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Menopause:

Women's Knowledge Sources

And

Management Decisions

A thesis presented in partial fulfillment of the requirements for
the degree of Master of Arts in Nursing at Massey University by
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Abstract

During the last two decades the topic of menopause has become more openly discussed as evidenced by the prevalence of items in the popular press as well as research done by health professionals. The information that is published in the popular press is largely orientated towards menopause being a disease and the pharmaceutical interventions needed to correct the disease. Literature published in medical and nursing journals is also predominantly orientated toward menopause being a state of oestrogen deficiency. Increasingly though, nurse researchers and feminist writers are challenging these views of menopause. However, information about menopause is not as openly available as women want it to be.

The aim of this research is to discover how women gain knowledge about menopause and how women make decisions about 'managing' their menopause. In this study knowledge is defined as being more than information. Knowledge is the understanding that occurs from the synthesis of all data, about menopause, collected from various sources. It is from the responses of the participants when they are interviewed, and the data analysis using grounded theory that these questions were answered.

The population for the study was women aged between 45-55 years of age. They were recruited from my local community via a newspaper advertisement. The sample group included eleven women.

The methodology used in this research was Grounded Theory as developed by Glaser and Strauss. Ethical approval was gained from the Massey University Ethics Committee and the Central Health Regional Authority as well as from the participants. The participants were all interviewed once, with two participants being consulted for comment on the findings. The interviews were taped and transcribed. Data collection and analysis occurred concurrently as prescribed by grounded theory. Categories were generated from the data.

A descriptive model is presented. This model illustrates that women who have a tertiary level of knowledge and support have the intrinsic qualities needed to be seekers of knowledge about menopause. This group of women, the large majority of the participants, was able to be self-controlling of their own menopause. One of the greatest determinants in being self-controlling was the level of support that women had. A few participants had their menopause controlled by others. However, once adverse effects from the management interventions were experienced, they then gained the abilities to develop partial control of their own menopause.

This study has highlighted that it is important for nurses to take every opportunity to educate women about their health as in this study nurses were not seen as possible sources of education about menopause. Limitations of the study as well as recommendations for nursing research, nursing education and future research are included.

Acknowledgments

I am grateful to the research participants who engaged with me in the undertaking of this study. It is due to their openness and willingness to give their time, share their very personal thoughts and their experience of menopause that this research was possible.

Grateful thanks are extended to my colleagues at Whitireia Community Polytechnic. These women have been very unselfish in the support they have shown me. Meaningful dialogue and critique has always been given if requested. They have supported me to have blocks of time out of the work environment so that I can write. On a personal level they have always been encouraging and assisted in providing literature that they thought may be helpful. This personal and professional support has been greatly appreciated.

Whitireia Community Polytechnic has provided financial assistance in contributing to the cost of the research.

Mention must be made of two people whose patience and technical expertise have helped this research journey. Marie has patiently guided me to computer literacy and Linda cheerfully assisted with the finishing processes of the final document.

During the writing of the thesis three supervisors have provided constructive and valuable feedback. Dr Jo Walton began as my supervisor before leaving to work in Australia. She assisted me through the process of gaining ethics approval. Professor Julie Boddy has given methodology guidance and direction. Lesley Batten has been responsible for steering me along the right paths, encouraging me when in the depths of despair and giving encouragement along the way. Without Lesley's quiet reassurance that I would get there the journey would have seemed a lot longer.

Lastly, I wish to acknowledge the relationship of joint supervision that I shared with Sue MacDonald. Sue contributed to the clarity of the research process and also provided support.

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Chapter 1

Introduction to the Research

Introduction

The word menopause means different things to different people. It is not just a single event but part of a transitional period in a woman's life. Menopause occurs at the stage of a woman's life where children may be leaving home or returning home to live and parents and in-laws may need increased levels of assistance. It is also at this time that women reevaluate their life, deciding 'where to from here'. Garfield (1991, p. 324) believes that "menopause is a critical turning point in a woman's life cycle equal in significance to the menarche, the first intercourse and the birthing of a baby". Bensussen (1991, p. 81) agrees with Garfield, but with an added bonus saying:

It is like going through adolescence a second time: changing hormones upsetting the body's measured responses; questioning one's future and place in life. But now, one has the knowledge and experience to face these questions in a positive way. The long view back helps light up possibilities for the future.

Women experience menopause differently, some 'sailing' through with no appreciable symptoms. Other women identify both physical and psychological effects of menopause, which result in varying degrees of discomfort. These affect how women cope with their everyday experiences of midlife. Some changes which may have no connection to menopause but which occur at midlife can also have significance for women at this time. It is how these issues and symptoms are addressed that is of importance for the future ongoing health of midlife women.

Aim of the Study

The aim of the study was to discover how women gained knowledge about menopause and how women make decisions about 'managing' their menopause. The broad questions to be answered in this study were:

- How do women gain knowledge about menopause?
- How do women make decisions about 'managing' their menopause?

Justification for the Topic

At a World Health Organisation (WHO) meeting of the Scientific Group on Research on the Menopause held in Geneva in 1994, statistics were released which outlined the numbers of women aged 50 years and over. In 1990 it was estimated that there were 467 million and the prediction for the numbers of women aged 50 years and over in 2030 was 1,200 million. As life expectancy at birth increases across the world so will the number of menopausal women. The New Zealand census carried out in 1986 reported that there were 414,348 women between the ages of 45-55. This is equal to 17.4% of women in the "usually resident population" (Statistics New Zealand, 1998, p.25). In the span of ten years there has been an increase of 67,236 or 13.9% of women aged between 45-55 in New Zealand. This increase in itself is not a source for concern. It demonstrates that accurate sources of information must be available to an increasing group of women in this age bracket.

As well as women having the right to knowledge about menopause as part of their overall health maintenance, it is especially important for this group of women to understand their bodily changes as they enter a new phase of social and family responsibilities. Midlife women are sometimes caregivers for elderly relatives. Eliopoulos (1997, p.490) registers that "more than half the elderly caregivers are wives; the next largest group of caregivers is daughters and daughters-in-law". Women have always had multiple social roles but in today's society they are more likely to be in full or part time employment, manage households and assist in charitable work. In short their lives are busy. As well and in comparison to the past, more women are striving to attain further educational qualifications to increase employment options. Woods and

boomer woman is better educated than her mother's generation, lives alone longer, and participates in the labour force throughout her life regardless of her marital status and the age of her children".

To enable women to cope with the multiple roles they have at midlife it is therefore imperative that women are given accurate information about menopause as well as management choices available to help women cope with any concerns that they may have. With the demands of multiple roles women do not always take the time to think about what is happening in their own bodies and more importantly they may not have the time to acquire knowledge about menopause. These factors can have detrimental effects on the health of women and consequently their ability to maintain their roles in society.

My interest in this study stemmed primarily from a personal base. Personally, living away from my family meant that I had no older female family member to discuss menopause with. Older women I knew were reticent to discuss the topic. This resulted in me having no intimate first hand knowledge on what to expect or how I could successfully manage the developmental experience of my own menopause. Speaking with other local women I found that this was not an uncommon position. In the families of some of the women I spoke with, menopause was still thought of as taboo, as dirty or it was admitted that it was 'not natural' to talk of it, with the implication being that a woman should just accept it and 'get on with it'.

It was after these discussions that I realised that this area of womens' lives needed further research. I recognised that there was a need for improved health education directed at the midlife woman. It was due to my own perceived unpreparedness surrounding menopause as well as not knowing the range of options available to treat symptoms attributed to menopause that I decided I wanted to know how widespread these issues were. Did other women know about menopause? Was I the odd woman out? Sheehy (1993) compared the differences between gaining knowledge about pregnancy and about menopause. She found that women were fully prepared for pregnancy and birth but not for the experience of menopause.

My professional interest came from teaching about the health concerns of people who are middle-aged or older, in a Bachelor of Nursing programme. The topic of

menopause was part of the teaching curriculum. I felt that it was important that students received accurate and current information to assist them to play a role in dispelling myths surrounding menopause and to give them the skills, attitude and knowledge needed to educate women about menopause. These students have the potential to change how great numbers of women think about as well as what they know about menopause. This is important as it can allow women to make choices about preventative midlife health measures as well as assist them to manage present concerns. Wuest (1993, p.416) states that “health care professionals have the power to effect change by developing a greater sensitivity to the social factors that influence women’s health in today’s society and lobbying for social change”.

I have both personal and professional reasons for doing this research study. Personally I had found that I needed access to a broader range of literature about menopause. What was available was predominantly from overseas and from a medical perspective. Professionally I felt that although menopause has been previously investigated from different viewpoints, for example the feminist and the biological viewpoints, for example there remained a need for more research around how New Zealand women view menopause. Once this information was known the gaps in educating and providing appropriate sources of information about menopause can be developed to ensure that women are as informed as they choose to be both about menopause and how they can manage it. In a study addressing the theories of menopause, Barile (1997, p.38) concluded that “adopting an inclusive theory of menopause would broaden viewpoints and reduce misunderstandings, myths and misconceptions”.

History of Menopause and Menopausal Women

The book of Genesis, chapter 18, verse 11, contains what may be the first reference to menopause in the literature. “Now Abraham and Sarah were old and well stricken in age; and it ceased to be with Sarah after the manner of women.” Quinn (1991, p.25) notes that “in ancient times the Goddess of Wisdom, the Crone, represented the third, or menopausal, phase of a woman’s life, and her shrines were served by priestesses who were in this stage of life”. In the nineteenth century the predominant ideas held by doctors about menopause were what would now be called patriarchal and disease focused. To prevent women getting into medicine doctors used the

prevailing ideas of the times which portrayed menopausal women as being emotionally unstable (Walsh 1977). These portrayals briefly depict the identification of menopause from the time of the Bible to the nineteenth century and demonstrate how menopausal women of these times were viewed.

However in the 20th century, the way that menopause has been viewed by some in society gives a different picture of women and menopausal women. Coney (1991, p. 15) states that “in previous years medicine treated the mid-life woman as a kind of stateless refuge, denying her citizenship in the land of the sick. No more. The mid-life woman is a prime target for the prevention-orientated general practice”.

Major Definitions of Menopause

The term menopause refers to the date at which the last natural period takes place. Menopause is said to have occurred when there has been no menstrual period for a year and as Stewart (1995, p.10) notes, “many women have menopause without even knowing it”. They do not stop and think, ‘I’m 45 and must be perimenopausal’ for example. It is often only after a length of time has passed that a woman may realise that things have begun to change in her body. It is only after this initial awareness that she may be alerted to the ongoing changes.

The term menopause has been widely used to describe the loss of reproductive capacity in women. Women, usually between the ages of 45 to 55, experience menopause in that menstruation ceases and pregnancy is no longer possible. Blackwell and Blackwell (1997) described the difficulty in diagnosing menopause because it can only be accurately diagnosed in retrospect.

The terms premenopause, perimenopause, and postmenopause are also commonly used. Fishbein (1992, p.954) writes that “perimenopause spans a 25 year time period from approximately age 35 years to 60 years and encompasses the transitional time when changes due to altered hormonal levels occur. Perimenopause is often divided into three phases. These are the climeratic period, which is 8 to 10 years before the last menstrual period; menopause which marks the last menstrual period; and post menopause, which begins one year after menopause and is characterised by the end of ovarian activity and the signs of oestrogen decline”. Kenton (1995) disputes

Fishbein's propositions of oestrogen decline. She proposes the opposite; namely that:

We now live in a world where it is easy for a woman's biochemistry to become distorted by declining physical activity, the proliferation of highly processed convenience foods, and the rise of a whole new - as yet largely unrecognised - phenomenon known as oestrogen dominance (Kenton, p.5).

The way in which menopause is currently defined has been shaped by the combined interests of medical, media and pharmaceutical concerns/interests. It was the pharmaceutical industry which financed Robert Wilson who received \$US1.3 million for the purpose of promoting oestrogens (Coney, 1991). Some doctors hold a view of midlife women as wasting medical time by complaining unnecessarily. Added to this is the view held by some, that menopause is not part of a normal process. Utian (1996, p. 736) states "medical opinion and to a larger extent popular opinion as well, views menopause as a malady, the afflicted woman demonstrating hypochondriasis and fear of aging. Menopausal women are therefore a population requiring treatment". Recalling that the combined interests of the medical and pharmaceutical industries have condoned and abetted the idea of menopause being a disease of oestrogen deficiency, Coney (1991, p, 16) states that "the idea of normal aging has collapsed into a definition of pathology". These dominant views, as well as trying to shape how women see themselves in midlife, aim to tell them how they should act and what their roles are in society.

How menopausal women are viewed also extends to the research that is done with women. "Most often research and health care of menopausal women have mirrored the dominant values of society" (Dickson 1990, p. 16). The medicalisation of women's bodies results in the treatment of menopause as a pathological issue, and means that women's health can be seriously compromised through the use of potentially unneeded medication as well as reinforcing the stereotypes of midlife women - that they need treating.

So do women define menopause differently? Since beginning this research I have asked many women in my local community what their definitions of menopause are. Although some have mentioned worrying symptoms that they attribute to menopause they have also said that it is usually a self-regulating time with some positive aspects.

Responses have included, "It's the end of periods", "It's the end of worrying about pregnancy", "Freedom", "Wonderful". In this research a broad definition of menopause will be used encompassing the terms peri and pre menopause. This is because women themselves do not separate this phase in their life into separately differentiated components.

Menopause and the Media

In many societies the basic inequalities in health between men and women are representative of already established gender inequalities (Van Wijk, Van Vliet & Kolk 1996). Media reports shape the views of how women are seen by society. These views include how women should look. There is an expectation that women need to look forever young despite the fact that they are ageing. Famous women are reported as having plastic surgery, breast reductions or supplementation, liposuction or excessively exercising to retain the youthful appearance of an adolescent (An age-old dilemma, 1997). There are some actors such as Mary Tyler Moore, Vanessa Redgrave and Joan Rivers who are not afraid to play their age in movies. But these women are not in the majority. Retaining a perpetual image of youth is not possible for the average midlife woman who may not have the time, money, or the inclination to have surgery or excessively exercise. Furthermore, it is how the medical profession have seen women that has influenced how women have seen themselves and are seen by others (Kaufert, 1982).

As the interest in menopause increases it seems that the number of articles about it in the media also increase. The media is a popular source for women to gain information about health issues, including menopause. How is menopause portrayed in the media? The image of how menopausal women are portrayed in the media is changing. Although the media still carries articles about the dire physical symptoms attributable to menopause, such as osteoporosis and heart disease, these are beginning to become more balanced by reports of ways a midlife woman can retain wellness. Others refute this however. Referring to media reports, Dekker (1997, p.21) states that although it is increasingly hard to determine who is a midlife woman and who is not, "the myth of midlife being a spiralling, inevitable reduction in the quality of women's lives persists". Mickelson (1991) feels that while we should delight in the natural progression in the cycles in our bodies, others do not endorse

this. She notes that the message about menopause is that it is bad. "The drug companies, the physicians, and most of all the advertising media, have given us the message that this change, the climeratic, is a time to be dreaded, avoided and postponed" (Mickelson, p. 33).

Women and others who peruse the media for information about menopause are influenced by both the content as well as the neutrality, or lack of, contained in the articles. How are women to know what constitutes accurate information? How are they to judge what to believe? Some articles have no mention of the qualification of the author. What is attributed to the author may be no more than personal opinion and completely lacking in fact altogether. Carlson, Li and Holm (1997, p.559) found that:

Of forty-five articles surveyed, seventeen had no author listed, sixteen had an author listed with no credentials, five listed had a member of the magazine's editorial staff, three listed frequent writers on health, one listed a freelance author, one listed a physician in private practice, and one listed Gail Sheehy, a professional writer who has authored a book on menopause.

Media consumers may not generally be aware of issues of credibility of information. They also have no influence over the articles that are printed. Although the media does provide items of interest about a variety of topics, it is profit driven and wants stories/articles that will have an impact and help induce more readers to continue to buy their product. One way of doing this is to provide news about items that have elements of human interest. Using interviews from people who will impress readers, such as medical specialists, adds credibility to the impact and validity of the news item. When reports are attributed to people who are well educated and belonging to a profession that has traditionally been revered, it is little wonder that they are believed totally. Robert Wilson was the first physician recorded to decide that menopause was a deficiency disease and that fixing it simply meant the addition of what was deficient, in this case oestrogen.

It certainly helped that at the time that Wilson made his belief known, oestrogen was available and wanting to be increasingly marketed by the pharmaceutical companies. Goodman (1980, p. 740) believes it is the opinions of people like Wilson that "form

the betrayal of the menopausal woman which readily finds its way into medical textbooks and other media". Increasingly the messages propounded by the medical profession in relation to menopause are being more closely examined and not taken so much as being the only view of the topic (Cobb, 1987; Coney, 1991; Furman, 1995).

In a study undertaken to analyse popular literature on menopause 86 themes were isolated. The majority of these themes addressed the medical aspects of menopause. Forty-two of these themes were related to HRT, nine to medical care and ten to symptoms of menopause (Carlson, Li & Holm, 1997). This left a total of 24 themes that addressed factors related to preparation, and myths and attitudes towards menopause. This study shows that there are still a comparatively larger number of references to the medical aspects of menopause as opposed to those that address menopausal myths and how to prepare for menopause.

Options to manage menopause reported in the media included information about medication, as well as ways to assist women to maintain general good health in midlife. For example Beverley Lawton (1996 b), a Family Doctor for "The Evening Post", writes about the advantages and disadvantages of hormone replacement therapy (HRT). In an earlier article she had discussed the health implications for a woman having a planned hysterectomy as a woman was requesting knowledge about the relationship of her ovaries to the hysterectomy (Lawton, 1996 a).

An article printed in a local newspaper in August 1997 informed the public about a new class of drug, which could be on sale within a year. This new class of drug will "tackle the harmful effects of the menopause without the problems associated with the hormone replacement patches" (Targeted drugs tackle menopause, 1997). This new class of drugs, known as a selective oestrogen receptor modulator, targets specific receptors in specific places. These places include the cardiovascular and skeletal system and the receptors reduce the risk of osteoporosis and cardiovascular disease. As a result of the media reporting about menopause the public are being continually informed of the various aspects of menopause.

Summary

Chapter one has provided an introduction and preview to this study about how women gain knowledge of and how they manage their menopause. The reasons for choosing to do the study were presented. The history and definitions of menopause as well as the statistics of menopausal women were discussed. The impact of how the media presents menopause in terms of the education of the public about menopause was presented. An overview of the chapters to come in this thesis follows.

Overview of chapters

Chapter two reviews the literature on menopause from different perspectives. These perspectives include the writings of the medicalisation of menopause, the 'alternative' ways of treating the symptoms of menopause such as homoeopathy, and the involvement of the nurse in educating and treating menopausal women.

Chapter three describes the research methodology of grounded theory that was used to carry out this research. This methodology was chosen because it can help nurses to understand what is happening to the people we care for as well. Hutchinson (1986, p. 129) believes that "grounded theory can help nurses better understand their own world-people in changing, complex situations".

Chapters four and Chapter five contain analysis of the data collected from the study participants. Also included in these chapters is literature that supports and is challenged by some of the data. Also included in Chapter five is the descriptive model with an explanation of it.

Chapter six provides discussion about the findings of the research, the limitations of the research, recommendations for future research and the implications for nursing education. This chapter ends with a concluding statement.

Chapter 2

Literature Review

Introduction

This chapter will examine selected literature related to menopause. Published literature has addressed the subject from many different perspectives – from the commonly held myths surrounding menopause; ageing and menopause, the history of the ‘modern menopause’, the language of menopause, to menopause in relation to other illnesses. Women’s views of menopause, how culture and norms influence the woman in midlife, and the ‘medicalisation’ of menopause will be addressed. The controversy surrounding how the ‘symptoms’ of menopause are treated, including natural therapies and HRT will be discussed. Finally, the involvement of nurses in assisting menopausal women will be identified.

Myths and Menopause

Historically menopause was a mystery. Life expectancy was short and that meant that few women even reached menopause. Furman (1995, p.37) notes that “when the Roman Empire was in its prime (about 275 B. C.) a woman only lived to be 26 years old”. These women would have had little knowledge about menopause. In the times when witches were burnt at the stake and the causes of ill health were attributed to witchdoctors and the like, myths abounded about what happened to the body and why. Some of these myths and the stereotypes that developed from them still exist.

There are myths in every society. In the case of menopause the myths have been primarily negative. Myths around menopause include all women becoming irritable, hard to live with, irrational emotionally and depressed (Kaufert, 1982). Myths serve the purpose of supporting what we may wish to believe and so justify not having to change our thoughts or behaviour. Human nature dictates that it is much easier to not ‘upset the apple cart’ than to raise questions or challenge or look at ourselves in terms of our own perpetuation of the myths. This behaviour in itself perpetuates myths.

Myths can become so institutionalised that they are seen to be unable to be challenged. For example if a myth is seen to be a revelation from God, the power of the myth may make it too sinful to contemplate challenging it. Myths can also be quite destructive to our society. If the myths are inaccurate everything that is predicted from them is also inaccurate and this means that negative outcomes are multiplied. Coney (1991, p.100) notes that as a result of myths "menopause has become a catch-all, a dump bin for everything that is happening to mid-life women". Our rapidly changing society and the changing role of women means myths may not be investigated. This is because the effort and potential recriminations may be too much to cope with. It is only comparatively recently that literature, that assists women to learn which information is a myth and which isn't, is emerging (Kaufert, 1982, Kenton, 1995).

Menopause and Ageing

Organisations, such as Age Concern, which aim to promote the rights of middle aged and older people, are gaining strength and expanding. They are having some influence on governmental decisions in health and welfare. However, it is the youth and beauty, primarily of the younger female person that is promoted in magazines and the media. Some people in society still believe that it is inevitable that older women will become depressed, incontinent, senile and a burden on society. This does happen for some older women, but not all. This portrayal of the midlife woman can have the effect of preventing some women from believing that they do have the capacity to remain strong, attractive and vital throughout their lives. Supporting this view, Neugarten, Wood, Kraines and Loomis (1963, p. 150) made the point that maybe "it is only the middle-aged or older woman who can take a differentiated view of the menopause and who, on the basis of experience, can as one woman said, "separate the old wives' tales from that which is true of old wives."

Sociologists such as Davey (1994) describe the fundamental changes in the lives of midlife men and women. This includes new career opportunities and options, new recreational pursuits, and in many cases a higher degree of affluence than in the earlier years of home building and child rearing. Coney (1991, p.34) uses the words "release from domestic thralldom" to encapsulate the changes in the ways that women lives have altered from the 1960s sexual revolution, the 1970s liberation

movement to the life of women in the 1990s. Literature such as this is assisting society to see the potential and vitality of midlife women.

History of the Modern Menopause

In the latter half of the 19th century, the dominant view held by physicians was of menopause being a physiological crisis that could lead to many physical and psychological diseases (Utian,1996; Lewis,1993; Kaufert & Gilbert, 1986). Scientific explanation of why menopause was such a crisis ranged from the notion of a woman having too much education, past attempts at birth control or abortion, undue sexual indulgence, insufficient devotion to husband and children, and the advocacy of women's suffrage (MacPherson, 1990).

In 1966 gynaecologist Robert Wilson, author of "Feminine Forever", played a major role in defining menopause as a deficiency disease. Using scientific reasoning, the logical response to a deficiency condition is to replace what is lost; in the case of menopause, to replace the oestrogen which is being produced in decreasing amounts by the woman's ovaries. Once this is done the definition of menopause changes from being a normal process of ageing to become a health hazard (Kaufert & Gilbert, 1986). Wilson's book heralded a dramatic increase in HRT prescribing in the United States. Coney (1991, p. 59) calls Wilson "the Hugh Hefner of menopause" and describes him as "single-handedly cementing the idea of menopause as a disease".

During the past two decades research, surrounding menopause, particularly its 'management', has come under increasing scrutiny by women and the medical profession. Until relatively recently, physicians and pharmaceutical companies have produced much of the literature on menopause. During the last thirty years this literature has mainly addressed the use of HRT for the 'symptoms' of menopause. Women are increasingly writing about their health experiences and undertaking research into menopause with the support and assistance of women.

Language of Menopause

The present medical definition of menopause lies within a context of disease and pathology as opposed to the context of normal ageing of which menopause is only one transitional stage. Women's bodies are seen as being similar to a machine with the ovaries declining in their function and the words "atrophy", "shrink" and "deficiency" were commonly coined to describe the menopausal ovary. These words are negative in their connotation and promote the image of menopausal women as wasted and useless. Logothetis (1991) reviewed literature from the 1960s, 1970s, and 1980s and gave examples of language used to describe menopause. Words used to describe physical deterioration relate to a woman's appearance: "obese, sloppily dressed and needing to visit the beauty shop more often" (Logothetis, 1991, p.41-42). This author also states that the medical literature portrays the menopausal woman as emotionally disabled by her menopause and words she has used to demonstrate this include "forgetfulness, anxiety, lassitude and a wide variety of psychosomatic aches and pains".

However, a growing number of feminists, nurses, and doctors are challenging the view of menopause as a disease. Some women view menopause quite differently; they are influenced by the knowledge gained from other women on how menopause is generally portrayed. Women increasingly believe that menopause means freedom from having monthly menstruation, and the beginning of a new phase in their lives. Daly et al. (1993, p.838) note that increasingly "the age of menopause is not viewed with regret or resentment".

Hormone Replacement Therapy

Oestrogen replacement therapy has been prescribed for decades and though once heralded as the elixir of eternal youth, it is now seen to have limitations. After the publication of studies, which showed that using oestrogen on its own increased the risk of getting uterine cancer, progestin was added to protect against uterine cancer. The combination of oestrogen and progestin is known as HRT.

The popular literature is a common place to read information about menopause. An article by Reuben (1995, p.131), in the Reader's Digest, gives detailed information about oestrogen, calling it a "bone saver" and "heart protector". The article addresses the potential risks of oestrogen only hormonal therapy and the forms of oestrogen therapy. Despite the title of her book, "Beat the Menopause without HRT" Stewart (1995) presents current medical understandings about HRT and includes both the advantages and disadvantages of taking HRT. Cabot (1991, p.44) proposes that "if HRT is given for 10 to 15 years after menopause a large reduction in heart attacks stroke and bone fractures will result".

Lockie (1989, p.243) echoed the concerns of taking HRT and said "gynaecologists are uneasy about long-term effects of HRT". The future for women taking HRT is addressed by Vines (1993) when she questions the overall long-term benefits and risks associated with prolonged use of current formulations of HRT. Women who go onto HRT after suffering endometriosis may find that the drug reactivates the problem and notes that a major study has found those women on HRT increase their chances of thrombosis nearly four times (HRT can reactivate, 1996).

Concerns about the long-term use of HRT and an increase of breast cancer in older women who take HRT or the contraceptive pill have been noted. This discovery was made accidentally when measuring the bone density of these women. They found that those women with increased bone density also have a far higher chance of developing breast cancer (HRT dense bones, 1997). Other authors contend that there are some women with breast cancer who have severe menopausal symptoms which would respond to oestrogen and to refuse these women HRT is to decrease their quality of life (Eden, Bush, Nand & Wren, 1995).

It has been proposed that a reduction in the levels of circulating oestrogen occur during a woman's midlife (Lawton, 1996). This is one way in which osteoporosis has been linked to menopause. It has been postulated that if a woman reaches the age of 60 and has no osteoporotic fractures that she should be started on HRT as a prophylactic measure (Gangar & Zakaria, 1995). However this intervention does not acknowledge the other factors which also play a part in bone density loss. If women were informed of other preventative measures that slow down and prevent bone loss,

they could then have a choice of whether to take oestrogen for the prevention of osteoporosis.

In the debate over whether women should or should not take HRT, Coney (1992, p.179) identifies the pharmaceutical industry as the predator on menopausal women. She says “the only prerequisites leading to a recommendation to use HRT are female gender and being in the age group approaching menopause”. This view is supported by Dumble and Klein (1993, p.327) who state:

We are currently in the middle of a veritable assault on midlife women by medical experts, pharmaceutical companies, and a large part of the media whose message is that only with the help of powerful hormones - oestrogen and progesterone - taken for the rest of our lives - can women cope with what is medically termed ‘the death of our ovaries’ and survive.

Menopause in Relation to Other Illnesses

Menopause, and the natural reduction of oestrogen that is a part of menopause, is currently being linked with diseases associated with mainly older people, including cardiovascular disease, cancer and osteoporosis. Prescribed HRT is being widely used by women to address the symptoms of menopause. In New Zealand in 1996, there were purported to be 86,500 women of the usually resident population, that is 45 %, using HRT compared to 53,000 or 27% in 1992 (The big change, 1996). However, there is much controversy among women, feminists and health professionals, surrounding the use, abuse and the long-term effects of HRT. The literature, connecting menopause with the diseases usually seen in older women, will now be addressed.

Cardiovascular Disease

As women age they become more at risk of cardiovascular disease. Cardiovascular diseases are among leading causes of death in industrialised countries (Cherry & Runowicz, 1994). A number of studies have demonstrated that “cardiovascular mortality of postmenopausal women on (HRT) decreases by approximately one-half”

(Samsioe, 1993, p.23). In the same year this statement was refuted. Delivering a paper at the Novo Nordisk International Symposium on menopause, Rehnqvist (1993, p. 118) noted that “there have been no randomised, prospective studies that have utilised the hard end-points of myocardial infarction and death in assessing the value of HRT in populations at risk of cardiac vascular disease”. Landers (1995) concurs with this view in that the relationship between heart disease and the use of HRT preparations that combine oestrogen and progesterone is not conclusive and that the argument against the use of HRT appears to be that not enough is known about the relationships. However, Vyas and Gangar (1995) believe while acknowledging the absence of a large scale controlled trial, that postmenopausal oestrogen use is associated with a significant reduction in cardiovascular morbidity and mortality. Vines (1993) cautions though that “adding progesterone to the hormonal cocktail may also obliterate oestrogen’s potential effects on the heart” (p.22). The literature discussed above presents a clouded view, at best, of the advantages or disadvantages of taking HRT to improve cardiovascular health.

A more balanced view of cardiovascular disease and its relationship to midlife is needed. Often articles are written for health professionals and not easily understood by the lay person. There are many other factors besides reducing levels of circulating oestrogen that put women at risk. These include diet, smoking, lack of, or a decrease, in activity and exercise, hypertension, diabetes and a family history of cardiovascular disease. The literature often focuses on one symptom of menopause or on one aspect of management without examining the total picture of women’s lives and the society they live in. Women’s health needs to be evaluated holistically. In a challenge to HRT Vines (1993, p.21) asserts that “epidemiologists are less confident that long-term treatment with analogues of human sex hormones is an unalloyed boon for women who have passed the menopause”.

Osteoporosis

One of the strongest arguments in favour of oestrogen therapy has been the potential for postmenopausal women to develop osteoporosis as the reduction of oestrogen increases the loss of calcium in older women. As the potential for osteoporosis increases so does the incidence of fractures. In younger women calcium loss can occur and may not be directly associated with oestrogen, an example being of

excessive exercise. The solution for the prevention of osteoporosis is far more complicated than just dramatically increasing the amount of calcium fortified milk and calcium tablets that may be ingested. Calcium uptake is also impaired by the high intake of phosphorus that is in the typical Western diet (Acting now to make sure of future bone growth, 1995).

As well as having a sufficient level of serum calcium, factors such as exercise, sunlight, and an adequate diet in protein, vitamins C and D are also vital ingredients in the reduction of the risk factors for osteoporosis (Coney, 1991). Smoking is known to negatively effect the uptake of calcium (Coney, 1991). Weight-bearing exercise positively effects calcium uptake (Osteoporosis risk for many, 1995). Cobb (1987, p.19) states that "osteoporosis is a culture-specific condition and is unknown in countries where women do hard labour". However, it may not be that simple. McDonald (1994) informs of a worker at the Ancient Monuments Laboratory at English Heritage in London who told of his work where he x-rayed the bones of women, buried hundreds of years ago in the churchyard of a deserted village. This worker revealed that these female peasants did not have the hip or wrist fractures common among modern women and postulated that environmental reasons for this might have included medieval homes having a softer floor, the lack of furniture and lack of a paved road. Not all women with osteoporosis will have fractures and not all women with fractures have osteoporosis. Some women with osteoporosis will not become aware of it unless they have a fall while others may have a fall purely due to other causes. Other potential factors can be involved with falls and these include compromised eyesight, decreased muscle strength, and uneven walking surfaces. These factors could be as important in the prevention of falls as the density of bone mass is to osteoporosis.

From her experience at a nurse - run hormone implant replacement service Jordan (1994), observes that the incidence of fractures is decreasing in women using HRT and that prophylactic use is considered more effective than correction of established osteoporosis. Jordan also argues that the reduction in hip fractures is increased with increased duration of HRT and that prevention of osteoporosis may be maximised by starting HRT within three years of the menopause. There is no rationale stated for this time frame. This finding of Jordan's is partially supported by a study done in 1988 which concluded that "taking oestrogen for less than seven years had no net

protective effect on women's bones by the time they reached 75, though it may have briefly slowed their bone loss rates while they were on the drug" (Brief oestrogen use negligible, 1994). Alendronate, a drug approved for use in the United States and increasingly prescribed by doctors to help prevent hip and spinal fractures, was used in a study involving women with osteoporosis and who had all had a previous spinal fracture. Results suggested that these study participants had a 51% lower risk of having a hip fracture than those in the placebo group. This drug is marketed in New Zealand under the name of Phosamax and is available in 10mg and 40mg tablets. It is not subsidised and is expensive, costing approximately \$100 for a month's supply of the 10mg tablets (J. D. Mackley, personal communication, October 3, 1998).

HRT has been shown recently to produce a clinically significant increase in the bone mass of patients who have established osteoporosis, especially in the first two years of treatment (Way & Ghose, 1995). However, McTaggart (1996, p.180) states that "at London's Biolab, Dr McLaren Howard has found in his studies of women with osteoporosis that not one woman, compared with healthy controls and even menstruating women, has suffered from low levels of calcium." O'Neill (1995, p.30) notes that "for the woman entering menopause, the lifelong risk of hip fracture is about 15%, which is equal to the combined risk of breast, uterine and ovarian cancer".

These contradictory reports result in confusion for both health practitioners and the lay person, and do little to aid in the management and prevention of symptoms (McTaggart, 1996; Lemaire&Linz, 1995; Blackwell & Blackwell) . Have we become a generation wanting instant cures and are not really wanting to 'do the hard graft' that is involved to positively alter our lifestyle? Coney (1992) suggests that information given to women about osteoporosis has been presented in such a way as to encourage hormone use, rather than to help women identify modifiable risk factors in their lives. Therefore, it is important to always have the larger picture of women's health at hand as other lifestyle factors also influence the level of oestrogen in the blood; these include smoking, exercise and a high intake of alcohol (Jordan, 1994).

Cancer

During the 1970s oestrogen therapy given to menopausal women was found to be linked to abnormal bleeding and an increased risk of adenomatous endometrium, endometrial hyperplasia and carcinoma (Maddox, 1992). It was at this stage of the use of oestrogen replacement therapy that synthetic progesterone was added to the tablets to counteract the carcinogenic effects of unopposed oestrogen (Ripper, 1994).

Despite some evidence that postmenopausal oestrogen replacement protects against osteoporosis and cardiovascular disease, the relationship between oestrogen therapy and breast cancer remains a subject of debate (Gambrell, 1993). A nested case-control study done with a cohort of women with a personal history of breast cancer suggested that using combined continuous HRT may reduce the risk of recurrence of breast cancer and be safe for the women to use (Aden, Bush, Nand, & Wren, 1995). However, Landers (1995, p.35) said there appears to be an “increased risk of breast cancer for women using HRT for both natural and surgical menopause by thirty to eighty percent when HRT is used for ten years or more”. This is supported by Way and Ghose (1995) who say that taking HRT for a substantial period of time poses serious and life-threatening risks and that two of the major ones are increases in the incidence of endometrial cancer and of breast cancer. As using HRT for the prevention of osteoporosis and cardiovascular disease is still controversial so is its relationship with cancer of the breast and uterus. Coney (1992, p.203) notes that “the final chapter in the story of HRT will not be written until large-scale long-term independent studies prove or disprove the risks, to women, of cancer”.

Medicalisation of Menopause

Sociologists began to examine the origins and consequences of treating human conditions as medical problems about twenty years ago. They labelled this practice medicalisation (Bell, 1990). Agreeing with Bell, Coney (1991, p.15) writes that:

in previous years medicine treated the mid-life woman as a stateless refugee, denying her citizenship in the land of the sick and likely to be called a hypochondriac, now

doctors and medical entrepreneurs wish to measure her bones, her breasts, the cells on her cervix and her hormone levels.

So how did menopause become 'medicalised'? Bell (1990, p.174) interprets medicalisation by stating that "on a conceptual level, a condition is medicalised when a medical vocabulary or set of concepts is used to define a problem and that once a problem is defined medically, a medical approach appears to be the only logical solution to it". Riessman (1983) argued that both physicians and women have contributed to the redefining of women's experience into medical categories and physicians seek to medicalise experience because of their specific beliefs and economic interests.

Dickson (1990, p. 18) states "once menopause was constructed as a disease by the American medical profession, the notion was sold to the public under the banner of the neutral, value-free concept of scientific truth". Also laying the blame for the naming of menopause at the feet of the medical profession, Kaufert and Gilbert (1986, p.8) maintain that "it has been the medical researchers who have tried to take over the word by stripping it of all its social and cultural baggage and giving it a precise and formal definition as a woman's final menses." Late twentieth-century feminism has been severely critical of mainstream medical care with the criticism being that modern medicine has exerted patriarchal control over women's bodies, both through the imposition of new technology and through the doctor/patient relationship (Lewis, 1993). Wuest (1993, p.409) agrees saying that "the hegemony of patriarchy continues despite the changing roles of women". Dickson (1990, p.16) adds that "the extant knowledge of menopause transmits and perpetuates, through the sanctity of science and the authority of the medical 'expert', the knowledge and power relations that help structure and reinforce society's expectations and stereotypes of menopausal women".

The medical profession, nurses and feminists are researching menopause. The correlation between menopause as a disease and obtaining research funding is highlighted by Cobb (1987, p.221), who notes that "pathologizing menopause may make it more credible when seeking research funds or getting sponsorship for a clinic but women should not have to be diseased to be interesting to health care providers". MacPherson (1990), in discussing how nurse-researchers respond to menopause,

makes the point that because of the medicalisation of menopause there are nurse-researchers designing and implementing research in order to hear women's voices about their experiences.

Women's Views on Menopause

In a study reported by Neugarten, Wood, Kraines and Loomis (1963) on women's attitudes toward the menopause, many women volunteered the information that they seldom talked about it with other women but that they also wished for more information and communication. Most of these women had heard many tales of the dangers of menopause, though they professed not to believe what were termed old wives tales. A decade later Reitz (1979) provided data which enabled women to develop an informed approach in their anticipation of menopause. She also spoke with many women, both menopausal and postmenopausal, on their experiences during this transition. Goldsworthy (1994) also collected personal musings on the effects of menopause and explored the implications for women both in the past and today.

More women are writing about menopause and, among many women, the topic of menopause has 'come of age'. Mary d'Apice (1989) a doctor, psychotherapist and "spiritual director", explores the challenges and the risks as she invites women to welcome and understand changes during mid-life and ageing. Stewart (1995) writes with a positive approach to the menopause giving excerpts from women's experiences and providing information on management options available to women. She specifically promotes nutritional answers to assist with menopausal symptoms. Christine Northrup (1995) an obstetrician and gynaecologist, shares with women how they can heal themselves by listening to their own body's wisdom and intuition. Moreover, Fishbein (1992) notes that viewing menopause as merely the absence of symptoms, problems and complaints denies the potential for growth and liberation that may occur for many women. Nachtigall (1990) cautions against treating all menopausal women but also adds that medication should not be withheld from all women.

Significantly also, as the discussion of menopause continues among women, so does the discussion of the position of women in society and a call for women to have more

control over their health. Laurence (1992) notes that we live in a society that values and rewards power and status in the public arena and views as less significant the roles and functions performed in service to and in support of those who do the 'real' work of running the society. In health care, the 'battle' in the menopause stakes is often compared with the 'revolution' that happened with pregnancy and natural childbirth.

Culture and Menopause

The process of menopause occurs in a socio-cultural context and is impacted upon by the cultural beliefs that are imposed by society. In the past Western women's views of menopause were influenced by a rapid period of change in the Victorian era when the status of women was based on their reproductive capacity. However, Western women's views of menopause can not be generalised to other cultures or societies as culture also effects the way in which women feel, anticipate and cope with menopause. Women in some societies attain different status on reaching mid-life. They have fewer restrictions and an increase in authority and status with recognition for their wisdom. Until the end of the last century, there was no word for menopause among Japanese women although there is now - *konenki*. (Sanseido, 1985).

In a study at Grey Rock Harbour, a Newfoundland fishing village, Davis (1992, p.157) found that women there attributed menopause to being a "non-event, a normal, prolonged part of the ageing process". In this society "giving in" to sickness or "being a problem" are not valued traits. This is because the role of women's inclusion in the workforce is vital to the survival of this community. With suffering seen to be stoic, it discourages women in the fishing village against voicing concerns they may be having for fear of being seen as inadequate in comparison to other women.

Other cultures view menopause differently to Western cultures. This is due to both how society depicts the worth and role of older women and how menopausal women see themselves. Gifford (1994, p.299) studied twenty middle-aged Italo-Australian working-class women, living in Melbourne, and the experiences they had had since immigrating that have shaped their expectations of menopause. The women in this study had come to Australia as young wives. Their experiences were common to

immigrant women; changes in women's roles, adjusting to not having an extended family present, an inability to speak English and the cultural gap between themselves and their children who are growing up with differing values. These women saw menopause "as the end of life" and had a fear of cancer. Menopause was also representative of social and physical death. Midlife was seen in terms of "loss over the fertility of their youth, ambivalence about their lives in Australia and grief over a life left behind in Italy". They were fearful of becoming old and dying in a country far from "home".

Flint and Samil (1990) undertook a study in central Java among urban, rural and migrant women. They noted that in the search for negative symptoms attributed to menopause that the positive attitudes are not paid enough attention. The three groups of women in the study all scored over 80% for criteria such as having feelings of well being, and orderliness, excitement, and affection. These women reported fewer oestrogen-dependent symptoms in the study and bought *janu* (native herbal drinks) and ate papaya which is an oestrogenic fruit. Another study, done by George (1996) with the women from a fishing village in southern India, showed that the women of this village looked forward to menopause and had virtually none of the usual symptoms associated with menopause in the West. One reason for this relates to the belief that menopause was seen more as a liberation in that the women could have more time and freedom to pursue their fish-selling business.

Natural Therapies and Menopause

Coming from discussions with women before the study it appears that women are increasingly opting to take charge of their health in terms of self-medication. They discuss and compare symptoms with friends and other women and find out what works and what does not. As the discussion surrounding the safety of prescribed medication for menopausal 'symptoms' continues, more and more women are deciding to try herbal ingredients as well as look at lifestyle changes to assist with management.

Women are also becoming more aware of the influences of other factors that effect midlife health. For example boron plays an important role in body biochemistry as it is responsible for the "facilitation of the serum concentration of 17-beta-estradiol, the most biologically active form of oestrogen" (Conroy, 1992, p. 25).

Homoeopathy is a source of natural therapy which is becoming both more known and used by women. This is because, unlike chemical medicines where the higher the dose the greater the effect, just the opposite is the case with homoeopathy. A good homoeopath will always prepare a remedy after a total picture of a woman's constitution and symptoms have been determined (J. Radley, personal communication, April 27, 1997). Because homoeopathy is personally tailored to suit each individual constitution it is hard to validate the outcomes of homoeopathic remedies. Kenton (1995) reports a study done in 1992 in which a homoeopathic combination known as Mulimen was used over a three-month period. Of the 82 women treated in this study over half experienced significant relief with half of the women who had been having hot flushes becoming completely free of them.

Women also use herbs to address menopausal symptoms. Black Cohosh and Blessed Thistle Combination is recommended by Pederson (1990) as an excellent herbal source of iron and vitamin A for the treatment of menopause and other symptoms such as nervous tension, anxiety, dysmenorrhoea and menstrual cramps. A recommendation for the use of pyridoxine for reducing water retention, vitamin C with bioflavonoids to relieve hot flushes and evening primrose oil for keeping a healthy hormone balance was made by Hasnain (1995).

Some reports indicating an increase in psychological symptoms during menopause were based primarily on studies of women attending menopause and gynaecology clinics. Wilbur, Holm and Dan (1992, p. 269) recognised that "large-scale random surveys of midlife women in Sweden, England, the United States and Canada all suggested there was no increase in psychological symptoms at menopause"

Exercise is important for overall psychological as well as physical health. It can be particularly beneficial for the menopausal woman. Notelovitz (1990) believed that the reason why women are not advised of the potential physical and psychological benefits of exercise by physicians and other health professionals is because these practitioners are not actually physically active themselves. Vines (1993) agrees with this view contending that physical exercise continues to be promising in the prevention of both osteoporosis and heart disease. As well as assisting in the promotion and prevention of cardiovascular disease, cancer and osteoporosis,

exercise also promotes and produces psycho-social benefits. Exercise also gives feelings of well being and companionship if shared with a friend or a group of people.

The latest claim, about the benefits of natural progesterone, published to assist women with the symptoms of menopause is not new. A leading exponent of natural progesterone, John Lee, began giving it to his patients twenty years ago. As a family doctor he had come to know that some of his patients could not take oestrogen, which he was prescribing for osteoporosis, due to the risk of developing cancer. As a result of his knowledge he began prescribing a cream, extracted from a wild yam, which is said to replicate progesterone. Tests carried out by Dr. Lee show that the women's bone density increased and that other symptoms they had, which were associated with menopause, began to disappear (Yams said to ease menopause, 1998).

Nursing Involvement with Women's Menopause

Nurses in New Zealand have traditionally been involved with midlife women in their roles as practice nurses, in hospital wards nursing women with gynaecological concerns and in Family Planning clinics. Do women see these nurses as appropriate information sources? Mendham and Rees (1992) reported a study of menopausal women done in the Bristol area of Britain in which only five out of forty-three women stated they accessed their information about menopause from a nurse. In this 1992 survey the majority of women gained their knowledge from their general practitioner (G.P.) and the authors wondered if this meant that women did not see a professional alternative to the G.P.

In many countries, including New Zealand, menopause clinics have been established to assist women with the varied physical and psychological concerns that are experienced as they go through the perimenopausal period. Do women who visit a menopause clinic receive a balanced view of menopause and their choices in its management? Hay, Bancroft and Johnstone, (1994) express concern about the lack of nursing involvement in these clinics as they note that menopause clinics are usually run by gynaecologists.

Summary

This chapter reviewed a selection of the literature that is available around menopause. The topic has been explored beginning with the history of menopause to the way in which some women have changed their thinking of this transitional period. The viewpoint of feminist writers has shown that they believe that some medical practitioners and the pharmaceutical companies have a vested interest in continuing the idea that menopause is a stage of a woman's life that requires medical intervention. Chapter three will present an overview of the research methodology of grounded theory. A discussion addressing the reasons for its use will be included. The way in which the methodology was used in this study forms the final part of the chapter.

Chapter 3

Research Methodology

Introduction

Grounded theory is based on the generation of theory from data. The term 'grounded' means that the developed theory is intrinsic to that data. Glaser places emphasis on both how the researcher goes into the field, gathers the data and makes meaning of it as well as the many facets of the researcher including "skill, fatigue, maturity, cycling of motivation, life cycle interest and insights and ideation from the data" (1978, p.2).

Grounded theory is "the discovery of theory from data systematically obtained from social research" (Glaser & Strauss, 1967, p.2). In relation to grounded theory the term systematically means that a series of structured steps in the process beginning from data collection to generation of the theory are followed. Orderliness and rigor are also stressed by Glaser (1978, p.2) as he states that "grounded theory method offers a rigorous, orderly guide to theory development that at each stage is closely integrated with a methodology of social research".

Grounded theory was developed in the 1960s by sociologists Anselm Strauss and Barney Glaser. These sociologists were attached to the School of Nursing at the University of California, San Francisco. They had been given a grant to study what the experience of dying meant for patients. Their observations of the relationships of patients dying in a hospital environment led to Glaser and Strauss discovering that dying is a social problem involving patients, families, and health care staff in many settings (Holloway & Wheeler, 1996). Through this study of dying Glaser and Strauss discovered "that their method of researching constituted a new approach to scientific investigation and to them grounded theory brought together the two worlds of research, qualitative and quantitative"(Glaser, 1978, p.372-373).

The qualitative research approach of grounded theory, developed by Glaser and Strauss (1967) and further developed by Glaser (1978), was chosen as the methodology for this research. This chapter provides a description of grounded

theory, outlines how grounded theory can be useful for addressing questions related to nursing practice and discusses why grounded theory was used in this study. A discussion of how the study was conducted, including ethical considerations will complete this chapter.

Description of grounded theory

Grounded theory, “is more structured than other qualitative methods even though it uses generally similar approaches to data collection and analysis” (Holloway & Wheeler, 1996, p.98). Glaser articulates grounded theory as being a general methodology for generating theory and useful in any field, whether data is qualitative or quantitative. As this project is qualitative, comments in this chapter are confined to the research methodology grounded in social processes and qualitative aspects of human life. Qualitative research, including grounded theory, aims to discover, generate or verify knowledge about phenomena. Hutchinson (1986, p.111) describes grounded theorists as searching “for social processes present in human interaction” and asserts that this “guards against the eternal danger that scientists lean too heavily on inherited dogma or theories”.

Symbolic Interactionism

Grounded theory is underpinned by the interpretative tradition of symbolic interactionism. Blumer (1969, p.47) acknowledges the groundwork that George Herbert Mead did in establishing the foundation of symbolic interactionism and sees symbolic interactionism as a “down-to-earth approach to the study of human group life and human conduct”. By this Blumer means that the study examination has to be “intimate” in terms of the researcher being true to the group and the conduct being studied. Blumer (1969, p.37) describes one way of studying group life as “lifting the veils that obscure or hide what is going on”. By this he means we need to understand the phenomena that we are studying and to also increase our understanding of it. Melia (1996, p.380) describes the basic tenet of symbolic interactionism as “the essential defining of self through social roles, expectations, and perspectives cast on self and by those within society”. The basis of symbolic interactionism is identified

by Stern, Allen and Moxley, (1984, p.373) “as a basis of symbols that have meaning and value when humans act and interact”.

Blumer (1969, p.2) posits symbolic interactionism as having three basis premises. These are:

Human beings act toward things on the basis of the meanings that the things have for them, that the meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows and that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.

With symbolic interactionism, as the basis of grounded theory, there could be many different theories developed from the same research question. People’s responses to the same question are influenced by what has made the person develop and interact with society in the way that they have.

Data Collection and Analysis

In grounded theory the analyst’s goal is to “generate an emergent set of categories and their properties which fit, work and are relevant for integrating into a theory” (Glaser, 1978 p.2). Data collection and data analysis occur simultaneously and are interrelated processes and called constant comparative analysis. This begins as soon as the first data are collected. The collected data are transcribed and then coded line by line. This first form of coding is known as open coding. In open coding the data is coded “in every way possible; another way to phrase it is running the data open” (Glaser, 1978 p.2). When doing open coding the analyst is challenged to examine the data to find codes that may fit and work. Glaser posits a number of questions which govern open coding and states these ensure its proper use and success. The three questions are: “what is this data a study of, what category does this incident indicate and what is actually happening in the data” (Glaser, 1978 p.57). Keeping these questions uppermost while coding means that the researcher has to focus and identify the patterns emerging from the incidents and this also allows them to rise above that of a “fascinating experience” (Glaser, 1978 p.59).

In substantive coding the researcher summarises the substance of the line. The words used by the participant are often included in the substantive code and with substantive coding different events are coded into as many different codes as possible. From a transcript an example of a substantive code is one that I called 'not quite taboo'. Gillian said,

I mean it was a sort of taboo thing. It just wasn't sort of talked about and you sort of - I don't know her attitudes were different. Yes they were. They were totally different (Gillian, 1: 4).

As further data are obtained it is essential that the researcher ensures that the new data fits with the codes appropriately. The term 'fit' means that the data collection and constant comparative analysis occurs codes will begin to emerge and merge and become categories. Codes which all share similarities, then become categories. As categories form and enlarge the researcher begins to make tentative attempts to form a conceptual framework.

Grounded theory entails collecting data and the use of constant comparative analysis until no new information is forthcoming; this state is then known as data saturation. Glaser and Strauss (1967) describe saturation as when the researchers are not learning anything new; meaning that new and additional data will not change the central themes emerging from the data.

As data are collected the researcher makes notes known as theoretical memos. Theoretical memos record thoughts or ideas that the researcher has had about connections between the data; these may be similarities or differences. These memos are grounded in the substantive codes and categories and this groundedness prevents the researcher from making abstract concepts that are not pertinent to the research under study. During the process of memoing repetitive questioning occurs, as each memo is checked for its relationship to others.

The process of memo sorting is important in the process of generating a theory, as the descriptions of the events have to become abstract to a certain degree. Glaser (1972, p.72) notes that:

this stage is one that can not be skipped and that it is this stage which puts all the fractured data back together. Unlike data collection where other help may be accepted, theoretical sorting is work needing to be done by the researcher as she knows the concepts and how they relate to one another.

The use of the term 'fractured data' refers to data that has been coded and then put into categories. During constant comparative analysis the core category becomes identified. This core category links all the findings of the study and is the pivot for the description of what is happening in the area under research.

Basic Psychological Process

The core category may also be the Basic Social-Psychological Process (BSP). Holloway and Wheeler (1996, p.106) explain a BSP as "a process which occurs over time and explains changes in behaviour". Chenitz and Swanson (1986, p. 134) extends this explanation and describes a BSP as "an analytic focus on process to integrate the who, what, where, when and why questions of the research problem". Glaser (1978, p.100) explains a BSP as being "theoretical reflections and summarisations of the patterned, systematic uniformity flows of social life which people go through, and which can be conceptually "captured" and further understood through the construction of BSP theories".

In terms finding a BSP Glaser says that some people will be better at it than others. The two ways of finding a BSP are by discovery and emergence fit. By discovery it is meant that the analyst goes to a "fairly contained social unit attempting by observation and interviewing to see as much as possible and find out the most salient social problem of the people there" (Glaser, 1978, p.107). The BSP encapsulates the ideas from the data that are the most important to the participants. Using emergence fit the researcher has a BSP which has been discovered.

Theory Development

Hutchinson (1986, p.12) describes the method of constant comparative analysis as forming "a theory which encompasses as much behavioural variation as possible". Open coding involves breaking each sentence and putting it into as many codes as

possible to ensure full theoretical coverage. Coding results in achieving a full theoretical coverage, which is grounded in the data. The other type of code is the theoretical code. With theoretical coding the researcher thinks substantively and at the same time of the relationship between the codes. This involves making the data more abstract through putting the codes into schemes or diagrams. When similar patterns in the data are identified they can be labelled as a category and incidents that are different, within the category, may become a characteristic of that category. This then leads to a theory being generated from the core category or categories. Beck (1996, p.7) encapsulates the aim of grounded theory succinctly by saying, "it accounts for a pattern of behaviour that is both relevant and problematic for the participants involved".

In qualitative research, the aim is to generate theories and hypotheses and in quantitative research these theories or hypotheses can then be tested. Field and Morse (1985, p.5) note that "often the strongest research findings are in studies that utilise both methods". This study is limited, by the scope of a Masters thesis, to the development of a descriptive model.

Literature in Grounded Theory

Describing the use of literature in grounded theory Hickey (1997, p. 371) says that "unlike most approaches to research, grounded theory requires that literature is not viewed before commencing a research study because to do so could lead the researcher into making misconceived assumptions about what issues warrant further investigation". Glaser (1992, p.31) states that in grounded theory the protocol is that "there is a need not to review any of the literature in the substantive area under study".

The rationale for not reviewing literature before commencing the study in grounded theory is to prevent the researcher being influenced or inhibited in the task of forming the concepts and categories from the data. When using a qualitative research methodology such as grounded theory the data are collected first and the literature used to support the data. If the literature is reviewed first the data, as collected from the participant, cannot be said to be fully grounded and could be seen to be made to 'fit' the literature. This has the possible effect of removing some of

the 'groundedness' from the results. Contrasting grounded theory with quantitative research Beck, (1996, p.7) notes that "reading related literature is reserved until the later stages of the research study".

Grounded Theory Methodology: Discussion and Debate

Since developing grounded theory together in the 1960s Strauss and Glaser have differed in how they have used the method. Glaser (1992, p. 123) asserts that Strauss has taken the grounded theory method that they developed together and changed it. Glaser wrote of how Strauss had developed grounded theory from their original work and details this in his book, "Emergence vs Forcing Basics of Grounded Theory Analysis". Since the original development of grounded theory other theorists have also added to and altered the basic grounded theory method. This has resulted in confusion for some students as it is unclear which method is the 'right' one to use.

In regard to data analysis there is disagreement between Glaser and Strauss and Corbin about how open coding should be done. While Strauss and Corbin believe that incidents should be labelled and then grouped together to form a category Glaser believes that all that is needed is for the researcher to compare the incidents and then make concepts of the pattern among them (Hickey, 1997). Glaser asserts that when using Strauss's 'new' method the data is not allowed to speak for itself and Glaser names this new method developed by Strauss as full conceptual description (Melia, 1996).

Anells (1997) describes very clearly the many differences between the 'classic' grounded theory method of Glaser and Strauss and that of the method late developed by Strauss and Corbin. Instead of focusing on a substantive area, Corbin and Strauss focus on a phenomenon. Using the grounded theory method, for Corbin and Strauss, means development of grounded questions, development and testing of hypotheses whereas Glaser allows these to emerge. With the focus on process Corbin and Strauss link action or interaction sequences whereas Glaser has a basic social process. All this results in Glaser having generated grounded hypotheses whereas Corbin and Strauss have some degree of verified grounded theory.

In discussing the limitations of grounded theory Keddy, et al. (1996, p. 450) comment that the language that Glaser and Strauss use in their 1967 book sounds “static and linear” but note that because it was written at a time when the predominant methodologies being used were quantitative they had to use this type of language to make themselves clear to these researchers. Keddy, Sims and Stern do not advocate changing the language as they feel it is important that it remain stable and separate; this assists researchers, new to grounded theory, to understand the terminology. However, Keddy et al. suggest that it is the language of positivism, central to quantitative research which causes frustration for the qualitative researcher.

It is therefore essential to understand and to be able to differentiate the original theory from the later adapted grounded theory method. For the researcher it is imperative that they know and understand the differences in grounded theory according to Glaser and Strauss and the way that grounded theory has changed since then. The researcher also needs to state which approach they are using in their own research. This study has used grounded theory as developed by Glaser and Strauss. The reason for this is simple. After doing some reading around the two ways of conducting grounded theory the method, as outlined by Glaser and Strauss, seemed to be the ‘purer’ of the two to me. As a new researcher I felt it was important to understand and use the method of grounded theory in its original form. I felt that unless I could understand and use Glaser and Strauss’s method that I may be unable to do the same to the more recent method developed by Strauss and Corbin.

Where Grounded Theory fits with Nursing

In New Zealand in the past much of the literature published about menopause has been from a medical and not a nursing perspective. This literature has stated relationships between menopause, diseases and treatments. It has not asked women what they feel about menopause or what they think should be available for them during midlife.

Nurses utilise an inductive approach to their practice. This ‘from the ground up’ approach is used as opposed to the ‘from the top down’ deductive approach. In the course of each nurse’s day they are asking questions of their clients regarding, for example, how their level of pain is affecting their ability to cough or move. Stern

and Pyles (1986, p. 1) agree with this approach stating that “nursing is a practice discipline whose essence lies in processes”. When a client is being discharged the nurse has to make out a discharge plan. However the success of the plan is inherent on the nurse thinking of the reasons which will allow it to work or not work for the client. It involves thinking of processes and problem-solving them prior to discharge. It follows then that the use of grounded theory, which has symbolic interactionism as its underpinning, would be appropriate to use when undertaking nursing research.

Holloway and Wheeler (1996, p. 100) note that “grounded theory helps health professionals to give up their own model of patient care and disease management in order to adopt an alternative perspective based on the perceptions and beliefs of patients”. This belief is substantiated by Hutchinson who proposed that grounded theory allows nurses access to:

systematic, legitimate methods to study the theory offers systematic, legitimate methods to study the richness and diversity of human experience and to generate relevant plausible theory that can be used to understand the contextual reality of behaviour (1986, p.129).

Obtaining funding to conduct research remains a real concern for nurses and for nursing students. With the technological advances being made to assist nursing practice and the pressure on nurses to do more research, the use of grounded theory offers the possibility to explore new areas of research and new ways of delivering care. Hutchinson (1986) also suggests that grounded theory could be used as a means of evaluating nursing care from the perspective of clients as well as experiences of nursing students and nursing programmes.

Reason for the Use of Grounded Theory in this Study

Previous research done with menopausal women has largely been of the quantitative type. Some of it has been in relation to HRT and the classification of physical and psychological symptoms. Glaser and Strauss (1966, p. 56) note that “sociologists (and informed laymen) manage often to profit quite well in their everyday work life from analyses based on quantitative research”. In view of the comparative deficit of research done with women to elicit their view of their menopausal experience, it was

decided that a qualitative methodology would be the most appropriate for this research study. Grounded theory was chosen as the research methodology for this research study because it is of interest to the researcher and because the use of this methodology is capable of eliciting the perceived deficit of women's knowledge of menopause. Nurses need to know what women wish to know surrounding menopause so that they may be in a position to educate women to be aware of the changes in their bodies as well as how they may be best able to cope with them.

Stern (1980) points to the strongest case for grounded theory use as being investigations of relatively uncharted waters, or to gain a fresh perspective in a familiar situation. The nurse can generate a theory with data gathered from the client rather use one that may not be relevant to the needs of the particular client or population of clients.

Trustworthiness of the Study

When discussing how the researcher may convey and judge credibility, Glaser and Strauss consider that the researcher faces two tasks; to assist the reader to understand the theoretical framework used and to bring alive for the reader the social world of the participant. The concepts the researcher chooses to use must be analytic but be accompanied by illustrations meaningful enough that the reader could relate them to their own experience.

Conveying credibility is a joint responsibility, shared by the researcher and the reader. The researcher's responsibility is to make the research clear enough so that the reader may assess the researcher's understanding of the framework used. In discussing the interplay between the researcher and the data Corbin and Strauss (1990, p. 19) suggest that the researcher must be able to 'see' what the data is indicating to enable creative interplay. This ability to 'see' is important in explaining the ability of the researcher to convey the study to the reader. The reader's responsibility is to demand succinct explanations about interpretations if the researcher has not provided them. Credibility of the research also comes from how the researcher arrived at the study's conclusions.

Qualitative research emphasises the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses. The rigor of qualitative research is addressed in several ways (Sandelowski, 1986). In this research, rigor has been promoted by the regular contact with my research supervisor who has monitored the research process, as well as providing advice and critique. I also had another Masters student provide critique of some of the coding and formation of categories and this also assisted validate the research processes.

Appleton (1995, p. 993) warns that researchers who do qualitative research need to be clear as to the issues of trustworthiness of the study's components. This prevents the researchers from "falling into the trap of not being able to justify proposed methodologies to positivist investigators and omnipotent scientific funding and research committees".

Any research study must be open to scrutiny and critique by other researchers. This means that all elements in the research process must be available to allow others to see that the correct research process was followed. Auditability can be achieved when someone else can track the researcher's decision trail from beginning to end. This other person must also be able to understand the logic behind decisions that have been made throughout the study. Koch (1994, p. 997) likens this process to a fiscal audit when an auditor is required to "authenticate the accounts of a business".

In a comment related to qualitative research Streubert (1994, p. 489) suggested that to increase auditability a "listing of each theme cluster, its subsumed formulated meanings and their original numeration" be available to clarify the transition of formulated meanings to theme clusters. In this study, though grounded theory was used the same audit trail could be used as the transcripts with the numbered lines, the open coding, the substantive codes, the memos and field notes are available as are the codes and categories.

In qualitative research the issue of credibility of research findings has to be addressed. In reporting on the trustworthiness of this study the concepts of credibility, fittingness and auditability need comment. The inclusion of numerous quotes from the participants' descriptions of how they integrated menopause into

their lives increases credibility. The fittingness of the study was demonstrated by “portraying the reality of the participants, described in enough detail so that others in the discipline can evaluate importance for their own practice, research and theory development” (LoBiondo-Wood & Haber, 1994, p.277).

After data analysis has been completed, a descriptive model will be formulated. This model will “fit” with the data collected from the participants and have “grab”. By “grab” I mean that the participants will look at the model and be able to identify their own experiences.

The Study - Menopausal Women: Method and Procedure

The way in which the methodology of grounded theory was used in this study will now be presented.

Organising the Study and Recruiting the Participants

The decision to recruit participants from my local geographical area was made for practical reasons, such as access to participants and time limitations. The participants were obtained by placing an advertisement in a free local community paper that is published weekly and reaches a population within the greater Wellington area. This free paper was chosen so that all women in the desired age group could have access to the paper and consequently to reply to the advertisement.

When women replied to the advertisement they were thanked and any questions about the research study were answered. They were assured that complete confidentiality and anonymity would be maintained during and after the research was completed. I explained that they had the right to withdraw from the study at any time as well as what the study involved in terms of their involvement and their time. Some of these women said at this time, that they had decided to participate in the study before they rang me. However, two participants said they wanted to know the level of their involvement before committing themselves to it. They later called to say they wanted to be included.

Potential participants were sent an Information Sheet (Appendix 2). If after reading this they were still interested in being part of the research, they were sent a Consent Form (Appendix 3) to sign and to return to me in a stamped envelope. All eleven participants returned their signed consent form. A copy of this consent form was returned to each participant in due course.

Ethical Considerations

Ethical considerations included gaining permission from various institutions. Firstly, ethics approval for the study was gained from the Massey University Human Ethics Committee. Then a research proposal was made to the Whitireia Community Polytechnic Research Committee. Included in this proposal was an application for ethics approval. A final research approval was then forwarded to the Ethics Committee of the local Crown Health Enterprise (CHE). This was because the participants in this study were residents and consumers of health services of this CHE. Both the Polytechnic and the CHE granted approval for the study.

All the data and accompanying identifiable material such as field notes and tapes were kept in a secure, safe place throughout the research process. Of importance also is that the data that has been collected can be checked. Participants were asked if they wished to have their tape as well as a copy of their transcript returned to them. They were also given the choice of having all recorded material such as tapes and computer discs cleared at the end of the study.

At the beginning of each interview I asked each participant if they were still willing to be interviewed and reiterated the participant's right to withdraw from the interview or have the tape turned off if they wished. This was followed by a period of time spent in developing rapport and trust between the participant and myself. I am grateful that the participants were so open and willing to share such personal and private thoughts with a stranger. Without these intimate personal thoughts being shared the data would have lacked the richness it has and certainly not been as valuable to the overall research findings. Each participant was also informed that they would have access to a completed thesis and that I would give each a summary of the thesis.

Study Participants

Women between the ages of 45-55 were invited to apply to be part of the research study. A group of eleven women answered the advertisement (Appendix 1) and became the participants for the study. The reason for choosing women of this age was because it was expected that women of this age would be either going through the process of menopause or would have completed the process. As the women had volunteered to be included in the study, I assumed that the women who replied to the advertisement would be literate, understood English and were motivated to be included in the study.

Research Setting

When the women agreed to participate in the research, I asked them where they wanted to be interviewed. All stated they wished to be interviewed in their own homes, as this was convenient for them. All interviews were done at night after the participants had had their evening meal and for some women after their children had gone to bed. The interviews were conducted with just the participant and myself present in the room although there were sometimes other people in the house.

Data Collection

The collection of data was undertaken over the period of four months, between February to May 1997. All interviews were of an hour to ninety minutes duration and were audiotaped. A dictaphone was used and, apart from on one occasion, worked perfectly. This latter interview was to be repeated but the participant moved from the area. Cues for questions came from data being offered during the interview and from previous interviews. Initial interviews tended to be less structured partly due to my inexperience in grounded theory interviewing and also because it was important to discover the participant's perspective of menopause. Two participants were reinterviewed to clarify categories and finally saturate them. The time span of four months during which the interviews were held, as well as allowing for transcription to take place, allowed the literature related to the emerging categories and properties to be explored.

When collecting data for research the interviewer needs to be friendly but, at the same time, constantly aware of where the conversation is moving. The researcher must also be alert for ideas which need following up. This did become a little easier as the number of interviews increased. Participants asked questions of me during the interview and these were answered at the completion of the interview. This was in contrast to what Oakley (1990, p.34) sees as “properly socialised respondents not engaging in asking questions back”. Despite good planning on the part of the researcher and the participant distractions such as animals, telephones and other people temporarily interfered with some interviews.

It is important that the researcher not express opinions on the topic on which information is being sought, as this can potentially lead the interview away from the participant's experience. As it was not possible for me to be without an opinion on the subject I was advised by my supervisor to write my own experience of menopause. As I was proceeding through the later interviews I found that I did not think about my own experience at all.

Data Analysis

Interviews were tape-recorded and then given to a selected typist for transcription. All typists signed a form (Appendix 7) pledging confidentiality of the information on the tapes prior to beginning transcribing. Participant anonymity was respected throughout the transcriptions. The typists were asked to identify pauses in conversation or language that was stressed by the participants. After transcription, each tape was listened to while reading the typed transcript. This was to ensure the accuracy of the transcription.

The first interview was taped and transcribed and the coding began. While the coding was being done memoing was also happening. Memoing is involved at this stage of data analysis as the memos come from the data with their purpose being to document the thinking process and ultimately assist in the generation of a quality theory. Memos enrich the conceptual schemes of the data analysis and also assist in the opportunity to cluster the concepts (Hutchinson, 1986, p.123). After this first interview, and due to the personal circumstances of myself and the next three

participants who had been organised to be interviewed, the three interviews were done without the process of constant comparative analysis taking place. This failure to be faithful to the grounded theory methodology form of data analysis has implications for the process of constant comparative analysis as well in terms of strict theoretical sampling and an audit trail.

Summary

In summary, Chapter Three focused on descriptions of grounded theory methodology as well as the reasons for selecting this particular methodology. Also addressed in the chapter were the underpinnings of grounded theory, constant comparative analysis and the use of the literature in grounded theory. Discussion about the debate surrounding grounded theory and where grounded theory fits with nursing was included. Reasons for using grounded theory and the trustworthiness of the study were explained. Finally the actual study including issues related to participant selection, ethical considerations and data collection and analysis were outlined. The process for ensuring credibility, fittingness and auditability in the study was also addressed, as was the relevance of this study to nursing.

Chapter Four focuses on the participants' responses to the research question of where they gained their knowledge of menopause and how they knew that they were perimenopausal.

Key to Abbreviations of the Data Chapters

Words in bold are words that the participant has stressed.

(...) indicates a word or name that has been withheld to protect privacy and anonymity.

... indicates a gap/pause in between what the participant is saying.

Participants' names are included in brackets at the end of data attributed to them eg. (Wilma) These names are aliases.

The number of the interview is included in the brackets directly after the participant's name at the end of the data eg. (Wilma, 1)

The page of the interview is included in the brackets after the participant's name and interview number eg.(Wilma, 1: 4).

*Chapter Four**Becoming menopausal***Menopause**

What is it? What is it?

Women have said,

Is it all really happening or is it all in my head?

My feet are a'tingling, my soles all aglow,

My periods just come and go.

In the car on a cold day my husband says 'make up your mind'!

I have the heater on my feet and the wind on my face is ever so kind.

Sometimes my memory and focus forget to stay,

And I want to know, is it menopause or a TIA?

Introduction

This poem captures my own experience of menopause. However other women I know have expressed similar uncertainty in terms of wondering what is happening in their bodies. How the methodology of grounded theory applied in this study was also included. This chapter introduces the reader to the ways in which women found out that they were menopausal and includes the sources of knowledge as well as their perceptions of who they see as contributing to expanding women's knowledge.

Category Generation

After the initial interviews were transcribed I identified that the emerging findings seemed to be similar to my own beliefs. Because of this the categories were checked with a colleague and my supervisor. The involvement of my colleague was sometimes done while my colleague and I had joint supervision and at other times informally. The transcripts did not allow the participants to be identified.

Early categories and properties emerged quite quickly from the initial interviews. Data from consequent interviews fitted these categories. The categories, which emerged from the data, will be identified and explained. Categories will be presented in table form as well as described later in this chapter. These categories were clarified with the emergence of issues related to how the women in this study obtained their knowledge about menopause and determined that they were menopausal.

As the final interviews concluded the categories became more refined. It was at this stage that two participants were re-interviewed to ascertain that the categories 'fitted' with their experiences and that there was nothing new to be added. As there were no changes to be made I decided that saturation had been reached. Glaser and Strauss (1967, p. 61) define saturation as meaning "that no additional data are being found whereby the sociologist can develop properties of the property. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated". It was at this stage that the core categories were formed and these are now presented below in the form of tables and then subsequently explained.

Table 1
Category – Becoming Aware and Informed

<p>“Family and friends as knowers”</p> <p>Menopause not quite a taboo subject</p> <p>Acceptable and accessible sources of menopausal information</p>

Becoming Aware and Informed

1.1 Family and Friends as Knowers of Menopause

Individual women come to midlife with differing social, cultural, educational beliefs and backgrounds. The participants' views and knowledge base reflected their diverse life experiences. The participants differed in terms of when they had first known about menopause as well as where or from whom they had received the knowledge. Some women found it difficult to actually identify a specific time denoting when they had first found out about menopause. Responses made by three participants are included below.

Well menopause is something I have always known about (Wilma, 1: 1).

I think that was the word I knew of, (menopause) yes. ... You know everyone was just aware of it. I'm not sure when I'd have known the word or anything else, it's just as I get older I'm just thinking about heading towards my mother's age or something like that (Carol, 1: 1).

So it's something I've known about and knew was going to happen, but hadn't really thought about how it would affect me until recently (Alison, 1: 1).

Some women thought they were not old enough to be menopausal. This was partly due to the preconceived ideas of menopause that they held. Kaufert and Syrotuik (1981) note that a cultural stereotype of an event (whether menstruation, childbirth or menopause) will structure what is experienced and how this experience is reported. Women gain information about menopause from different sources. This depends partly on their preferred method of gaining knowledge and partly on their proximity to close female relatives, friends or female colleagues. Women in the study spoke of learning about menopause from their sisters and close family relatives.

I think I started thinking about it while talking with my sister, who's a couple of years older than me and is actually a nurse and had some information and a

book; so I've looked at that with her. I think my sister and I discussed it later when we realised what was going on with her (my mother) (Alison, 1: 1-2).

I have an older friend, (...) she had a hysterectomy. Sometimes it's nice if you've got an older friend who might be in her 60s or something – it's quite nice (Gail, 1: 9).

I contacted my mother and said, "Mum, can you tell me what you experienced in menopause"(Marie, 1: 1).

At the time when these women were experiencing symptoms which they were identifying as menopausal, they made decisions as to where they would seek information, if they saw that they needed it. Yet other women were unsure as to where they would go to find out the information they needed.

No, no, no, other than what my doctor told me –I'd never seen anything on menopause at all. And I wouldn't even know where to go to look (Mary, 1: 12).

Some participants had memories of their mother's menopause. They spoke of their mother's experiences and how their symptoms were treated as well. Brenda was also able to place her mother's menopause in the context of her mother's life. She reflected on the concerns that her mother expressed.

There was some family trauma at the time that she was at that age and from what she said she had no overnight menopause so ... well she still refers, with fairly negative tones, flooding, and "nice" things like that (Brenda, 1: 9).

For Carol, her mother's menopausal experience pinpointed for her the age at which she could maybe expect her own menopause. This discussion highlighted that, for some women, menopause could bring problems.

She had very bad hot flushes, but she also had to have a total hysterectomy because she had excess bleeding...I, I can't recall when I was aware of it, except that I would say like okay, I knew 20 years ago, I was probably aware of the change. My mother had a very bad menopause, so I was aware that a

woman in her 40s perhaps started to have some symptoms and changes that caused problems (Carol, 1: 1).

1.2 Menopause Not Quite a Taboo Subject

Just as some women spoke of knowledge that they had received from their mothers and close female relations, others spoke of reasons why they were unable to gain knowledge from these sources. Batten (1991, p. 15) explains the manner in which she found out about menopause.

The atmosphere surrounding menopause for women of my mother's generation was extremely repressive. I cannot remember even hearing the word menopause spoken out loud, though I was once, as a teenager, handed a pamphlet on the subject and told to read it.

Marie spoke of possible embarrassment and reluctance by midlife women to discuss sexual information with their daughters.

I remember, I can (remember) back as early as in my teens that I didn't know anything about periods- let alone where a baby comes from. My mother still lives by that code of ethics even today and...I had to prompt her to find out anything and then at times she's very elusive (Marie, 1: 5).

Wilma had always thought that the topic of menopause would be openly discussed but admitted that there would be some women who were not able to discuss it.

It's not quite a taboo subject but I don't know whether there are some people who sort of don't like to admit they are of menopause age or whether it's a very delicate subject to them or just what it is. You know it never actually crossed my mind that there would be people who wouldn't want to talk about it and that sort of thing (Wilma, 1: 3).

1.3 Acceptable and Accessible Sources of Menopausal Information

When asked where they had obtained their knowledge of menopause, magazines were mentioned and one participant was keen for the library to be more proactive with its displays of literature about menopause. Mary had read only one article about menopause and it was about the use of HRT. She admitted to being concerned about whether HRT should be taken by women at all as the people she sees as experts, the scientists, couldn't even agree.

This concern about the lack of clarity on the effectiveness of HRT was echoed by Carlson, Li and Holm (1997) who caution, however, that nurses need to know what women are reading about menopause and also the source and credibility of this information. They also discuss the importance of knowing the qualifications of the authors of the articles that are printed as this has a bearing on the accuracy and bias of the material. Mary summarised the confusion surrounding the value and accuracy of knowledge for women when the health professionals can not agree.

I subscribe to the Reader's Digest. I did read one article about hormone replacement therapy. It was about 6 againsts – their arguments- you know- and you sort of scratch your head and-well then you just forget about it- and these were scientists. Some were for it and say that – one lot were saying women should be on HRT all their lives – they can only but benefit from it. On the other hand there was these other scientists saying there was no proof that HRT was good for women, instead of waiting till you've got the symptoms – started going through the menopause – start it when you're in your 30s. Yet they can't agree on it and that's the only time I've read anything and it was an article on HRT (Mary, 1: 22 - 23).

But the fine details I actually got from a book called 'Menopause without Medicine', which although it was mainly herbal remedies and that sort of thing, it did pinpoint a lot of the aspects of menopause that I wasn't aware of (Wilma, 1: 10).

An increasing number of articles about menopause are appearing in the popular press. Andrist (1998, p. 243) concluded that “midlife women’s health, particularly the menopause, has become a major topic of research, media attention, and clinical discussion among providers and consumers of health care during the last decade of the 20th century”. In a study respondents were asked about the resources they used to make them better informed about menopause. They found that “the popular media was cited more than any other source even more than physicians” (Mansfield and Boyer, 1990, p. 448). Women’s magazines and books were also popular choices as sources of knowledge for the women in this present study.

In the course of gaining information about menopause some G.P.s were seen as approachable and as sources from where information could be obtained. Three participants saw G.P.s as supportive. The mother of one G.P. was currently menopausal and this had personalised the topic of menopause for him. This helped Mary have faith in the knowledge of menopause that her G.P. had. Although the doctor may have been taught about menopause the knowledge gained about it from his mother was important to Mary. To her it gave him the authority to speak on the subject; a woman who was going through menopause had informed him of what it was like. Thus Mary attributed his knowledge of menopause down to learning first hand of his mother’s experience. Without this input Mary would have wondered about his knowledge of menopause due to his young age. Other women spoke of their GP’s helpfulness and understanding when they visited the surgery.

He was excellent and to know that his mother- somebody else –you know- my age was going through it. I thought okay this guy knows- because I was a bit thing (shy/embarrassed) with him being so young- you know. I guess doctors do study for these things but it still doesn’t give you confidence going- you know (Mary, 1: 6-7).

So I usually ask my own GP, if I have any questions about anything, he’s pretty good; libraries, help lines if there’s one applicable, friends, anybody who might have information (Carol, 1: 3).

I said I feel like a fraud sitting here with you and my GP said, “Well, you just tell me what’s happening” (Mary, 1: 2).

However, respondents in an earlier study gave a low ranking to both mothers and physicians as resources of knowledge about menopause (Mansfield & Voda, 1993). In this study, women also spoke with mixed feelings about gaining information from doctors and information available in waiting rooms. Mary and Carol also identified this deficit of information available.

He (G.P.) never had pamphlets out either. He went through his brief case to get me some (Mary, 1: 12).

No, I don't think I've actually ever seen anything on menopause in the doctor's waiting room (Carol, 1: 4).

From the participants I tried to ascertain whether women thought that there were some people who were more appropriate than others to be key people to disperse information about menopause. One participant identified her GP as her main source of information and another saw the GP as the only source. Nurses were not identified at all but were alluded to as possible educators if doctors "properly prepared them for this task" (Carol, 1:5).

Oh, I'd probably go to my GP (Rachel, 1: 2).

I see them (G.P.s) as the only reliable source really. Not to say that doctors can't train others to do some sort of public education (Brenda, 1: 4).

Despite the support some women spoke of receiving from doctors, others admitted that unless they knew to ask about menopause the topic would not come up in the visit if the consultation was for another reason. I wanted to determine if G.P.s inquire about women's general health if they went for another reason. Rachel and Paula stated that their GP did not.

Not a lot. Nothing has ever been discussed in any great depth with any questions. It did come up when I was having a smear test done I seem to recall but nothing major (Rachel, 1: 2).

No, the one I go to doesn't ask anything. That is all quite bad really; I have to really push. I go with a list about once every three years and ... he doesn't actually ask about the wider things at all (Paula, 1: 2 – 3).

There are other avenues from which women can seek knowledge. The Wellington Menopause Clinic offers services for women with health concerns that occur from menopause. The clinic offers a one-hour initial consultation and examination. The initial consultation fee of \$190 includes a full medical history, physical examination, and blood tests are arranged. Follow-up visits are \$40. Wilma knew about a Menopause Clinic but was concerned that the price of the service may put it out of the reach of some women. Menopause Clinics were mentioned as an avenue for gaining information, however for various reasons, Alison and Wilma stated the clinics would not be their first choice of avenue to obtain information about menopause.

Um, all I know is things I've seen advertised. I'm aware it's there at the hospital in Newtown...I may go there if I feel I don't get the information I want from my doctor (Alison, 1: 2-3).

I think there's one in (...) Hospital, but I'm thinking about the one at (...) and the main thing is that it's reasonably expensive which may, for some women cause a problem. You know, it may be a bit out of their reach or they feel that you know with all the other commitments that they really can't afford to – you know go to something like that (Wilma, 1: 4 – 5)

The category of becoming menopausal and the codes that are included in it will now be presented and explained in Table 2.

Table 2
Category - Becoming Menopausal

<p>Recognising body change</p> <p>Seeking confirmation of change</p> <p>Menopause and midlife</p>
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2.1 Recognising Body Change

The body changes experienced during menopause both physical and psychological, brought to women the realisation that something was happening to them. However, these changes were not always initially recognised as related to menopause. Obvious and documented changes attributable to menopause include hot flushes and vaginal dryness. Other symptoms such as lack of concentration, forgetfulness and mood changes could relate to other reasons. Stress and pressure at work are examples of factors that can cause these symptoms to occur. Mary did not realise that her communication with family members had deteriorated though other members had noticed. However it was not until a crisis occurred that it became apparent that something was happening to her.

And then one day she (daughter) turned on me – she yelled at me- now I knew. She never gets angry with me; there was something wrong with me. That’s when I went to the family doctor. ... I didn’t know I was experiencing menopausal symptoms because I’d never had any pain, anything I could go to the doctor with (Mary, 1: 1).

The mother of Mary’s GP was menopausal. The GP spoke with Mary about his mother’s menopause and prescribed her HRT to take.

Physical symptoms, identified as menopausal by some women, were varied and differed in their regularity as well as intensity. The participants were aware of the

changes that were happening and were using different means of coping with the changes. For Alison it meant simply keeping a record of the changes in her periods.

And I'm sort of tracking my periods just to see because they had gone so haywire before and then sort of settled down (Alison, 1: 10).

Um – I get a bit of a lack of interest in sex I think to an extent. That sort of comes and goes a bit. That can be a bit painful if I'm not careful. I had a lot of waking up at nights and sleeplessness (Rachel, 1: 7).

Hot flushes are the only ones that get me because I get them during the night. I don't have any problem with them during the day thankfully but these cooler evenings I'll be throwing the duvet off (Brenda 1: 10).

Not the usual ones I don't think- hot flushes or anything like that. But what happened was that I started having – well a couple of months ago - strange turns during the night where I'd wake up with the shakes - occasional sort of night sweats (Wilma, 1: 5-6).

2.2 Seeking Confirmation of Change

For some women, other health concerns that were present at midlife either had the effect of masking the onset of menopause or made it harder to decide if the symptoms were related to menopause. Uncertainty about the changes that are happening sometimes directs women to seek medical assistance for confirmation. Some women think they are over reacting and are embarrassed and uncomfortable when visiting their GP while other women found that their concerns were not treated seriously or addressed to their satisfaction. Participants thought that support and assistance from the medical profession would have made it easier for them to distinguish which changes were or were not attributable to menopause. This situation could have been alleviated if women had an understanding of what constitutes 'normal' in the woman's body as it goes through menopause. For Alison, general life events and crisis also contributed to confuse the issue of her interpretation of symptoms as related to the menopause.

I think places like the Menopause Clinic that's set up now...I think that's actually very good because I've had - leading up to menopause - I've had a lot of problems that I didn't realise were actual menopause problems and neither did the various doctors I went to (Wilma, 1: 3)

But I still don't really understand what menopause is all about. I don't know much about it at all. There are not many pamphlets available and my doctor offered me a pill that I didn't want to take on top of my other medication (Marie, 1: 1).

I think a holistic approach is so important you know, because of all the medical things that are going on with people, to find out what menopause is causing. Because I think everything coming at this time of high stress, it's been very difficult to actually identify what's, you know, causing what. In fact there's been three things going on because I've had the divorce and the, you know, maybe menopause obviously and the (...) thing, so I had gone through after having the fourth child of being lacking in energy and you know, all that sort of thing (Alison 1: 11).

2.3 Menopause and Midlife

While some women were unaware that they were already menopausal they identified specific symptoms that they associated with menopause. As well as having an awareness of the changes that were happening and knowing how to address them, there was the feeling menopause was only part of the total reproductive cycle. As Gail had no problems as she menstruated throughout her adolescence and as a young adult she had an expectation of having a successful transition of menopause as well. She also saw menopause as being positive and wasn't concerned that the experience of menopause meant that she was becoming older.

I really think my body is coping quite well with the changes. I sort of liked the idea of embracing it - you know my body - you know I've done the menstruating bit and now it's going through menopause. You know I'd like to become a gracious old lady - without hanging onto youth (Gail, 1: 10).

As women realise that the changes happening in their bodies are menopausal it reminds them they are halfway through their lives. This can bring feelings of loss for a part of their lives that cannot be revisited, and of the knowledge that they are becoming older. Connections between menopause and middle age were made.

Particularly without a partner at the moment, I think well who wants a menopausal woman? You know, I mean that is an issue I guess (Alison 1: 9).

I get a bit anti. I sort of see it (menopause) as slowing me down a bit so I resent that a bit - you know - I suppose just seeing middle age is a bit ah - a bit depressing at times (Rachel 1: 5).

If you start putting on weight when you're 32 you say, "Oh God I'm putting on weight, I'd better diet, exercise, do something". But if it happens when you're 52 you say, "Oh well what else can I expect at this age?" (Carol, 1: 7).

Nelson (1991) remembered her mother as she described feelings of hopelessness, resignation, powerlessness and inevitably. "Although I vowed never to look like that, here I am in her image, helpless in my body. The more I sweat, the more I feel fat, stupid, out of control; no longer the radical feminist professor, but a babbling middle aged housewife" (Nelson, p. 162). As demonstrated above, participants in this study alluded to some feelings that were similar to Nelson's.

Carol made the connection between menarche and menopause and she expressed ambivalence around the meaning of having no period. She is pleased that she will no longer menstruate but is scared by the meaning that the end of menstruation brings with it, namely increasing age.

I'm actually intrigued by it. I make a joke about the fact that when you're younger for a long time you're scared you're going to get pregnant. When you're older you're scared that, you know, you've had a guts full of it, you don't want any more but when it comes to it you're actually quite scared that it's going to stop and what does this say about who you are any more, that you're now getting old (Carol 1: 6).

Bensussen (1991, p. 81) defined menopause as a second adolescence as “changing hormones upset the body’s measured responses; questioning one’s future and place in life. But now one has the knowledge and experience to face these questions in a positive way”.

Coney (1996, p.13) believes that if women isolate the experience of menopause and focus exclusively on it without making it just one part of midlife that there is a “wrong route, a side-alley that leads simply to narcissism and frustration, not change”. Bircham (1991, p 128) agrees and describes good things about being fifty and menopausal, such as “becoming a first time grandmother and the fact that my spouse and I are so far doing our aging at approximately the same rate. So I’ll just take those hot flushes or flashes or whatever they are and face the challenges on each calendar page”. Marie subscribes to Coney’s belief and stresses the necessity to remain positive about the experience otherwise it may become overwhelming for her.

What a woman really needs to do – and this is getting back to the positive thinking side of it – I think that when a woman realises that she is going through menopause – is not to forget that it’s there to try to push it to the back of the memory and just get on with life. You know – you’ve got to be positive the whole way through. Once you start getting negative thoughts you’re likely to lose it (Marie, 1: 14).

Using the informality of the workplace cafeteria also proved beneficial for one woman who was seeking knowledge but uncertain or unable to obtain it. This woman was experiencing body changes (hot flushes) which were evident to others. The experience and knowledge as well as the caring attitude of colleagues assisted her to gain knowledge and understanding of what was ‘going on’.

A woman I’m working with. She was insecure about asking for help, and you know, wouldn’t discuss it, and we figured that was what was going on with her (Alison, 1: 6).

Workplace discussions can also be useful in educating other women who are not yet of menopausal age.

But there is a young girl who is about 23 who is aware of this (menopause) and she said, “that’s where you find out about stuff like this – our staffroom” and so she’s obviously been around when it’s been discussed (Rachel 1:1-2)

Summary

Chapter Four has created a picture of the sources from which women gained information around the topic of menopause as well as how they came to realise they were perimenopausal. Sources of information, seen as helpful in imparting knowledge about menopause, included the media, colleagues, older female relations, and medical practitioners. These women have been proactive and have essentially sought information as they required it and treated the gaining of knowledge of menopause the same as they would any other health concern. Chapter 5 will explore the ways these women managed menopause as it occurred in their lives.

Chapter Five

Decision making

Menopause

(Anonymous)

What shall I do? Who should I ask?
Maybe I should just get wine and drink by the cask.
St John's Wort, evening primrose oil and herbal tea
All highly recommended to help me remain me.
Do I need it? I think I'll survive
And once through this I'll simply resuscitate my original drive.

Introduction

In this study the term “decision making” is used to mean that explanations of issues, including both knowledge and interventions of menopause, are critically thought through before the women resolve which is the best way, for them, to integrate menopause into their lives. Chapter Five will focus on how the participants viewed menopause, how they coped with the issues they have identified as arising from their menopause and finally how they integrated menopause into their lives. This integration will be demonstrated in the form of a model with an accompanying explanation. As in Chapter four, categories will be identified and presented in Table form and then described in further detail. As coding progressed my supervisor invited me to look more carefully at the categories. This was in relation to the categories of women and management, self and attitude towards menopause. I had seen them as distinct categories. After further examination of the data and in consultation with two participants I could see that these three categories and the properties inherent in them, actually belonged together and could not stand alone.

Another issue for deliberation was whether the word ‘management’ was the right one to use in terms of what it meant to this group of women. According to the Concise

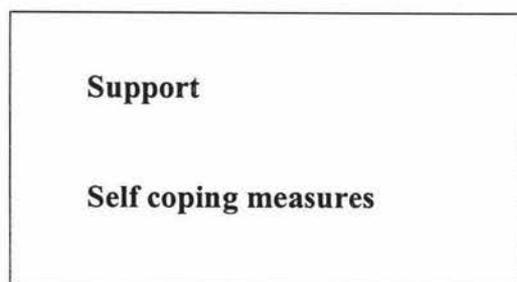
Oxford Dictionary (1964, p. 739) the word manage means to “handle, wield, (tool etc); conduct (undertaking etc.); control (household, institution State); take charge of (cattle etc.); subject (person, animal) to one’s control; gain one’s ends with (person etc.) by using flattery, dedication etc”. In terms of the contexts in which women in this study used the word it does not match the meanings above.

As the collapsing of the categories progressed it became obvious that what I was seeing happening for these women was the integration of menopause into their lives as opposed to management of their menopause. The Concise Oxford Dictionary (1964, p. 632) defines integration as “complete (imperfect thing) by addition of parts; combine (parts) into a whole; (Math.) find the integral of; indicate mean value or total sum of (area, temperature etc.)”. This latter definition accurately encapsulates how the women in this study spoke of their experience of menopause. They were not all happy about the intrusion of menopause in their lives for various reasons but accepted the inevitability of it and wished to address the issues involved, move on and continue to see themselves as a whole person. Table 3 lists the third category as well as the codes that comprise it.

Category –Menopause Controlled by Self

Women in this study accepted that menopause was inevitable in their midlife. They wanted to be as well informed as possible in order to place menopause in perspective in terms of it fitting in with their lives and not dominating it. They wished to reduce the impact of the symptoms of menopause and they did this by ensuring they had support and adopting self-coping measures.

Table 3
Category - Support and Self coping



3.1 Support

All women stated the importance of having support as they experienced menopause. This support was seen as an integral necessity in allowing women to integrate menopause into their midlife. The support was seen to come from a variety of sources and being able to provide support to other women was seen to be as beneficial as actually receiving it. This was because the women in the study not only sometimes received more information about menopause but they were reaffirmed of the normalcy of the experience of menopause. Exchanging views with other women also allowed for more knowledge about coping and therefore assisted them make decisions about how they could self-cope.

3.1.1 Friends and Colleagues

To the women in this study friends and colleagues were important. Women identified these groups of people as having a large part to play in both acquiring information about menopause and in coping with their menopausal symptoms. All but two participants were in paid employment and many were involved in professional occupations. The support that they receive from colleagues in the workplace is invaluable.

There are women in the staffroom who discuss it. When people realise that someone else is, you know, in the same boat, they start sharing experiences. We are supportive of each other (Alison, 1: 6-7,8).

Three of the women had conditions for which they were requiring continuing medical intervention and monitoring. They were also experiencing menopause. As Woods and Mitchell (1997, p.452) point out “midlife women are not wondering what to do with the rest of their lives as much as they are wondering how to juggle the demands of family and work-related responsibilities”.

3.1.2 Family

In terms of support, husbands/partners and other family members contributed to the wellbeing of the women, to varying degrees.

My husband – he was absolutely marvellous. He just walked out and when he came back into the house it was as if nothing had happened – it was just cuddles and kisses (Mary, 1: 5).

Some of them (other menopausal women) have partners but they're not supportive or not interested (Alison, 1: 7).

My husband is (supportive). He said he should be interviewed! (Rachel, 1: 8).

O'Neill (1992, p. 64) contends that psychosocial variables effect a woman's menopause and specifically refers to “her work environment, her social support network and commitment to and involvement with her children”.

Understanding, as a form of support from family members, was seen to be important to the menopausal woman. Women felt that family members needed to have some understanding of the feelings the woman was experiencing and also to understand that feelings sometimes expressed, especially if viewed as negative by family members, were not meant to sound that way.

I think it's important that they understand why we're feeling the way we are...not with the sort of horror stories that I think came from the previous generation...yes, I think it's important that your kids understand why you're feeling the way you are (Brenda, 1: 10).

They pick it up when I'm quiet...and they might say, 'come on let's go and have a game of yahtzee or a game of cards or let's go out in the garden' (Marie, 1: 8-9).

3.1.3 Supporting Others

These are examples of how once women are educated about the changes they are experiencing as a part of normal midlife development they can assist in educating others. Gillian identified another potential avenue for supporting menopausal women. She spoke of seeing a menopause support group advertised and thought this was a really good idea. And Marie, while acknowledging her lack of medical knowledge, offered her assistance to other women who she thought might be not coping with menopause.

If there was, you know, a group of women out there who were struggling with their menopause – I would like to go along to a meeting and say, "Hey listen, look at me. This is what you can do. I am not a medical person. I am just an ordinary Jo Bloggs off the street but this is how I look at life. This is what I do" (Marie, 1: 15).

The best way to gain support for anything is to talk to people who have experienced it because they can relate to what you are talking about and understand it. It's like two heads are better than one and can come up with a range of solutions (Gillian, 1: 13).

Experiencing menopause meant that some participants noticed outwardly physical signs of menopause, such as excessive perspiration, in other women. They then took the opportunity to share specific information about what may be the cause of the symptoms. Informally in the workplace as well as in areas of recreation women discuss menopause and assist each other.

I've actually helped about three other ladies in my bowling club...seemed to be going through the menopause. The doctor had given me pamphlets so I just passed them on to my friends (Mary, 1: 9).

3.2 Self-Coping Measures

Self-coping, in this study, is explained as being the ability to take care of self while integrating menopause into daily life. Most women were “self-coping” in this study. Self-coping involves different things, all of which contribute to the overall success of integration. Viewing menopause as normal and being positive are two ways which assist women to cope with their menopause. Recognising and identifying the physiological and psychological changes as well as being aware of how to self address these are also seen to be necessary in order for the women to be able to cope.

3.2.1. Viewed as Normal

Women in this study viewed menopause as a normal event in their lives. Accepting that menopause is a normal part of midlife is important in regards to how much importance women allow menopause to have in their lives. As seen in Chapter four they gained information about it from various sources. The kind of information that they gained, in terms of what to expect, and how others had experienced it may have covertly given these women impressions of not only what they may expect but also how they may cope with menopause. According to Stewart (1995, p. 50) “your expectations of your menopause may well influence the kind of menopause you experience”. If the event of menopause is seen to be a normal part of midlife development it is more likely that how it is coped with will be seen to be within the control of women.

Menopause should be treated as something normal, not some sort of freak because you're – or something not to be pitied (Brenda, 1: 9).

Ah, basically a whole new direction as one says, as one door closes another one opens. I've never considered it's the end of your youthful way of looking at things or the end of the child bearing years or anything like that (Wilma, 1: 6).

There are some things in life that are outside our control, such as eye colour. However, there are many things over which we can exert some control. Indeed,

speaking with the participants it became apparent that some had given menopause forethought and did not anticipate any problems. This was partly due to knowing other women for whom menopause had not caused any concerns and partly because they felt that menopause was not going to get the 'better of them'. In fact, Wilma had also determined that she wouldn't let menopause cause her any concerns.

You know I thought it was going to be a case of mind over matter. I was not going to be sort of swamped by this and it won't be a problem sort of thing. I don't know why but I just assumed I wouldn't have any problems – I just thought my periods would stop and that would be it (Wilma, 1: 2).

I think some people deny menopause, you know. They have mothers or aunts or someone who just went through it without any problems...so they sort of hope that it'll, you know, it'll go by without being noticed (Alison, 1: 9).

Other women did not see menopause as a topic to dwell on. It was to be acknowledged and then the women moved on, recognising menopause as inevitable.

It's like the pain of childbirth; you put it out of your mind (Carol, 1: 6).

I haven't really been embarrassed by it...I'll just let it run its course, happy in it (Paula, 1: 5).

Carol however, spoke of being "intrigued with" menopause and pointed out the irony in the comparison of being fertile and menopause. By this she meant that when you had your periods you didn't want them but that when they stopped you wanted them back as being without them meant that that part of your life had gone. She correlated menopause with ageing and seemed to think this correlation took away the positiveness of menopause for her. Choi (1995, p. 57) expands on this by her remarks that "for many women now in midlife, menopause and aging have been ranked among the least desirable experiences imaginable. To some menopause and aging represent unspeakable losses."

...you're actually quite scared that it's going to stop and what does this say about who you are anymore, that you're now getting old. I think the trouble is that it actually identifies a woman's age, not with, well I'm not going to get pregnant anymore, but I am now old (Carol, 1: 6).

The majority of the women who took part in this study had completed education to the tertiary level. They spoke of using libraries and doing their own research in finding what they needed to know about their health generally including menopause.

I'm fairly well educated and you know when it comes to health - if there's anything that I've heard I try and look it up and obtain this much information (Marie, 1: 6).

Yes I am a self-seeker of knowledge. I mean I read a lot about, you know, go to the library and find as many books as I can about it (Alison, 1: 2).

As well as seeking out information to remain healthy and information about specific issues the majority of women in this study took responsibility for maintaining routine examinations such as self-breast examination and cervical smears. Women in this study have taken the initiative when it comes to seeking information about their health. All have been proactive in gaining the information they needed, either to establish what the changes were that were occurring in their bodies, or to investigate possible avenues of support if they were experiencing symptoms. Once the participants understood what was happening they were able to proceed on with the experience of menopause within the context of their lives. They were keen to be knowledgeable about the changes their bodies were undertaking for general as well as specific reasons.

I just like to keep tabs on what's going on in that part of my body because you know as I said I have two younger children and I have to stay alive for quite a few more years so I really watch my body (Gillian, 1: 2).

Women also spoke of the need to care for both their mental and physical health during midlife. They also wanted to have accurate information so they could remain able to alter their lifestyles and maintain control of their health.

By and large I mean I'm quite health conscious and I try to be aware of what's going on...and I think if you are physically fit it sort of helps everything else. Yes I sort of try and take that positive approach and it sort of helps to keep things humming along (Rachel, 1: 6).

Well in this last year I've joined the gym. I've been aware of osteoporosis and that sort of thing and the need for more exercise so going to the gym is not just for weight loss but also I'm aware of the need for increased fitness and that sort of thing (Brenda, 1: 11-12).

I have a lot to do with a lot of people. I try to keep a positive attitude. I laugh as much as I possibly can because I think well - if you can laugh about it - you know it lightens the load (Marie, 1: 8).

In this study an awareness of the total benefit of keeping and remaining physically fit as well as keeping a positive attitude were seen as factors in maintaining control of their health and lives in general. This contrasted to a study carried out with elderly people to examine their perceptions of ageing and exercise. Stead, Wimbush, Eadie and Teer (1997, p.3) found that "older people are unlikely to participate in exercise for its own sake, nor for health reasons; attempts to promote activity should stress the social rewards".

3.2.2 Positives of Menopause

Some women were looking forward to their future, as being post-menopausal, with feelings of expectation and freedom. Their expectations were for continuing good health. Freedom from regular menstrual periods was seen as a huge bonus for participants from both a personal and financial viewpoint. A study by Mansfield and Voda (1993) conducted with midlife women found that 75% were looking forward to the cessation of their menstrual periods. Gillian saw financial advantages to being

postmenopausal. She was eager to dispose of all the personal hygiene items that she had.

No more money to Johnston and Johnston! I gave all my tampax, tampons and panty shields to my daughter-in-law – Here take this, I don't need it anymore. Wonderful, yes, it's great (Gillian, 1: 9).

Category - Menopause Controlled by Others

A few women chose to seek medical intervention for symptoms associated with menopause. Two of these women consulted both their GP and a gynaecologist about problems associated with menopause. This involvement of consultants was necessary due to the complexity of the women's existing medical conditions. The consultants involved the women in the decision-making process in terms of the best way to address their health issue. However this has not been the case for other women in this study who have sought assistance with menopausal symptoms from other health professionals.

Table 4 lists the fourth category of menopause controlled by others as well as the codes that comprise it.

Table 4

Category - Menopause Controlled by Others

<p>Medical treatment offered</p> <p>Concerns with medical practitioners</p> <p>Preferred educator</p>
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4.1 Medical Treatment Offered

The use of HRT as a preventative measure for menopausal women has succeeded in making menopause into a medical condition in the eyes of women (Hampson &

Hibbard, 1996). It does seem that some doctors may be using HRT as the first treatment of choice when women visit them with symptoms that they identify as menopausal.

Andrist (1998, p. 255) found that women “personalise their need for HRT on the basis of analysis of family history” in relation to issues such as breast cancer. Brenda visited her GP about her sore breasts and mood swings that she thought were related to menopause. She was told by her GP that it was too early for HRT. Brenda has not approached her GP for any information about menopause since then.

When I discussed with her the side effects of the sore breasts, the mood swings, that side of things and all she said was that it was too early for HRT...I hadn't gone to her asking for information (about HRT) either (Brenda, 1: 2).

Mary sought medical advice when she realised something different was happening with her health; she was aware there was something changing but couldn't be specific. Mary was given HRT as treatment. When I asked if her doctor had spoken to her about any other alternatives to help her she said:

No, that was the only thing. He explained how the ovaries stop once you go through the menopause (Mary, 1: 16).

Mary subsequently ceased taking HRT due to the panic attacks she was having. Of her own volition, Mary decided to see if the HRT was the cause of these. To test this theory she went off the HRT. On recommencing HRT, the panic attacks started again. Mary said that the GP hadn't spoken to her about the side effects of HRT.

I stopped them (the HRT). The panic attacks stopped – then I went back to them just to see if it was – if I thought it was and yes, as soon as I went back on to the hormones I had more attacks so I just went off them I don't think that's been researched. ... I think HRT is so new – I don't think they know – I don't think they realise that there could be side effects to the hormone replacement (Mary, 1: 4).

Marie stated that her GP wasn't very helpful and didn't have very much information on menopause. Again HRT was the offered solution for her menopausal-identified symptoms of night sweats, insomnia and restlessness

Unfortunately the doctor wasn't very helpful and didn't have much information on it. My doctor offered me a pill, which I didn't want to take on top of my other medication. So I thought well it's better to do it on my own with a lot of support (Marie, 1: 1-2).

Wilma's friends, who are having menopausal symptoms, are on HRT. She said this in a matter of fact voice, not intimating that she felt pressure to go with her friends.

Well all my friends that are sort of having any symptoms at all are on HRT and it ceases to be a problem (Wilma, 1: 2).

It appears unhelpful that HRT is being offered to the women as the first mode of intervention for their body changes even without the GP taking a good history of what is happening for these women. Once women are aware of what is happening, what is causing the changes in their behaviour or physically in their bodies, they appear better able to cope with the changes. These women who have their own support networks may assist others through their menopausal symptoms.

4.2 Concerns with Medical Practitioners

In this study women have stated that assistance and support from their GP generally has not been forthcoming. Women, who consulted male GPs in regard to their menopausal symptoms, have expressed general dissatisfaction about the information and treatment choices offered. Some GPs appear to be not educating women about the choices available in regard to how they can better cope with the changes happening to them. These women see that they have not been treated holistically and have been given insufficient information to assist them in making decisions about coping with the changes in their bodies. Alison expressed dissatisfaction in this respect and ended up making the decision to change her doctor.

When I moved to (...) I went to a doctor here, and what happened was when I was going through my marriage breakup I was getting, my periods went all wonky, very off the wall, so I went to her and she said, "Oh, here take this". And I had at that stage not really thought of HRT, but she gave it to me and I realised what it was. So I took it, I think for about six months or so. But she never actually, I was very disappointed because she never discussed what was happening in my life, and I thought well stress could have been a factor. And I just felt that, I was disappointed. I've actually changed doctors since cos I felt that really it was something that I really wanted to think about and discuss all the pros and cons and find out, you know. I've since done reading about it (Alison, 1: 4).

On seeking confirmation for her own diagnosis of menopause Wilma also spoke of the attitude of the male doctor.

Well the male GP in the practice where I went to said that it could be menopause. Sort of lack of interest, lack of understanding I felt (Wilma, 1: 4).

When Alison was asked whom she saw as providing information to women about menopause she said:

Well I hope that the doctor would. But I actually had a bad experience with my doctor so I'm a bit cynical now (Alison, 1: 3).

Alison consequently changed her GP and found the new doctor more approachable but Alison still didn't get the information that she wanted.

The other person I've got is a woman and she's been much better. I think she was aware of why I had changed...it's the same practice. I think she probably gave me some literature, a pamphlet or something about it, but not really as much as I would have wanted, I mean I had to go searching it out for myself (Alison, 1: 5).

Changing to a female GP is sometimes done for the reason that women think they will be able to relate more easily, on personal and intimate matters. This was the

case with Carol; she changed her GP because she felt her previous GP did not understand her feelings about excessive bleeding. Carol felt that only another woman could understand the embarrassment caused by excessive vaginal bleeding.

I do have a very good GP and I have no problem with him. The only time I felt he did not, he has not understood totally where a woman's standing is on excessive bleeding. I don't think he's totally understood how embarrassing or difficult it is for women. When I discussed it with him I was going on an overseas trip and I expressed my concerns about this may be happening while I was overseas, he couldn't seem to see what my problem was. So again I went to another female doctor...and she immediately understood my female concerns and discussed with me the best way to approach it (Carol, 1:3).

4.3 Preferred Educator

Women in this study identified GPs as the preferred educators for women prior to and during menopause. Women needed to be able to decide which were and which weren't changes attributable to menopause. Unless they were able to do this Mary felt that women would not be able to decide whether to approach a key person to seek the education they may require. To enable this Mary thought that education needed to happen well before menopause. A concern about symptoms would also warrant a visit to the GP for education.

I mean a person who is suffering would have to recognise that there was something wrong with them to go to a key person. If they gave you information say late 30s and onwards about the menopause and with luck with that information the women would be able to recognise what they were going through (Mary, 1: 10-11, 15).

Well I suppose if you go to your doctor wondering about your symptoms he or she should (educate). Ah, but for me that didn't happen so, no, I don't really see anybody in particular. I suppose again oh, I suppose it was the doctor; you sort of take it (accept education) from your doctor (Paula, 1: 2).

With the onset of puberty young women are educated at college about the changes their bodies are going through. Special classes are held and generally it is the nurse who is the educator. This does not happen routinely for perimenopausal women. The role of the nurse in this study in terms of providing education for menopausal women was seen to be that of support for what the doctor told the woman. The role was simply one of reframing information so that it was presented differently and so consequently would aid the processing of the information. Brenda thought that only doctors could educate women about menopause. However, she did see that the doctor could instruct other health professionals to do this.

He might have a time when he asks the nurse to come in, somebody, a female – somebody that would be respected, perhaps put it a different way (Paula, 1: 3).

I see them (doctors) as being the only reliable source really. Not to say that doctors can't train others to do some sort of public education (Brenda, 1: 4).

In a study done in 1993 and 1994 in which 250 women were asked to respond to a model of health care delivery, results demonstrated many areas in which health professionals could improve service to, for and with women. In this study Taylor and Dower (1997, p.411) contend that the attitudes that health care providers hold of themselves effect health care delivery. They provided data from the respondents which illustrated that superior attitudes held by health care providers serve to keep “women uninformed and uneducated about their bodies and their health issues”. In this study women stated that they had not been fully informed about their bodies and the natural process of menopause.

The Model: Integrating Menopause into Midlife

Integrating menopause into midlife is the basic social process identified in this study. The explanation of the following model demonstrates and explains the two different routes, taken by participants in this study, as they attempt to integrate menopause into their lives. Apart from one, all the women in this study have a higher school qualification. The skills gained by undertaking learning at a tertiary level include gaining the ability, knowledge and confidence to seek information as well as to gain it. They also assist in making the difference between whether women gain or seek knowledge.

Gaining knowledge in this study is defined as acquiring knowledge in a passive way, for example overhearing women discuss menopause. "Gain" is defined by the Concise Oxford Dictionary (1964, p. 499) to mean "obtain, secure, obtain pretexts by or slow methods, win as profits or as result of changed conditions".

Seeking knowledge is an active process. It includes going to the library and borrowing books on menopause, asking other women about menopause and challenging and changing practitioners if not satisfied with their manner or interventions. The word "seek" is defined by the Oxford Concise Dictionary (1964, p. 1145) to mean "make search or inquiry for, try or be anxious to find or get, ask, aim at, pursue as object, endeavour to do, make for or resort to (place, person, for advice, health etc)". Women in this study who seek knowledge have a higher level of education and the internal personal resources, such as confidence and the perseverance needed to continue seeking. If a woman is not educated at a tertiary level does this have implications for her health in terms of seeking knowledge and having control of her health including menopause? The following model contains two strands. The top strand demonstrates the process of a participant who gained knowledge and the lower represents participants who were seekers of knowledge. These two strands will be discussed below the model identified as Figure 1.

INTEGRATING MENOPAUSE INTO MIDLIFE

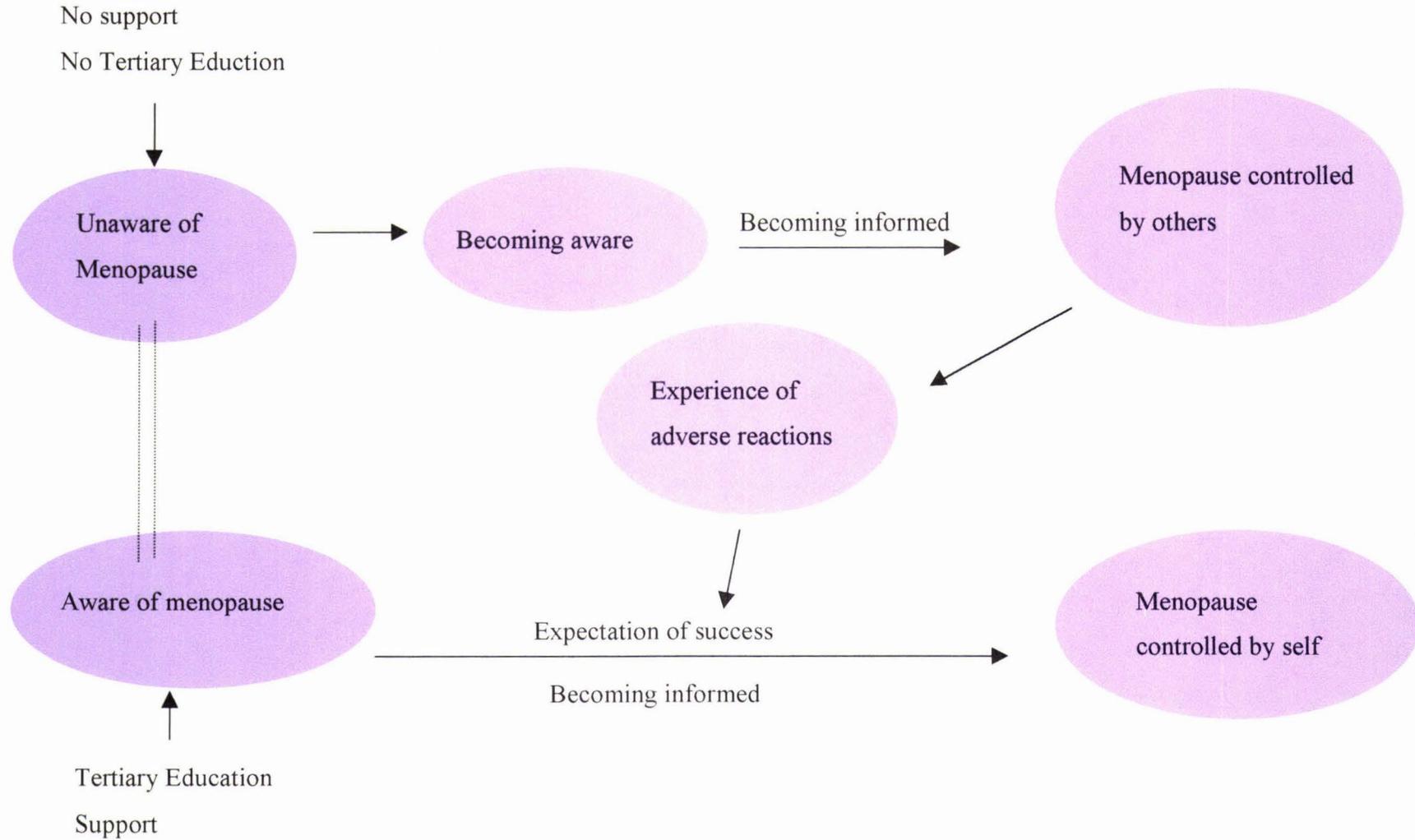


Figure 1

Explanation of the Model

The top strand of the model represents a small number of participants who were both “gainers” and “seekers” of knowledge. The “seekers” of knowledge used the GP in the same way they did other sources of information; they obtained the information they needed and then made informed choices of “where to from here”; their menopause interventions were controlled by themselves. However, Mary is a participant in this strand who did not have a higher level of learning and gained, as opposed to sought knowledge. Her husband encouraged her, after a series of incidents which highlighted changes in her behaviour and which were affecting her family, to go to her GP. It was then that she became aware of what was happening, ie that she was menopausal. She was not informed that this was a completely normal process for her body. To assist her to overcome her symptoms her GP prescribed HRT. Advice about other ways available to assist her to integrate menopause was not provided. This meant that she was not fully informed or given choices as to how she could cope and integrate menopause into her life. Mary’s menopause was controlled by her GP.

Once Mary had been told what was happening to her and put on HRT she then began to discuss menopause with other women. The HRT began to give her very frightening palpitations. She had been given no information from her GP, of the possible adverse effects of HRT. Of her own volition Mary decided to find out if the HRT was causing the palpitations. Not taking the HRT meant the palpitations subsided and recommencing meant they reappeared. This successful experiment gave her the confidence to take control of her own health and from that time she began to challenge her GP as to the reason she was both taking other medications as well as the dosages of them. She took a totally new view of her role as a recipient of health care and wanted to be involved in the decisions about her health. So although Mary initially gained knowledge about menopause, the process of having her health controlled by her GP inadvertently allowed her to become a seeker of knowledge and wanting to be in control of her own health.

Recent research also demonstrates the value of clients being involved in their health care. In a study investigating the predictors for treatment of people who had low back pain it was found that “those with more optimistic views of their health and

weak belief in control by powerful others had gained more from the treatment” (Harkapaa, Jarvikoski & Estlander, 1996, p. 123).

The dotted lines on the model between the two strands described as ‘unaware of menopause’ and ‘aware of menopause’ are included to indicate that at this stage some women in the study did fluctuate in their own belief of what they knew. The lower strand of the model represents those participants who had a higher level of education and who were seekers of knowledge. These women had intentionally sought information about health issues in the past, before becoming menopausal. They had gained the confidence to seek information both from having a higher level of learning and from the success that continual seeking of information brought. Alison was a typical example of these participants. She was a self-identified “self-seeker” of knowledge. Menopause was just one more health topic that she needed information about. A previous topic had included pregnancy.

I mean I read a lot. When I was pregnant I did a lot of reading about, you know, go to the library and find as many books as I can about it (Alison, 1: 2).

As this group of women sought information they confirmed, from others including their GP that what was happening within their bodies was menopause. As they had been able to be assertive and also be involved in the decision making of options for health care in the past, they had this same expectation of success when making decisions about how to integrate menopause into their lives. However, Wilma spoke of how difficult it was to find out what was happening within her. She had ruled out menopause, as what was happening to her because it did not match up with the symptoms of menopause listed in the book that she had read. The first GP she consulted told her she had an overactive thyroid when she had previously had a thyroidectomy. She was consequently assertive and requested an appointment to consult an endocrinologist.

Other participants in this lower strand were also assertive. They asked their GP for other options to control their symptoms. One woman was not happy with her GP’s attitude to her symptom of heavy menstrual bleeding and asked for a referral to another practitioner. Others in this strand decided to do more reading, talk with

colleagues and friends about what it meant to have menopause and to do what they called “being positive”.

These women saw menopause as just another phase of their lives. Some women had very minor disruption from menopausal symptoms. Others found their symptoms were intrusive in their lives. They wanted to integrate menopause so that it did not dominate their lives. To integrate menopause they used interventions that could control, or at best alleviate, their symptoms. These interventions included walking which helped in keeping healthy – for now and the future, as well as helping insomnia and giving a feeling of well being. Some of these women thought that some of their menopausal symptoms caused problems between themselves and other members of their families. These women sought measures to reduce what they saw as the cause of the problems. These measures included gathering support from colleagues, making lists to aid their memories, and making time for relaxation and massage. All interventions are controlled by the women and aimed at integrating menopause into their lives.

Summary

Chapter Five has shown how women identified what the changes were that were occurring in their bodies, how they integrated these into their lives as well as what measures they used to cope with the changes.

The descriptive model (Figure 1) has demonstrated the different pathways taken by women as they begin the journey of menopause. The women who have support and the qualities that are acquired from tertiary education follow a shorter route to be educated/informed about menopause. Tertiary education gives women confidence and other abilities that allow them to be more able than other women, to be seekers of knowledge. Also, these women are more likely to have self-control of their menopause than those women who do not have support and a tertiary education. They are also more able to integrate menopause into their lives once they have the knowledge that allows them to make informed choices.

Chapter Six

Discussion, Limitations, Recommendations, Implications for Nursing Practice and Future Nursing

Introduction

This chapter includes discussion about the study in relation to recommendations to improve women's access to information about menopause and also in assisting women to integrate menopause into their lives. It also identifies the limitations of the study as well as the implications for nursing practice and for future nursing research. Each participant in this small study provided insightful and meaningful information related to the way in which they were integrating menopause into their lives. The women who answered the newspaper advertisement were all accepted into the study and therefore the group is not representative of the total population. However, the use of grounded theory methodology has allowed for an overall picture of menopause to emerge from this small group. This snapshot of their experiences shows the diversity in the individual's experiences as well as the many-shared features. The women's stories and the analysis of the data have brought forward some implications for both nursing practice and nursing research.

Discussion

This study consisted of a group of eleven women, the large majority being well-educated Caucasian women. It has shown that these women have personal attributes to enable them to be independent and confident seekers of information. These personal attributes include a tertiary level of education, ability to be assertive in seeking knowledge, having support from others as they experience menopause and a self-belief that menopause "won't be a problem". Of the eleven women in this present study only three were unsure of what was happening with their bodies, including one woman who was very worried and had no idea whatsoever of what was happening. The other eight women knew that they were menopausal. Lemaire and Lenz (1995, p. 42) carried out a study to identify predictors of uncertainty among

a group of women attending an educational programme on menopause. In this study 57% of women identified a lack of information needed about menopause, 24% of the women were not sure and only 16% thought they knew all they needed to know.

Those women who were unsure of what was happening within their bodies had the change in their health status identified for them. This identification came through verification from friends, colleagues, books and their GP. Hampson and Hibbard (1996, p.179) suggest that "in the absence of knowledge women cannot participate as equal partners in deciding about menopause management". In the case of two women, an unsolicited script for HRT accompanied the identification of their menopausal status by the GP. Both of these women later decided not to take their HRT, one because of the adverse effects she was experiencing; the other woman because she had found other ways of coping with the symptoms she was experiencing.

Women in this study wanted health professionals to involve them in the decisions about how they could best manage their menopause. Though examining the current situation of women and midwifery, Ralston (1994, p. 455) puts forward a salient point about women's involvement in decision-making. This point is that a woman will only have "real choice if she has been fully informed of the options available to her". Rogers-Clark and Smith (1998, p. 213) agree that this involvement is necessary as women need to take "personal responsibility for health by working with health professionals" if they are to remain healthy. Two participants were continually invited to be part of the decisions that their consultants were making about the treatment of their menopausal symptoms.

Participants were motivated to investigate concerns about menopause in the same way they would for any other health issue. They sought out information from their various sources. They did not see the management and integration of menopausal symptoms in a different light to other health concerns; they found out what was going on and then made decisions as to what to do from there. They expressed interest in acquiring control over the symptoms when and if they became of concern. Some women accepted their presence and then tried to ignore them. Others tried a variety of ways to reduce or prevent symptoms they may be experiencing. One way of helping to overcome insomnia was to increase their exercise as well as take

evening primrose oil. If self-control could not be achieved they sought medical assistance.

Limitations of the Research

The small number of menopausal women included in the study is a limitation, and is acknowledged. As well as the small number, the ethnicity of the majority of the research participants limits the variety of the data collected and consequently the analysis of the findings. Only one participant did not identify culturally as Caucasian. Using a newspaper advertisement for participant inclusion meant that the women who replied were literate or had someone read the advertisement to them, wanted to be part of the study and were also prepared to make the time for their inclusion in the study. If women from the variety of ethnic groups living in this area, which include Samoan, Chinese, Cambodian, Korean, and African women had been included in the study, the data, consequent coding and categories could have been markedly different. A group of women from other cultural backgrounds could have expanded as well as altered the results of the research, and the recommendations to be made, as a result of it. This has implications for the generalisability of the results from this study.

Comparative inexperience in the research process and especially in the interviewing of the initial participants may have effected the data collected and subsequent limited use of theoretical sampling. When interviewing I found that I had two 'agendas' operating simultaneously. I was aware that I wanted to strike a balance between being friendly, in order to encourage the participant to come up with the desired information while at the same time distance myself enough to concentrate intently on the substance of what was being said. The two 'agendas' were not mutually exclusive and it was my self-perceived doubt of being able to successfully integrate the two that caused me some internal anguish during initial interviewing. Oakley (1990, p.33) believes that it is possible "to get reliable and valid data and make interviewees believe they are not simple statistics-to-be; it is just a matter of following the rules". After arriving at an interview I ascertained the willingness of the participant to still be included in the study and established rapport. The 'rules' in my interviews included telling the participant that I would be happy to answer any questions at the end of the interview and that the interview was for the purpose of

gaining her views on what I was asking. From the interviews it was the personal interest and subsequent subjective decisions I made from the data that meant that the directions taken in the research might have been different from another researchers.

It has been my own personal and professional interests and menopausal experience which instigated this research. This could have impinged on this study. Hutchinson (1986, p. 115,) notes that as “grounded research requires interpersonal interaction, the researcher is inevitable part of his or her daily observations. One must become aware of personal preconceptions, values and beliefs”. In fact, I was requested by my supervisor to write my own experience and then to both literally and figuratively put it aside until the completion of this study. This writing both validated my own experience and allowed me to be more objective about the information that other women were sharing. I believe that I was more sensitive to the women I interviewed because of my own experience but the writing of the experience meant that it didn't direct the research. I was then able to totally focus on the interview; it allowed the women to share their feelings and experiences with a researcher who was interested and empathetic to their experiences.

Implications for Future Nursing Research

The focus of this research has been on menopausal women and their experiences of gaining knowledge and coping with this stage in their life development. A major component of literature surrounding menopause does not address these issues and it is imperative that New Zealand research is further developed.

Research from diverse ethnic groups is needed to determine how literature, and the access to it, could improve women's knowledge base and understanding of issues pertaining to menopause. Presently the resources, as described by these women, illustrate that there is a paucity of information for women generally. Those women who do not feel able to access available material, for whatever reason, and those women, for whom the written word is not the preferred way of gaining information, are disadvantaged. The lack of information can leave women feeling powerless and isolated. Another reason why women feel they do not obtain information is the attitude of the people providing health care (Taylor &Dower, 1997). In seeking to overcome why women do not feel they have enough information about menopause,

research could address women's preferred mode of gaining information. This would allow resourcing to be distributed so women of this population are not being denied access to health education.

Women in this study were generous in sharing their personal experiences and indeed their lives as the two are interwoven. Many gained the information they needed from other women and from doctors. As the female population continues to increase and age it is imperative that doctors and nurses know more about women's views of what they understand menopause to be and also of the numerous ways they can assist women who have concerns around their health during menopause. The retirement age for women is now 65 years of age in New Zealand. If their menopause means time off from paid employment this has economic consequences for them in their retirement. Wilma describes the amount of time that she was not able to work due to her identified menopausal-related symptoms.

(...) contracted me back on a part time basis which I'm still doing at the moment. But it was just as well because for those three months there's no way I could have worked full time. There were so many days that I was so bad-I couldn't have gone to work (Wilma, 1: 11).

Research could address the potential financial impact on women who are ill informed about menopause and midlife generally. Women in this study have stated the desire for frank, open and informative knowledge around the issues of midlife. It is important that further research be undertaken to understand why women are still ill informed about their midlife health. This will be of benefit to both women themselves and society as a whole.

Implications for Nursing Practice

As explained previously, this study has included only a small sample of women. The study has shown that most of these women felt that there was insufficient information available to them. These women were literate and seekers of knowledge. Women who are unable to actively seek knowledge for health concerns may be even more disadvantaged. This study has shown that women want information from a variety of sources and the nursing profession is not being seen as

an avenue from which women may gain information about menopause. Women in this study were asked who they saw as the principal or key person to educate women about menopause. Women said they saw this as the responsibility of the doctor. However, participants have stated that often doctors only discuss the reason the woman has presented at the clinic; they do not ask if the woman if she had any other health concern she would like information about.

Only one participant saw a nurse being involved in dispensing information about menopause and then only if she had been “properly trained”. From these comments it is apparent that the nurse’s role in health education needs to become more overt and seen to be as legitimate as that offered by the medical profession. Conducting a cross-sectional survey in Massachusetts in 1982, Avis and McKinlay (1990, p. 237) found that “perimenopausal women may discuss problems in the context of a visit for some other reason”. Nurses are urged to provide holistic nursing care for their clients. Education is part of this holism and means that nurses must use each professional meeting with women as an opportunity to educate them about their health generally.

Midlife women gained information from media sources as well as nurses. The media both informs about menopause as well as advertises products for menopausal women. Whitehead (1997, p.1) questions “whether the stereotypes that have grown up about different sections of the population get in the way of effective action”. Though menopause is increasingly ‘out of the closet’ - being discussed more openly - the stereotypes surrounding it still abound and could be accepted by nurses unless education is given to refute these. Nurses and women, whose knowledge around midlife issues for women is both factual and current, need to take every opportunity to challenge the way in which menopause is portrayed in the common literature. Currently there is a lot of covert scaremongering with a severe lack of the total picture being given to women. This can be seen in the amount of contradictory public dialogue about menopause in the popular press.

Implications for Nursing Education

In this study the participants saw a very limited role for nurses in terms of providing information about menopause. Cook (1993) believes that the nursing management of

patients who are menopausal needs to include assessment, education and supportive counselling. Gane (1994, p.37) describes how she set up training for accident and emergency nurses to carry out hormone replacement implants to provide a better service for women having the implants and added that they "would also like an opportunity for health promotion with these clients". The role of the nurse has to include assessment of the menopausal woman, her total health and the nurse must be empathetic. This will assist to encourage women to see the nurse as an educator and a promoter of health.

As menopause is a natural part of ageing, women need to be able to take advantage of information which addresses menopause but which also addresses their health generally. They have the right to be able to find out what the research is saying, to be able to make informed choices. This education is often the role of the practice nurse or the nurse working on the gynaecological ward. This is not always the case. Working as a health visitor Hughes (1992) discussed how she set up a series of information meetings, for women facing menopause, at her general practitioner's surgery. The meetings consisted of invited speakers to discuss various aspects of menopause with time left for issues raised by the group.

Wasaha and Angelopoulos (1996, p. 25) state that despite much research into menopause and its treatments, to date the findings are "inconsistent, incomplete, and, in some cases, controversial". These authors encourage nurse colleagues, with their vast knowledge of all issues surrounding menopause to play a vital role by "providing individualised assessment, education and support". To illustrate this they relate an incident in which the value of expert nursing care makes a difference for the client. MacPherson (1990) acknowledges that a growing number of nurses are aware of the medicalisation of menopause. These nurses are demonstrating their scepticism as they design and implement research which puts the menopausal woman in the centre of the research design instead of menopause as a disease.

In a small Bristol study of menopausal women it was found that many women do not seem to see nurses as appropriate information sources. If women's views of the menopause are to change then nursing must play a more constructive role in reducing the consequences of this natural event. Removing the cloak of secrecy surrounding menopause, the nurse should be able to discredit the myths, clarify

misunderstandings and suggest relevant courses of action (Mendham & Rees 1992). Nurses have a responsibility to ensure that women's experiences of menopause are validated with sensitivity and empathy as well as to assist them to choose the options they consider best to suit them as they experience menopause (Dietsch, 1995).

Nurse educators have a part to play in ensuring nursing students are adequately prepared with knowledge and skills to debunk the myths around menopause as well as prepare women for this time. They can encourage and teach research skills needed to enhance knowledge as well as challenge commonly held dominant views by some in society, of menopause being a deficiency disease requiring pharmaceutical intervention.

Nurses cannot presume that women do have knowledge about menopause; other age groups going through transitional life stages are not presumed to be educationally prepared prior to entering the specific stage. Teenagers and younger students at school are taught about sexuality and contraception. Older people are encouraged to attend seminars on retirement. Because nurses are encouraged to empower women to manage their own health they need to be aware of the different strategies that may be applicable in dealing with women who may or may not have knowledge of menopause. Kittel, Mansfield and Voda (1998) believe that when working with women "health care providers may be more helpful by trying to identify a balance of internal and external resources for dealing with menopausal changes". Empowerment of women who understand how to access knowledge may mean that nurses need to use different strategies for these women, to those used for women who do not have these skills. Women who are not computer literate may be unaware that information about support groups and researchers doing studies about menopause can be obtained from the Internet.

As a group of health professionals, nurses, spend a large quantity of time with clients whether it is in hospitals or in the community. They also have an increased access to 'minority' cultures compared to other professions. Some nurses find it difficult, from a cultural perspective, to ask women older than themselves, about a topic such as menopause. Some nurses may also find it difficult to speak of these issues to a woman of a culture different to their own. In these instances a culturally acceptable

solution may be to seek the assistance of health workers from the relevant culture or to use nurses who are of similar ages to the clients being educated.

Concluding Statement

Women's experiences of gaining information and coping with some of the differing challenges that menopause presented was explored using grounded theory methodology. A model was developed to demonstrate the factors which enable women to better integrate menopause into their mid life development. The model reflected attributes deemed necessary to make this mid life transition proceed as harmoniously as possible. With more women living longer and with the multiple roles these women simultaneously hold it is of paramount importance that women are aided to successfully integrate menopause with midlife.

All women will experience menopause. Challenging myths and providing culturally safe relevant education to women could empower women to extend the choices they now may be unaware that they have in terms of coping with their menopause. This could also have a flow on effect in terms of improving their general health and that of their families and society.

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Appendices

Appendix 1

On the 11th of February, 1997 this advertisement, to recruit participants, was placed in the Kapi-Mana News/Norwester newspaper in Porirua.

MENOPAUSE
Women aged 45 years to 55 years!
INTERESTED IN VOLUNTEERING
INFORMATION FOR A RESEARCH
STUDY?
IF SO PHONE
DESLEY ON 233-8883



**MASSEY
UNIVERSITY**

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Palmerston North
New Zealand
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Facsimile +64-6-350 5668

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HEALTH SCIENCES

Appendix 2

Menopause: Women's Knowledge Sources and Management Decisions Information Sheet

Thank you for answering my advertisement and showing interest in this research project. My name is Desley Turia. I am a nurse and I live in the Kapi-Mana area and work in the Hutt Valley. I am conducting a study as part of the requirements of a Masters of Arts degree in nursing. I hope to find out:

- where women gain knowledge about menopause and
- how women manage menopause.

I am interested in learning how nurses might understand women's needs better in preparing and managing menopause. I am not associated with the pharmaceutical industry nor any formal clinics or organisations which address the management of menopause.

If you agree to be included in my study I would ask you to be interviewed twice, at a time and place convenient to you. Each interview would take no more than two hours. If you agree I would like to tape the interviews.

Personal information shared with me would remain strictly confidential. Your name would not be used and there would be no information that could identify you in any written or verbal research reports. The tape-recorded interviews will be typed and the typist will sign a confidentiality agreement. The topic of menopause is sensitive to many women. If you find yourself becoming distressed during an interview we can stop the tape. I will support you and can provide names of people who could give further support if it was needed.

There are no risks and no direct benefits to you taking part in the study, but as well as sharing the experience of menopause with someone who is interested you may gain

knowledge about menopause. I expect the results of this research will help women in the future.

I will give you a typed copy of each taped interview. You will be able to check this and change or remove anything you want. Tapes and transcripts will be given back to you at the end of the study, or destroyed if you prefer. During the research the tapes and notes will be identified by code and be kept in a secure, locked cabinet.

From the information that you give a thesis will be prepared. Later the material could be used in conference presentations and in journal articles.

Participation is voluntary. You have the right to withdraw at any time. Any questions or concerns raised by you will be discussed as they occur. You may have a support person with you at the interview.

A summary of the findings will be available for you at the end of the research. Please take time to consider if you would like to take part in this study and feel free to discuss this request with anyone you wish.

If you do wish to be part of this research I can be contacted on (04) 2338883.

If you need to you could contact my supervisor:

Dr Jo Ann Walton,
Senior Lecturer,
Department of Nursing and Midwifery,
Massey University,
Private Bag 11 222,
Palmerston North.
Phone (06) 3504326.

If you have any concerns about this study you may contact the Chairperson, Central RHA Wellington Ethics Committee, Wellington Hospital, Private Bag 7902. Tel: (04) 3855999 ext. 5185. Fax (04) 3855840.



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Appendix 3

Menopause: Women's Knowledge Sources and Management Decisions

Consent Form

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

If I agree to participate, I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (The information will be used only for this research and publications arising from this research project).

I agree/do not agree to the interview being audio taped. I understand that I may have the tape turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed.....

Name.....

Date.....

Appendix 4

Transcriber Confidentiality Form

It is acknowledged that during my employment with Desley Turia I will have access to highly confidential information concerning the research participants. I hereby undertake that during the term of employment and always thereafter, I will treat information obtained as completely confidential and will not divulge any information concerning participants' affairs to anyone, either directly or through casual conversation.

Transcriber.....

Date.....