

Beyond Hot Flashes: the Greene Menopause Index / Greene Climacteric Scale

A complete account of a standardized 21-item instrument for measuring menopause symptom burden across psychological, somatic, vasomotor, and sexual domains.

Contents

	Executive Summary	4
01	Introduction: Why Menopause Symptom Measurement Requires More Than a Checklist	6
02	Naming: Greene Menopause Index vs. Greene Climacteric Scale	7
03	History and Authorship	8
04	What the Scale Measures	9
05	The Common Missing Category: Sexual Dysfunction	10
06	Psychological Symptoms: Anxiety and Depression Are Distinct Subclusters	11
07	Complete Scoring Mechanics	12
08	The Full Symptom Range	13
09	Clinical Applications	14
10	Research Applications	15

11	Strengths of the GCS	17
12	Limitations and Interpretation Cautions	18
13	Practical Recommendations	19
14	Conclusion	20
	Appendix A: Sources	21

Executive Summary

The Greene Menopause Index, also known in the clinical and research literature as the Greene Climacteric Scale (GCS), is a standardized 21-item questionnaire used to assess the severity and pattern of menopause symptoms. The GCS is often described in simplified terms as a tool that measures three categories of menopause symptoms: psychological, somatic, and vasomotor. That description is directionally correct but incomplete. A complete account of the GCS must also include the scale's sexual dysfunction item, anxiety and depression subclusters within the psychological cluster, total-score mechanics, and its role as a clinical communication tool and a research outcome measure.

The GCS was developed by J. G. Greene to create a standard, replicable instrument for measuring climacteric symptoms. Before standardized scales such as the GCS, menopause symptom research often relied on inconsistent questionnaires. This made it difficult to compare findings across studies, populations, cultures, or treatment interventions. Greene's work addressed that problem by using factor-analytic evidence to organize symptoms into coherent domains and produce a practical instrument that could be used across medical, psychological, epidemiological, and social research settings.

The Greene Climacteric Scale asks people to rate how much 21 different symptoms bother them. Each symptom is scored from 0 to 3. A score of 0 means the symptom does not bother them at all. A score of 1 means it bothers them a little. A score of 2 means it bothers them quite a bit. A score of 3 means it bothers them extremely. The total score is the sum of all 21 symptoms, producing a possible range of 0 to 63. Higher scores indicate a higher overall symptom burden. In addition to the total score, individual cluster scores can be calculated to show which types of symptoms are most prominent. These include psychological symptoms, anxiety, depressed mood, somatic symptoms, vasomotor symptoms, and sexuality or sexual dysfunction.

This distinction matters because menopause is not only a vasomotor event. Hot flashes and night sweats are highly recognizable symptoms, but the menopausal transition can also involve sleep disruption, panic attacks, low mood, irritability, headaches, muscle and joint pain, tingling or numbness, dizziness, and changes in sexual interest. A scale that captures only hot flashes and night sweats misses many of the symptoms patients experience.

The GCS is useful in clinical settings because it is a structured way to report and track symptoms over time. It is also useful in research because it can establish baseline symptom burden, compare

symptom profiles across populations, and assess responses to interventions such as hormone therapy, non-hormonal treatments, behavioral interventions, or non-pharmacological therapies. However, it should not be used as a standalone diagnostic tool. The GCS measures self-reported symptom burden; it does not determine the cause of symptoms, diagnose menopause by itself, or replace clinical evaluation.

Introduction: Why Menopause Symptom Measurement Requires More Than a Checklist

Menopause is often discussed publicly through a narrow set of symptoms: hot flashes, night sweats, irregular periods, and sleep problems. Those symptoms are important, but they do not capture the full experience of the menopausal transition. Many people also report psychological, somatic, cognitive, and sexual symptoms. Some experience vasomotor symptoms as the primary problem. Others are more affected by mood changes, fatigue, joint pain, headaches, panic-like symptoms, or changes in sexual desire. The same person may also experience different symptom patterns at different points in perimenopause, menopause, and postmenopause.

This variability creates a measurement problem. If clinicians and researchers rely only on informal symptom lists, they may overlook important symptoms, understate the total burden of menopause, or fail to distinguish between symptom clusters. A patient with severe sleep disturbance, irritability, fatigue, and joint pain may have a high symptom burden even if she reports few or no hot flashes. Conversely, another patient may have a dominant vasomotor profile with relatively few psychological or somatic symptoms. Without a structured instrument, both clinical care and research analysis become less precise.

The Greene Climacteric Scale was created to address this problem. It offers a standardized method for recording the severity of a broad set of symptoms associated with the climacteric period, a term that refers to the reproductive transition surrounding menopause. Its value lies not only in the fact that it contains 21 items, but in how those items are organized. The scale is designed to capture the multidimensional symptom picture of menopause, including psychological, physical, vasomotor, and sexual symptoms.

This is why simplified descriptions of the Greene Menopause Index can be misleading. A definition that says the scale contains 21 questions and is divided into psychological, somatic, and vasomotor categories is incomplete unless it also explains that item 21 addresses loss of interest in sex and that the psychological domain is commonly subdivided into anxiety and depressed mood. The omission is not minor. Sexual concerns are clinically relevant, frequently underreported, and often stigmatized. Anxiety and depression subscales are also important because the psychological domain is not a single undifferentiated category. A person's psychological score may be driven primarily by anxiety symptoms, depressed mood symptoms, or both.

Naming: Greene Menopause Index vs. Greene Climacteric Scale

The term “Greene Menopause Index” appears in some public-facing definitions and secondary summaries, but the formal name used in much of the peer-reviewed literature is the Greene Climacteric Scale. “Climacteric” is the broader term, referring to the transition around the end of reproductive function. In practical use, the scale is most often discussed in relation to perimenopause, menopause, and postmenopausal symptom burden.

For publication purposes, the most credible approach is to introduce both names early, then use the formal term consistently. For example: “The Greene Menopause Index, more formally known as the Greene Climacteric Scale (GCS), is a 21-item self-administered questionnaire used to assess menopause-related symptom burden.” After that first mention, “GCS” can be used throughout.

This naming choice matters because clinicians, researchers, and academic readers are more likely to recognize “Greene Climacteric Scale.” It is also the name used in the original Greene publications, in validation and translation studies, in clinical trial reviews, and in many menopause symptom measurement resources. “Greene Menopause Index” may be useful for search visibility or consumer comprehension, but “Greene Climacteric Scale” is the more precise technical term.

The name also clarifies the scope of the instrument. The scale is not limited to people who have already reached menopause. It has been used in studies of perimenopausal and postmenopausal women, as well as in broader midlife populations. It is intended to capture symptoms occurring during the climacteric transition, not to serve as a binary test that determines whether someone is or is not menopausal.

This distinction should be made explicit in patient-facing content. The GCS can help structure a conversation about symptoms, but it does not diagnose menopause by itself. Menopause is typically defined clinically after 12 consecutive months without menstruation, assuming no other medical cause. Perimenopause can begin years earlier and may include significant symptoms even when menstrual cycles still occur. A symptom scale can help document that experience, but diagnosis and treatment decisions require clinical context.

History and Authorship

The Greene Climacteric Scale was developed by J. G. Greene to provide a standardized instrument for assessing climacteric symptoms. Greene's work emerged from a methodological problem in menopause research: many earlier studies used ad-hoc questionnaires or symptom lists, making results difficult to compare. If one study measured hot flashes, insomnia, and mood symptoms while another used a different list or scoring system, researchers could not easily determine whether observed differences reflected real population differences, measurement differences, or both.

Greene's approach was grounded in factor analysis, a statistical method used to identify clusters of related symptoms. The goal was to determine which symptoms tended to group together and to construct a scale that reflected those groupings. The result was a tool that could measure several dimensions of the climacteric symptom experience rather than reducing menopause to a single severity score or a narrow set of vasomotor complaints.

The scale was described in Greene's 1998 *Maturitas* article, "Constructing a standard climacteric scale," and later appeared in a 2008 *Maturitas* reprint. The 1998 article is the key formal reference for the standard version of the scale. Greene's earlier factor-analytic work also contributed to the conceptual foundation for identifying symptom clusters during the climacteric period.

The scale's development reflected a practical research need. Menopause studies include medical trials, observational population studies, psychological research, sociological research, and epidemiological comparisons. A standard symptom instrument allows researchers to compare results across those contexts. It also allows clinicians to measure change before and after treatment or across follow-up visits.

The GCS therefore should be described not merely as a questionnaire but as a psychometric tool. Its value comes from standardization: consistent items, consistent response options, consistent scoring, and interpretable symptom clusters.

What the Scale Measures

The GCS measures 21 symptoms. Respondents are asked to indicate how much each symptom bothers them at the moment or during the relevant assessment period, depending on the version or study protocol. The symptoms cover psychological, somatic, vasomotor, and sexual domains.

The psychological domain includes items 1 through 11. These symptoms include rapid or strong heartbeat, feeling tense or nervous, difficulty sleeping, excitability, panic attacks, difficulty concentrating, fatigue or lack of energy, loss of interest in most things, depressed mood, crying spells, and irritability. This domain is often further subdivided into anxiety and depression or depressed mood. Anxiety is generally represented by items 1 through 6, while depression or depressed mood is represented by items 7 through 11.

The somatic domain includes items 12 through 18. These are physical symptoms such as feeling dizzy or faint, numbness or tingling, headaches, muscle and joint pains, loss of feeling in the hands or feet, and breathing difficulties. These symptoms are important because they often prompt medical concern and may overlap with other conditions. Their presence on the GCS does not mean they are automatically caused by menopause, but it does mean they are part of the symptom landscape that climacteric research has historically evaluated.

The vasomotor domain includes items 19 and 20: hot flushes or hot flashes and sweating at night. These symptoms are among the most recognized menopause symptoms and are often the primary endpoint in trials evaluating hormone therapy or other vasomotor symptom treatments. However, because the GCS places vasomotor symptoms alongside psychological, somatic, and sexual symptoms, it prevents the common mistake of treating vasomotor symptoms as the whole menopause experience.

The sexuality or sexual dysfunction component is item 21: loss of interest in sex. This item is sometimes described as a probe for sexual dysfunction. It is not a complete sexual function inventory and should not be interpreted as a comprehensive assessment of libido, arousal, pain, orgasm, relationship context, genitourinary symptoms, or sexual distress. Still, its presence matters. It acknowledges that sexual interest can change during the menopausal transition and that this change belongs in a complete symptom assessment.

The Common Missing Category: Sexual Dysfunction

One of the most important misconceptions about the Greene Menopause Index to correct relates to sexual dysfunction. A summary that says the 21 questions are divided into psychological, somatic, and vasomotor categories leaves out item 21, which assesses loss of interest in sex.

There are two ways to describe this accurately. One approach is to say the GCS includes three major symptom domains—psychological, somatic, and vasomotor—plus a separate sexuality item. Another approach is to describe the scale as measuring four areas: psychological, somatic, vasomotor, and sexual function or sexual dysfunction. A third approach, used in some measurement summaries, is to list five or six score categories: anxiety, depression, somatic, vasomotor, sexual function, and sometimes overall psychological symptoms. Any of these descriptions is more complete than a three-category description that ignores sexuality.

The omission matters clinically because sexual symptoms are often underdiscussed. Many patients do not volunteer sexual concerns unless asked directly, and many clinicians do not ask unless a tool prompts the conversation. Loss of sexual interest may reflect hormonal changes, relationship factors, mood symptoms, sleep disruption, pain, medication effects, stress, body image concerns, genitourinary syndrome of menopause, or other medical conditions. The GCS does not distinguish among these causes, but it does create a standardized opening for identifying the concern.

The item also matters in research. If studies compare only psychological, somatic, and vasomotor clusters, sexual symptoms may be excluded from analysis or treated as peripheral. That can distort understanding of the menopausal transition, especially in quality-of-life research. Menopause affects physical health, mental health, sleep, relationships, self-perception, and sexual well-being. A symptom instrument that includes sexual interest is more aligned with that multidimensional reality.

However, the sexual dysfunction item must be interpreted carefully. It is a single-item probe, not a diagnostic sexual medicine instrument. A high score on item 21 should not be treated as proof of a specific sexual dysfunction diagnosis. Instead, it signals that the respondent reports being bothered by loss of interest in sex and may benefit from further discussion or assessment.

Psychological Symptoms: Anxiety and Depression Are Distinct Subclusters

Another frequent omission is the subdivision of psychological symptoms into anxiety and depression or depressed mood. The psychological scale as a whole includes items 1 through 11, but those 11 items are not all measuring the same experience. Items 1 through 6 are commonly used to calculate an anxiety score, while items 7 through 11 are used to calculate a depression or depressed mood score.

This distinction is clinically meaningful. Anxiety-type symptoms can include heart beating quickly or strongly, feeling tense or nervous, difficulty sleeping, excitability, panic attacks, and difficulty concentrating. These symptoms may feel sudden, physical, and alarming. A patient may describe them as “wired,” “panicky,” “unable to settle,” or “unable to focus.” Some symptoms, such as palpitations or breathing difficulties, may also overlap with medical conditions and warrant evaluation.

Depressed mood symptoms include fatigue or lack of energy, loss of interest in most things, feeling unhappy or depressed, crying spells, and irritability. These symptoms may present as low mood, emotional sensitivity, lack of motivation, reduced pleasure, or a shortened temper. In midlife patients, these symptoms can be incorrectly attributed solely to stress, aging, work, caregiving, or personality change unless hormonal transition is also considered.

Separating anxiety and depression subclusters improves interpretation. Two people may have the same total psychological score but very different clinical profiles. One may be primarily anxious, with panic attacks and sleep disturbance. Another may be primarily low in mood, with fatigue, crying spells, and loss of interest. A third may have elevations in both. A combined psychological score is useful for measuring broad psychological burden, but subcluster scores provide more specific information.

This subdivision is also important for research. Studies can examine whether anxiety symptoms, depressed mood symptoms, somatic symptoms, or vasomotor symptoms differ by menopausal stage, treatment exposure, cultural context, socioeconomic status, or medical history. Without subcluster analysis, important patterns may be hidden inside a single psychological score.

Complete Scoring Mechanics

The scoring mechanics of the GCS are simple but should be explained clearly. Each of the 21 symptoms is rated on a 4-point severity scale. A score of 0 means the symptom is not bothersome. A score of 1 indicates the symptom is present or bothersome to a small degree. A score of 2 indicates a moderate or substantial level of bother. A score of 3 indicates the symptom is extremely bothersome.

Because there are 21 items and each item can receive a maximum score of 3, the total score ranges from 0 to 63. The total score is calculated by adding all item scores. A higher total score indicates greater overall symptom burden.

In addition to the total score, cluster scores can be calculated. The psychological score is the sum of items 1 through 11. The anxiety subcluster is the sum of items 1 through 6. The depression or depressed mood subcluster is the sum of items 7 through 11. The somatic score is the sum of items 12 through 18. The vasomotor score is the sum of items 19 and 20. The sexuality or sexual dysfunction score is item 21 alone.

This cluster scoring is one of the scale's main strengths. A total score tells the clinician or researcher how much symptom burden is present overall. Cluster scores tell them what kind of burden is present. For example, two respondents may both score 24 out of 63, but one may have most of that score concentrated in vasomotor and sleep symptoms, while the other may have high psychological and somatic scores with minimal hot flashes. These are different symptom profiles and may suggest different clinical conversations or research interpretations.

Scoring should also be described with caution. The GCS score is a severity measure, not a diagnostic conclusion. A high total score indicates that the respondent reports a significant symptom burden, but it does not prove that menopause is the only cause. Several GCS symptoms can overlap with thyroid disorders, anemia, depression, anxiety disorders, sleep apnea, medication effects, chronic pain, cardiovascular symptoms, neurological conditions, respiratory illness, or high stress. A high GCS score should prompt assessment, not replace it.

Accuracy in scoring is especially important because the scale uses 0–3 ratings, not 1–4 ratings. A later correction to a study using the GCS noted that scores had initially been calculated with a 1–4 scale rather than the standard 0–3 scale, requiring recalculation. That correction illustrates why even a simple scoring system must be described precisely.

The Full Symptom Range

The GCS does not measure only hot flashes, night sweats, rapid heartbeat, and sleep difficulty. Those are four of the 21 items. The remaining symptoms are essential to the purpose of the scale.

The psychological symptoms include panic attacks, difficulty concentrating, tiredness or lack of energy, loss of interest in most things, unhappiness or depression, crying spells, and irritability. These symptoms can meaningfully affect daily functioning, relationships, work, and quality of life. They also overlap with common midlife stressors, which is why structured assessment can be useful.

The somatic symptoms include dizziness or faintness, numbness or tingling, headaches, muscle and joint pain, loss of feeling in hands or feet, and breathing difficulties. These symptoms are sometimes less publicly associated with menopause than hot flashes, yet they appear in the GCS because climacteric symptom research found them relevant to the symptom pattern experienced by many midlife women.

The vasomotor symptoms are hot flashes and night sweats. They are central to menopause research because they are common, measurable, and often used as treatment endpoints. They can disrupt sleep, concentration, work performance, and quality of life. But when these symptoms dominate public definitions of menopause, other symptom types may be minimized.

The sexual item is loss of interest in sex. This is a broad and sensitive symptom. It should not be reduced to a simple hormone issue, nor should it be ignored. Sexual interest can be influenced by sleep, mood, relationship quality, pain, medications, vaginal or vulvar symptoms, body image, stress, trauma history, and cultural context. The GCS item is valuable because it makes sexual interest visible, but it should be followed by more nuanced assessment when clinically relevant.

The breadth of the GCS is the central point. The scale does not treat menopause as a single-symptom condition. It treats the climacteric transition as a multidimensional experience involving emotional, physical, autonomic, and sexual symptoms.

Clinical Applications

In clinical practice, the GCS can be used to structure symptom conversations, document baseline severity, and track change over time. It is especially helpful when patients have difficulty organizing a broad set of symptoms or when they are unsure whether their symptoms may be related to perimenopause or menopause.

At a first visit, the scale can help identify the dominant symptom clusters. A clinician can see whether the highest scores are psychological, somatic, vasomotor, or sexual. This can make the visit more efficient and more patient-centered. Instead of asking only about hot flashes, the clinician can see whether sleep, mood, pain, panic, concentration, or libido are also major concerns.

The GCS can also be used before and after intervention. A patient may complete the scale before starting hormone therapy, non-hormonal medication, cognitive behavioral therapy for insomnia, lifestyle changes, pelvic health treatment, or another intervention. Repeating the scale later can show whether the total score changed and which clusters improved. This is more informative than asking generally, “Do you feel better?” because symptom improvement may be uneven across domains.

The scale may also help normalize patient experience. Many people do not realize that symptoms such as joint pain, tingling, palpitations, panic-like episodes, irritability, and concentration difficulty can appear during the menopausal transition. Seeing these symptoms listed in a standardized instrument may help patients describe them more confidently.

However, the GCS should not be used as a shortcut for diagnosis or treatment selection. It does not replace medical history, menstrual history, medication review, physical examination when indicated, or evaluation for other causes. For example, palpitations may warrant cardiovascular assessment. Breathing difficulties may require respiratory or cardiac evaluation. Depressive symptoms may require mental health assessment. Loss of sexual interest may require discussion of relationship factors, pain, medications, genitourinary symptoms, and distress.

The best clinical use of the GCS is as a structured symptom assessment, not as a diagnostic label.

Research Applications

The GCS is widely used in menopause research because it provides a standardized outcome measure. Researchers can use it to establish baseline symptom burden, compare groups, evaluate interventions, and analyze symptom clusters across populations.

In clinical trials, the GCS can help measure whether an intervention changes overall symptom burden or specific symptom domains. Hormone therapy trials have often focused on vasomotor symptoms, particularly hot flashes and night sweats. However, reviews of vasomotor symptom assessment tools have noted the importance of validated patient-reported outcome measures that assess broader health-related quality of life. The GCS is one such measure, though it is not the only menopause-specific instrument available.

The scale is also useful in cross-cultural research. Studies have used translated or adapted versions to compare climacteric symptoms in different countries and populations. This use is important because menopausal symptom reporting is influenced by biology, culture, language, health literacy, social expectations, access to care, and willingness to discuss sensitive symptoms. A standardized scale allows researchers to compare patterns while still acknowledging that cultural adaptation and validation matter.

The GCS can also be useful in underserved populations. Research among underserved or homeless women has used the GCS to document symptom burden and identify which symptom clusters are most prominent. Such studies are valuable because menopause research has often overrepresented healthier, insured, or clinic-connected populations. A standardized scale can help show whether symptom patterns differ among people facing housing instability, extreme heat exposure, limited access to care, or socioeconomic stress.

In epidemiological studies, the GCS can help compare perimenopausal and postmenopausal groups, examine associations between symptoms and demographic variables, and explore links between symptom burden and quality-of-life outcomes. Because cluster scores are available, researchers can move beyond total score and ask more specific questions: Are vasomotor symptoms highest in one menopausal stage? Are psychological symptoms associated with sleep problems? Are somatic scores higher in certain populations? Does a treatment improve vasomotor symptoms but leave depressed mood unchanged?

The scale's usefulness depends on correct administration, scoring, and interpretation. Translations should be validated. Adapted versions should be clearly described. If items are removed or added, the modified version should not be treated as identical to the standard 21-item GCS. Researchers should state whether they analyzed total scores, cluster scores, individual items, or all three.

Strengths of the GCS

The GCS has several strengths. First, it is brief. A 21-item questionnaire can be completed quickly, making it feasible for clinical practice and research visits. Second, it is self-administered, which allows patients to report symptom severity directly. Third, it uses a simple scoring system that is easy to understand and calculate. Fourth, it captures multiple symptom domains rather than focusing only on vasomotor symptoms.

The cluster structure is particularly valuable. In both clinical and research settings, total scores alone can obscure meaningful differences. Cluster scores help identify symptom patterns and avoid one-size-fits-all interpretation. This is especially important in menopause care because symptoms can arise from overlapping biological, psychological, and social factors.

The GCS also has historical value. Because it has been used across many studies, it allows comparison with prior research. That makes it more useful than a new, unvalidated checklist created for a single article, clinic, or marketing campaign.

Another strength is that the scale includes symptoms patients may not automatically associate with menopause. Items such as tingling, headaches, joint pain, panic attacks, irritability, and loss of sexual interest may prompt more complete discussion. For patient education, this breadth can reduce the misconception that menopause symptoms are limited to hot flashes.

Limitations and Interpretation Cautions

The GCS is useful, but it has limitations. It is a symptom burden instrument, not a diagnostic test. It cannot determine whether a symptom is caused by menopause, another medical condition, medication effects, psychosocial stress, or a combination of factors. This is especially important for symptoms such as palpitations, breathing difficulties, dizziness, depressive symptoms, panic attacks, and numbness or tingling.

The scale is also self-reported. Self-report is essential for symptom research because patients are the only people who can report subjective bother, but self-report can be influenced by mood, recall, expectations, culture, language, stigma, and the assessment setting. Sensitive items, especially sexual interest, require privacy and respectful handling.

Another limitation is that the sexual function component is only one item. Loss of interest in sex is important, but it does not capture the full range of sexual function concerns. It does not assess arousal, lubrication, orgasm, pain, distress, relationship satisfaction, vulvovaginal symptoms, trauma history, or medication-related sexual side effects. If sexual concerns are clinically important, additional assessment is needed.

The somatic symptoms also require careful interpretation. Muscle and joint pain, headaches, dizziness, tingling, and breathing difficulties may occur during the menopausal transition, but they can also indicate other conditions. A high somatic score should not be dismissed as “just menopause.”

Adaptations of the GCS can create comparability issues. Some studies have translated the scale, removed items, or modified wording. For example, one study using a Farsi version omitted an item due to test-retest reliability concerns. Such adaptations may be appropriate for a specific study, but they change scoring and limit direct comparison with the standard 21-item version.

Finally, the GCS does not directly measure quality of life in the same way as broader menopause-specific quality-of-life instruments. It measures symptom bother across key domains. That symptom burden may relate strongly to quality of life, but the two concepts are not identical.

Practical Recommendations

For clinicians, the GCS is most useful when used as part of a broader assessment. It can identify symptom clusters, document baseline burden, and track response to treatment. It can also help patients name symptoms they may not have connected to the menopausal transition. Clinicians should review high-scoring items individually rather than relying only on the total score.

For researchers, the GCS should be administered and scored consistently. Publications should state whether the standard 21-item scale was used, whether any items were modified or removed, whether translations were validated, and whether analyses used total scores, cluster scores, individual items, or a combination. Any adapted version should be clearly distinguished from the standard GCS.

For patient education writers, accuracy requires avoiding the “three categories only” simplification. Sexual dysfunction should be mentioned, and anxiety/depression subclusters should be included when explaining the psychological domain. Writers should also avoid presenting the GCS as a diagnostic test or a treatment algorithm.

For digital health tools, the GCS can be useful as a structured questionnaire, but user-facing results should be carefully worded. A high score should be framed as a reason to discuss symptoms with a qualified healthcare professional, not as proof of a diagnosis. Sensitive responses, especially sexual symptoms and mood symptoms, should be handled with privacy, clear disclaimers, and appropriate support pathways.

Conclusion

The Greene Menopause Index, more properly known as the Greene Climacteric Scale, is a standardized 21-item instrument for measuring the broad symptom burden associated with the menopausal transition. Its value lies in its multidomain structure. It does not merely count hot flashes. It captures psychological symptoms, somatic symptoms, vasomotor symptoms, and sexual interest, while also allowing psychological symptoms to be divided into anxiety and depressed mood subclusters.

A complete description of the scale must include its scoring mechanics: 21 items, each rated from 0 to 3, with a total score ranging from 0 to 63. It should explain that researchers and clinicians can analyze both the total score and cluster scores. It should also identify J. G. Greene as the developer and place the scale in its proper historical context as an effort to standardize climacteric symptom measurement.

The most common error in simplified descriptions is omission. Sexual dysfunction is omitted. Anxiety and depression subclusters are omitted. The total score range is omitted. The full symptom range is omitted. Clinical and research applications are reduced to a vague statement that researchers use the tool to study menopause. These omissions make the scale seem narrower and less clinically useful than it is.

The GCS is a structured, validated, patient-reported symptom measure that helps clinicians and researchers understand how menopause-related symptoms are distributed across emotional, physical, vasomotor, and sexual domains. Used correctly, it supports clearer patient conversations, better baseline measurement, more precise research analysis, and more meaningful evaluation of symptom change over time.

Appendix A: Sources

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