of income					
Income meets expenses	169	5.9±3.1	7.4±3.0	2.5±2.1	15.9±7.2
Income does not meet expenses	70	4.5±3.2	6.6±3.0	1.8±1.9	12.9±7.1
*p		p<0.05	p<0.05	p<0.05	p<0.05
Menopause medication use					
Still uses (a)					
Used but quit(b)	26	5.0±2.7	5.6±2.2	1.8±1.6	12.4±5.1
Never used (c)	39	4.9±2.5	7.2±2.6	1.9±1.7	14.0±5.6
***p	174	5.7±3.4	7.4±3.2	2.5±2.2	15.7±7.8
**Post-hoc		p>0.05	p<0.05 a<b=c	p>0.05	p>0.05
Knowledge about menopause					
Yes	121	5.6±3.3	7.5±3.2	2.8±2.2	16.1±8.0
No	118	5.3±3.1	6.8±2.8	1.8±1.7	14.0±6.3
*p		p>0.05	p>0.05	p<0.05	p<0.05

**Student t-test; **Mann Whitney-U; ***Kruscall Wallis*

Higher scores indicate high levels of complaints

Analysis of the factors affecting the women's menopausal symptoms revealed that of the women the following had fewer menopausal complaints: those who were over 50 years old, graduates of primary school or above, employed (except in professions related to psychology), unmarried, not knowledgeable about menopause; whose husbands were dead; who had no social security, had income lower than expenses and took menopause-related medication (except in professions related to psychology) (Table 3).

Table 4: Women's Menopause-related Health Problems and Coping methods

HEALTH COMPLAINTS	COPING MEHODS					
	SELF-COPING	%	MEDICAL	%	ALTERNATIVE	%
Hot flashes, sweating	-A cooler environment -Cold drinks -Taking a shower -Wearing sweat-absorbing, non-nylon underwear	79.1 31.4 47.3 31.4	-Vitamin B -Vitamin E -Oral contraceptives	1.3 0.0 2.1	-Yoga and Meditation -Exercise -Soya beans -Sage tea	0.0 1.7 0.0 35.6
Angina pectoris (stenocardia) or palpitations	- Staying away from stressful, tense places and events - Loosening clothes -Sitting in comfortable place and resting	47.7 48.1 46	- If necessary, quitting the hormone therapy -Taking Omega 3 tablets -Taking one child aspirin a day	2.1 0.8 0.8	-Licorice tea -Chamomile tea -Oatmeal -Green tea -Sage tea	3.3 27.6 1.7 27.6 27.6
Early wake-ups or inability to go to sleep for a long time	-Sleep medicine -A quiet environment -Avoiding over-sleeping -Not having tea or coffee in the evenings -Having milk, yogurt etc. before going to bed	1.7 49 31.8 38.5 43.5	-Hormone therapy -Taking sleeping pills -Psychological support	2.1 1.7 3.8	-Sage tea -Parsley -Evening primrose oil -Black cohosh -Soya beans	32.2 21.3 0.0 1.3 0.0
State of malaise (feeling down, sad)	-Calling beloved ones -Getting rid of these feelings by cleaning the house -Having a shower	57.3 29.3 4.2	-Hormone therapy -Visiting a psychologist	1.7 3.8	-------	
Nervousness (irritability, tension and losing temper quickly)	-Drinking something warm -Staying away from Cigarettes, tea, coffee, alcohol and spicy foods -Taking a shower -Sharing the distress with other people.	29.3 19.7 21.3 47.3	-Hormone Therapy -Taking Sedatives -Vitamin B -Vitamin C -Vitamin E	2.9 1.3 0.0 0.8 0.0	-Herbal teas -Garlic pills	44.4 1.7
Worry, anxiety, restlessness, panic	-Crying to relax. -Sharing the problems with others. -Taking a shower.	60.7 38.9 2.1	- Hormone therapy - Taking antidepressants (sedatives) -Receiving psychological support	1.7 0.8 2.5	-Black cohosh -Jerusalem artichoke (sunroot, sunchoke, earth apple or topinambour)	0.8 2.1
Physical and mental fatigue	- Paying attention to diet, not skipping meals -Eating energizing foods -Doing sports	42.7 38.9 0.4	-Hormone replacement therapy	3.3	-Yoga, meditation etc. -Eating almonds, hazelnuts,walnuts, sun dried (apricot) and raisins	0.4 53.1
Decrease in sexual desire, difficulty in having sexual intercourse	-Talk to the spouse and asking to be understanding and helpful -Using hormone-containing suppository, etc. -Trying new things in the bedroom	40.2 0.0 7.9	- Hormone therapy - Using regional creams or suppositories - Receiving psychological support when necessary - Taking libido enhancing drugs	2.9 1.7 0.8 0.0	-Soya beans - Ginger -Fennel - Cloves - Licorice -Arugula	0.0 17.2 6.7 14.2 2.9 7.9
Urinary problems (difficulty in urinating, frequent urination, urinary incontinence)	-Taking medication -Having treatment -Having diuretic drinks such as tea, coffee less	7.5 2.5 37.2	-Receiving hormone therapy -Taking antibiotics when necessary	2.5 21.3	-Soya beans -Parsley	1.7 39.3
Vaginal dryness (dryness and burning sensation in the vagina. Difficulty during Sexual intercourse)	-Using lubricants to moisten the vagina -Using hormone-containing medication, suppository, etc. -Spending more time on foreplay	0.0 0.0 6.7	- Using hormone creams -Receiving hormone therapy	0.0 2.9	-Black cohosh -Consuming apples, carrots, peas, garlic, cherry and so on.	0.8 41.8
Joint and muscle disorders	-Paying attention to diet (eating foods rich in calcium, etc.) -To dress appropriately for the temperature - Taking medication	55.6 41.8 17.2	- Hormone therapy -Taking medication as ordered by the physician	3.8 7.1	-Vitamin K -Folic acid -Vitamin C -Vitamin D -Calcium -Vitamin B6	5 3.8 5.9 7.9 24.3 4.6

3. Discussion

In recent years, complementary and alternative treatments have become popular among menopausal women. Menopausal symptoms experienced by women are affected women's level of education, age, occupation, economic independence, income level, social class, marital adjustment, marital status, interest in other areas, family's size, knowledge regarding this period, role reversal and the value attributed to women by the society (Stadberg, et al. 2000, Özcan and Oskay, 2013). Of the women who participated in the study, 50.6% were knowledgeable about the menopausal period, and 41.4% learned about menopause from friends or other people around. In line with the findings of this study, almost half of the women obtained information about menopause, but only 5% of them were informed about menopause by medical professionals. Ertem (2010) reported that 62% of the women obtained information about the menopausal period and that of the knowledgeable women, while 70.4% obtained information from the TV, radio the media, only 6.5% were informed by medical professionals (Ertem, 2010). In Conboy's study, it was determined that of the women, 80.0% obtained health information from magazines and books, 60% from other women, 60% from the internet, 41% from the television and radio, 21% at the seminars (Conboy, et al. 2001). Yurdakul et al. reported that of the women, who participated in their study, 72.3% did not receive any health services and 61.4% did not obtain any information about the menopausal period (Yurdakul, et al. 2007). The results of the present study are similar to those in the literature.

In the present study, the participating women's socio-demographic characteristics were compared with the mean scores obtained from the Menopause Rating Scale (MRS) in terms of their age groups. The comparison revealed that the mean MRS scores of the women who were in the $\leq$50 age group were higher than those of the other women ($p < 0.05$). A statistically significant difference was observed between their mean MRS scores in terms of education ($p < 0.05$). The higher the level of education was, the lower the mean score was. In our study, it was observed that menopause-related complaints decreased as the education level increased, which was consistent with the results in the literature (Varma, et al. 2006; Çoban, et al. 2008; Nehir, et al. 2009). This present study revealed that the participating women's education level played a significant role in the reduction of menopausal complaints. It is believed that reduction in menopausal complaints due to the increased levels of education might be related to the fact that these women's level of knowledge related to menopause was higher, that they were more willing to learn, and that they were able to use coping methods more effectively. Analysis of the women's mean MRS scores in terms of their marital status and spouse's being alive or dead indicated that women who were married or whose husbands were alive achieved higher mean MRS scores ($p<0.05$).

These high differences are thought to have resulted from the women's concern that their relationships with their husbands might be affected. According to the analysis of the women's, mean MRS scores in terms of their socio-economic status, those whose income was lower than expenses had lower mean scores than did those whose income was not lower than expenses. In Bawar et al.'s study of postmenopausal women in two different socio-economic status, women with higher socio-economic status were reported to suffer hot flashes, sweating, and vasomotor symptoms such as palpitations more than did the women in the other group (Bawar, et al. 2013).The results obtained from Bawar et al.'s study are similar to our findings. This situation is considered to result from the women's perceptions of menopause process: while women in the lower socioeconomic status group feel relaxed because with menopause, the risk of unwanted pregnancies will reduce, those in the upper socioeconomic status group perceive menopause as changes in physical appearance and loss of productivity as a result of which they will not be able to have a child especially in late marriages.

The mean MRS scores of menopausal women knowledgeable about menopause were higher than were those of the other women ($p < 0.05$), which may be due to the fact that the women in the former group were aware of the risks and potential complications of menopause. In dealing with menopausal symptoms, estrogen replacement therapy is an important aspect of medical treatment (Taşkın, 2012). Investigation of medical treatment methods used by women to cope with menopausal symptoms revealed that hormone replacement therapy is widely preferred (Table 4). Although hormone therapy is known as the most effective treatment method in coping with menopausal symptoms, it has been reported to have several disadvantages and adverse effects including breast and ovarian cancer, endometrial hyperplasia and cancer, stroke, and venous thromboembolism especially in long-term treatments (Beral, et al. 2011; Morelli and Naquin 2002; Utian, et al. 2008; Furness, et al. 2009; Nelson, 2004; Lacey, et al. 2006; Xu , et al. 2012).

Many women also prefer alternative treatments because of the side effects and risks of well-known approaches used in coping with hot flashes. Currently, herbal treatment offers some thoroughly researched options (Philp, 2003). In our study too, it was observed that the women widely used herbs for the treatment and alleviation of the symptoms of menopause. None of the women who participated in Seidl and Stewart's study reported any side effects related to the alternative treatment methods they used. Most of the women state that they believe alternative treatments are natural, and therefore they are more reliable (Seidl and Stewart, 1998). Many herbal products are recommended for menopause. The findings obtained from several randomized studies have revealed that black cohosh is the most studied herbal products and it may be useful for the alleviation of menopausal symptoms (National institutes of health, 2005; Morelli and Naquin, 2002; Huntley and Ernst, 2003). Geller and Studee reported black cohosh as the most effective and reliable plant in reducing menopausal symptoms, particularly hot flashes and mood disorders (Geller and Studee, 2005).

Alternative treatment methods used by women suffering menopause symptoms were as follows: having sage tea for hot flashes and sweating (35.6%), having chamomile tea, green tea or sage tea for angina pectoris or palpitations (27.6%), having sage tea for early wake-ups or inability to go to sleep for a long time (32.2%), having herbal tea for nervousness (44.4%), eating almonds, hazelnuts, walnuts, apricots and raisins for physical and mental fatigue (53.1%) and consuming parsley for urinary problems (39.3%). Borrelli and Ernst (2010) reported that herbs used to treat the symptoms of menopause were black cohosh, evening primrose oil, hops and Chinese herbs (also called seed cones or strobiles) (Borrelli and Ernst, 2010). Oil obtained from evening primrose is thought to reduce the symptoms of hot flashes (Demirgöz and Şahin, 2008). Vitamins and minerals are used by menopausal women in the hope of relieving some discomfort as well as for maintaining healthy bones and reducing mortality (Borrelli and Ernst, 2010).

Calcium requirement increases during the postmenopausal period; thus, postmenopausal women should take three servings of calcium-rich foods like milk, yogurt and cheese every day. However, many women have a diet poor in calcium. The target calcium intake for most postmenopausal women is 1200 mg / day. Women who are not exposed to sunlight every day and have low levels of vitamin D should take vitamin D supplementation as well (The Board of the Trustees of the North American Menopause Society, 2006). More than half of the women in our study paid attention to their diet and consumed foods rich in calcium (Table 4).

One of the non-pharmacologic methods used to alleviate menopausal symptoms including depression and anxiety is doing exercise regularly (Mirzaiinjmabadi, et al. 2006). In some studies, physical exercise was reported to lead to a reduction in menopausal symptoms, and to provide an increase in quality of life (Stadberg, et al. 2004; Elavsky and McAuley, 2007; Teoman, et al. 2004; Moriyama, et al. 2008; Lindh-Åstrand, et al. 2004) however, Yurdakul et al. did not determine a significant relationship between menopausal women's doing regular physical exercise and their quality of life (Yurdakul, et al. 2007). In our study, most of the women did not exercise; only a very small number of the women with complaints of hot flashes used it as an alternative method (1.7%).

Yoga is reported to have a short-term effect on psychological symptoms of menopausal women (Cramer, et al. 2012). The results of our study indicate that very few of the participants (0.4%) did yoga when they suffered physical and mental fatigue (Table 4). Consuming soy products is among popular treatments recommended to cope with menopausal symptoms (Kessel and Kronenberg, 2004). Soy consumption has been found to significantly reduce the incidence of hot flashes (Morelli and Naquin, 2002). In Alberttazi et al.'s (1998) double-blind, randomized, placebo-controlled study conducted with 104 postmenopausal women, 51 women consumed 60 g of soy protein daily whereas 53 women consumed placebo food, and it was found that the frequency of hot flashes among the women who consumed soy proteins dropped significantly (Alberttazi, et al.1998). In their (2000) study, Scambia et al. indicated that consuming soy products would be a safe and effective treatment method in eliminating hot flashes in women who rejected hormone replacement therapy (HRT) or developed complications to HRT (Scambia, et al. 2000).In our study, most of the women did not consume soy products; only a very small number of the women with complaints of urinary problems used it as an alternative method (1.7%).

4. Conclusion and Recommendations

Maintenance of the quality of life at menopause gains importance because the average life expectancy has increased. It has been observed that menopausal women suffer a lot of physical and psychological distress and use various alternative methods to cope with it. The increase in women's educational level had positive effects on menopausal symptoms. In line with these findings, it is recommended that women should be regularly followed before and after the menopause, and that nurses and midwives should organize education programs for women to help them meet their menopause requirements and have quality life during the menopause period, should update and enhance these programs, and should increase women's education levels.

During these education programs, women should not only be given medical treatment but also be offered alternative treatment options. It is also very important to provide women with the basic information about herbal solutions they use to alleviate menopausal symptoms. On the other hand, it should be kept in mind that use of certain herbs may lead to unwanted side effects. Women should also be informed about the symptoms of menopause, and the causes and effective coping methods of these symptoms. It is thought that education enhances women's menopause-related information and thus reduces their anxiety and activates alternative coping mechanisms.

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