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**UNIVERSAL CHANGE - INDIVIDUAL RESPONSES:
WOMEN'S EXPERIENCE OF THE MENOPAUSE AND OF
TAKING HORMONE REPLACEMENT THERAPY**

A thesis presented in fulfilment of the requirements
for the degree
of Master of Philosophy
in Nursing
at Massey University

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ABSTRACT

The purpose of this phenomenological study was to describe and interpret the phenomenon of menopause as experienced by women taking hormone replacement therapy. The study set out to answer the question "What is the experience of taking hormone replacement therapy during the menopause?" The narratives of the ten women who participated in this study provided rich descriptions which revealed some of the ambiguity and silence that has concealed much of this experience.

The conclusions of this study are that menopause as an universal event, in human females, is comprised of individual responses which are interpreted within the context of each woman's life. The inevitable-unexpectedness of the menopause, (knowing that it will come) does not prepare the women for the experience. Ways of coping with a changing body are directed by concerns which arise from each woman's societal, family and individual experiences. The findings of this study suggest that the decision to take or not to take HRT is not a definitive one, but the source of an ongoing dilemma. A dilemma caused by the women's desire to cope naturally and their need to regain some control over their bodies and their lives through taking HRT. Underlying the women's decisions is a weighing up of the possible outcomes of taking HRT - to prevent osteoporosis and heart disease, or to increase their chances of developing cancer.

The impact of conflicting information from both medical professionals and the press added to the women's concern about their bodies. This manifested itself in the women becoming very watchful of their bodies and taking surreptitious breaks from HRT regimes. For all the freedom and self management promised by HRT, we need to alert ourselves to the possibility that in some way HRT dampens down something that wishes to express itself, but which as yet modern Western society does not accommodate.

The central over-riding theme of this study is universal change-individual responses. This is supported by three essential themes: living-with-a-changing-body, being-on-hormone-replacement-therapy and relationships-past-and-present.

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Dr Cheryl Benn then took up the difficult task of guiding me to bring the whole thing together for presentation. It is not an easy task for a new supervisor to take up where another left off so I wish to acknowledge the skill with which this was done.

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KEY TO TRANSCRIPTIONS

The abbreviations and conventions given below are used throughout this dissertation, particularly when excerpts from the interview transcriptions are used.

Int.	interview
<i>Italics</i>	the words as spoken by the participants are presented in italics
p. or pp.	page or pages
()	comments or questions made by the researcher to clarify or explain aspects of the transcription
...	indicates a pause within the original transcription
./..	indicates where material has been edited

CHAPTER ONE

INTRODUCTION AND OVERVIEW

During this decade, the subject of menopause has attracted increasing attention in Western society. From a situation of near silence within the professional and lay press, menopause, and how it is handled, has emerged as a subject attracting considerable media attention and research (McKeon, 1994). Two main factors have contributed to this change. First, there has been an enormous increase in the number of midlife women in Western society this century, a trend which is expected to continue for the next 30 years (Whitehead, Godfree & Purdie, 1992; Kelly, 1993; Strickland & Giger, 1994). Secondly, the writings of such authors as Greer (1991), Coney (1994) and Sheehy (1994) have not only raised women's level of consciousness concerning menopause, but have chiseled away at our reticence to openly discuss this midlife experience, and challenged the escalating use of hormone replacement therapy (HRT).

However, as pointed out by Strickland and Giger, it is the confusion which surrounds the appropriate treatment for menopausal symptoms that has made menopause and HRT such a controversial issue in women's health care today. The "baby boomer" generation, now entering menopause, are not only facing more choices than their mothers did, but also a higher level of uncertainty as they are confronted with conflicting messages from both research and the popular press (White, 1995).

This study evolved from my desire to understand how midlife women are experiencing the taking of HRT during the menopause. I first became aware of the impact of HRT on the lives of my contemporaries through listening to their conversations. Women perceived to be ageing well were referred to as "being on hormones", while others confided that they were experiencing problems that they attributed to HRT. I became increasingly interested not only in what I was hearing, but also in what I found in the literature. An accruing body of evidence in the scientific as well as lay literature indicates that there is growing dissonance between women's perceptions of the menopause and those of physicians (Lemaire & Lenz,

1995). This incongruence tends to be reflected in women's attitudes towards the medical treatment of menopause, as evidenced by irregular compliance with HRT treatment, in spite of the medically perceived benefits (Lopes, 1993).

In this chapter, historical landmarks relating to the development of hormone replacement therapy are briefly discussed, and definitions of menopause and HRT are clarified. Also introduced is the rationale for the selection of the research methodology - hermeneutic phenomenology. This chapter concludes with an outline of the structure of this thesis.

Historical Aspects

Three major milestones are identified by Utian (1980) in the history of the development of hormones as treatment for menopause. The first was the successful isolation of a hormone from the urine of pregnant women by Butenandt, a Nobel prize winner in chemistry in 1929. This hormone was called estrone. The second was Robert Wilson's book *Feminine Forever*, which was published in 1966. Wilson's approach was in direct contrast to the unsympathetic attitude towards midlife women that existed at that time. The offer of eternal femininity appealed to thousands of women and their husbands. This heralded what Wilson named a biological revolution - no longer would women be doomed to premature ageing, loss of femininity and uncomfortable menopausal symptoms. Medical science "was pointing the way to a new biological destiny for every human female" (1966, p. 17). The solution was oestrogen replacement therapy (ERT). Worthy of comment is the fact that Wilson was funded by Wyeth-Ayerst, the manufacturer of Premarin, an oestrogen product prescribed to women during the menopause (Worcester & Whatley, 1992). Today Wilson's attitude appears patronising and paternalistic; however, his influence on both medical and public views of menopausal women in the 1960s and early 1970s cannot be ignored.

The third milestone identified by Utian appeared in the *New England Journal of Medicine* on December 4, 1975, claiming a link between oestrogens and endometrial cancer. Utian, referring to the 1970s in the Pieter van Keep Memorial Lecture of the

Proceedings of the 8th International Menopause Society Congress (1997, p. 5), stated:

The 'oestrogen forever' attitude of the late 1960s and early 1970s had been transformed to a fear of uterine cancer after the publication of some medical research studies in late 1975. Moreover, the power of the media, the influence of a youth-oriented culture, the attention of the consumerists, the well-expressed feelings of the feminists, the inconsistent attitudes of different governmental agencies, the medical profession's fear of potential malpractice litigation and numerous other factors, had obviously combined to cause confusion in the minds of many providing health care for women approaching menopause. They could no longer feel absolutely sure that they knew what it was all about or what they could or should do about it.

Not surprisingly this confusion continues to simmer into the 90s, even with the trend towards prescribing combination therapies of oestrogen and progestogen. The addition of synthetic progesterone was considered to lessen the carcinogenic effects of unopposed oestrogen (Ripper, 1994). Thus HRT was marketed as being "protective against" endometrial cancer. However, as Ripper points out this claim is true only by comparison with oestrogen (ERT) not when compared with normal ageing.

According to Dorlands Medical Dictionary (1965), progesterone is the correct name given to the hormone produced by the corpora lutea (situated on the ovary), whereas progestogen is a term applied to "any substance possessing progestational activity" (p. 1225). Progestin is another term used which originally referred to the crude hormone of the corpora lutea. However, since it has been isolated in its pure form it is now known as progesterone. Also according to Dorlands, "the name progestin is used for certain brands of synthetic progesterone" (p. 1225). The literature does not always make the distinctions between these terms clear. For purposes of clarity, I will use the term progestogen when referring to prescribed substances possessing progestational activity in HRT.

Today hormone replacement therapy, consisting of various regimens of oestrogen and progestogen, is given by prescription to supplement the minimal oestrogen production by the menopausal ovary. Women with an intact uterus are usually

prescribed oestrogen and progestogen, while the women who have had a hysterectomy are prescribed oestrogen. However, not only is HRT prescribed to treat menopausal symptoms, but increasingly to prevent problems like osteoporosis, heart disease and stroke (Farquhar, 1996). Hormone replacement therapy can be given in the form of oral tablets, skin patches, implants (under the skin), and vaginal creams and pessaries. Baber (1996) reports that modern HRT prescriptions commonly use five regimens, which incorporate oestrogen with or without progestogen.

Looking back over the years since 1980 when Utian identified those three milestones, a number of trends in the ongoing development of HRT, each influencing the other, have emerged: first, the rapidly increasing use of hormone therapies, partly due to the preference for combination hormone replacement therapy, a trend reflected in New Zealand (Loryn Scanlan, Therapeutic Group Manager, Pharmaceutical Management Agency Limited (PHARMAC) in a personal communication 2 April 1996); secondly, the proliferation of pharmaceutical brand names and preparations, and thirdly, the trend attracting much debate, that of prescribing HRT as preventive therapy. However, it has been the impact of the rising population of midlife women and the changing nature of their work roles, particularly in Western society, that has propelled much of the growth in the use of hormone replacement therapy.

It is difficult to obtain accurate figures on how many women are taking hormone replacement therapy, and whether they are taking it for symptoms of menopause or as preventive therapy. Sheehy (1994) reports that doctors have routinely prescribed HRT to somewhere between four and five million American women. The economic impact of this trend is that in "1991 \$750 million of oestrogen products were sold in the United States" (1994, p. 29). The figures quoted by Wallis (1995, p. 50) in *Time International* are even higher. "About quarter of U.S. women at or past menopause - roughly 10 million - take the hormone, making oestrogen a billion-dollar business".

In New Zealand, the costs of hormonal therapies have continued to increase. This is confirmed by Cristine Della Barca, Therapeutic Group Manager PHARMAC in a personal communication (18 March, 1998). This increase is shown in Figure 1 indicating the costs of HRT from 1993 to 1997 which includes pharmacy mark-ups,

wholesaler mark-ups, dispensing fees and GST minus patient co-payment. Until early 1997 these costs were to the Regional Health Authorities (RHAs), which after restructuring became the Transitional Health Authority and later (1998) the Health Funding Agency (HFA).

Year	Cost to HFA/RHA
1997	\$8,425,533
1996	\$8,231,938
1995	\$7,953,053
1994	\$7,697,368
1993	\$6,674,174

Figure 1 Costs of HRT to the HFA/RHA from 1993-1997

The present preference for combined therapies and the expanded use of HRT as preventive therapy, plus the impact of the “baby boomers” reaching midlife, suggests that this upward trend in HRT costs will continue. According to a Statistics New Zealand report *Baby Boomers (1995)*, a bulge in births occurred in New Zealand between 1946 and 1965. Consequently when the female “baby boomers” reach their menopause, approximately between 1996 and 2025, the number of midlife women in New Zealand will be at its highest in history.

Definitions

Definitions of menopause vary. According to the WHO (1996), despite recommendations made in 1980 by a WHO Scientific Group on Research on the Menopause, there is no consistency in the application of key terms. McCraw (1991) noted that the terms climacteric and menopause are often and incorrectly used interchangeably. The WHO (1996) advises that natural menopause be defined “as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity” and “is recognized to have occurred after 12 consecutive months of amenorrhoea, for which there is no other obvious pathological or physiological cause” (WHO, 1996, p. 13). This definition of menopause concludes by noting that the certainty of menopause is known only retrospectively and that no adequate

independent biological marker for the event exists. However, particularly in lay terms, menopause has come to mean the time leading up to and following the last period (Kelly, 1993).

This tendency towards biological explanations of menopause has meant hormones and particular behaviour have become inexorably linked. Vines (1993) suggests that this linking is gender specific, because hormones are most often seen as something women (and not men) have. This is demonstrated by the use of the term “hormonal imbalance” as a defining characteristic of women. Therefore, such definitions as above fail to consider the social and cultural context in which women live through the menopause, their understanding of it and varied emotional responses (Poland & Rakusen, 1996). The same can be said of much research which has traditionally been carried out within the scientific paradigm. The term menopause means not just fluctuating hormones and the cessation thereof, but also, “children on the move, and altered responsibilities on the homefront and in the workplace” (Farrell & Westmore, 1993, p. 16).

Traditional scientific inquiry, with its propensity to focus on the midlife female body as object, rather than the body lived, has tended to separate the phenomenon of menopause both from the body in which it is experienced and from the social and cultural context in which women live. Consequently, although acknowledging menopause as a natural event, the language used in medical reports is that of menopause as a disease entity. Thus inquiry into the female midlife body, investigating the meanings and actions of the phenomenon of menopause, within the context in which it is experienced, will offer an alternative understanding of the experience of taking hormone replacement therapy. It was these considerations as well as the recommendations of two reports (discussed in the next section) that guided the selection of the research methodology for the present study.

Rationale for selection of research methodology

Over the past few years the literature has increasingly acknowledged the need for qualitative data in relation to the taking of HRT. Two studies of particular

importance are the report of The National Advisory Committee on Core Health and Disability Support Services, on HRT, and Research on the Menopause in the 1990s by the WHO Scientific Group (1996). The following statement from the first report identifies the lack of qualitative data in relation to HRT use in New Zealand and supports conducting such studies.

There are, however, few qualitative data available about the acceptability to women of long term treatment with HRT. For each woman considering long term use of HRT, it would seem likely that the potential health benefits will be weighted both quantitatively and qualitatively against the potential health risks and possible adverse effects on quality of life of such treatment. It is unlikely that women will necessarily weigh the various outcomes affected by HRT equally (The National Advisory Committee on Core Health and Disability Support Services, 1993, p. 18).

The need for qualitative methods of data collection is also acknowledged by the WHO (1996), even if such methods are viewed with less regard than those within the scientific paradigm. The WHO report (1996) states that in menopause research, “the most highly regarded studies use descriptive and analytical epidemiological methods and controlled clinical trials” (p. 3). However, “qualitative methods of data collection and presentation are also sometimes needed” (p. 3). Focus groups as a method of data collection are considered suitable when the goal is “to determine the meaning of the menopause from a woman’s perspective” (p. 6).

According to the WHO (1996) report, there is a lack of understanding of why some women comply with prescribed hormone regimens, and others do not. The following figures support the degree to which women are not adhering to medical regimes.

Studies indicate that 20-30% of women fail to have prescriptions filled and that the continuation rate after 8-12 months is only 30-40%. These data illustrate the need to understand women’s reasons for not adhering to prescribed regimens (WHO, 1996, p. 77).

Undoubtedly, research that qualitatively explores midlife women taking hormone replacement therapy during menopause is required. Such qualitative studies would contribute to our understanding of women’s rationale for commencing, adherence to, and future expectations of HRT. Women’s voices, about living through the

experience of taking HRT during menopause, need to be heard. This is supported by Greer (1991), who strongly advocates that women must define their experiences and tell their own stories.

The experience of selecting the appropriate qualitative methodology for this study was an important step, one which can be likened to that of being a marriage broker. I explored what was known about the potential partners, the research question and the methods other researchers had used in studying this topic. Dialogue was also sought with midlife women who were taking HRT. After exploring the range of possibilities, I developed and presented the case for hermeneutic phenomenology in studying the experience of women taking hormone replacement therapy during the menopause (Anderson, 1997). This marriage of research question and methodology has proved to be a useful one. The richness of the qualitative data gathered reveals much that has been hidden concerning our understanding of the menopause and use of HRT, supporting the selection of methodology which aims to open us to “a deeper understanding of the nature or meaning of our everyday experiences” (van Manen, 1990, p. 9). The philosophical underpinnings which guided this choice, and situate the relationship of the research participants and myself as researcher in this study, are discussed fully in the first part of Chapter Three.

This study started out as an inquiry into the experience of taking HRT, but also became an exploration of the phenomenon of menopause as lived by the research participants, due to two influences. The first influence, that of taking HRT, cannot be understood without first elucidating the phenomenon of the menopause. The second influence, is the relationship of HRT to the menopause in Western society, where the subject of menopause and the decision to take or not to take HRT are inextricably linked.

Significance of the study

The purpose of this study was to answer the question *what is the experience of women taking hormone replacement therapy during the menopause?* My approach to studying this question is grounded in the premise that in order to understand the

experience of taking hormone replacement therapy during the menopause, there is a clearly identified need for hermeneutic phenomenological research. Menopause, and how it is handled, is experienced within the context of a woman's life and, in order to understand this experience, it must be studied within the context of that life. Consequently, a research methodology that aims to reveal how women experience this reality is required. This is the value of phenomenology as a research method.

Therefore this study offers an insightful view of the phenomenon of menopause and taking of HRT as experienced by the research participants. Through exploring the meanings the women gave to this journey, their reasons for commencing HRT and their future expectations, the findings give direction to what women want from health professionals during midlife. The value of exploring the meaning women give to the experience contributes to contemporary thinking, which shapes knowledge, related research, and the practice of health professionals.

Structure of the thesis

This thesis is presented in seven chapters. In Chapter One, an overview of the context within which the study question was developed is presented. This included a brief historical outline of the development and costs of HRT, clarification of key definitions and an introduction to the justification for why and how the thesis was conducted. The significance of the study and implications thereof are presented.

Chapter Two provides an overview of the literature that formed the knowledge context within which this study was conducted. However, the inclusion of the literature continues into the data chapters, developing into a three way conversation with the women's stories, the literature and myself.

Chapter Three continues the threads begun in the first chapter, developing the case for hermeneutic phenomenology in studying the experience of taking HRT during the menopause. Also discussed is how the study was conducted, including accessing the research participants, ethical considerations, methods of data collection, analysis and writing.

Chapters Four to Six present my description and interpretation of the study findings. From the central over-riding theme *universal change - individual responses*, three dominant phenomenological themes emerged - *living-with-a-changing-body*, *being-on-hormone-replacement-therapy* and *relationships-past-and-present*. Each of these themes are further developed into sub-themes which guide understanding of the women's experiences.

Chapter Seven brings together the women's experiences and presents my interpretations of the research findings. The study's strengths and limitations are explored, followed by an examination of its trustworthiness. The role of the human science researcher is reflected on in light of my experience with this study. Those aspects of the study that have implications for nursing practice and education are discussed, with particular attention on the way in which the findings could be used in the care of midlife women. Recommendations are made for further research.

CHAPTER TWO

LITERATURE REVIEW

This chapter provides an overview of the literature, both professional and lay, that relates to the taking of hormone replacement therapy (HRT) during the menopause. Over the past ten years an enormous amount of information has been published in this area. Thus for reasons of manageability and accessibility, this review assesses a selection of literature that reflects the views that have shaped our understanding of the menopause and subsequent taking of HRT. This selection is based on the rationale that the way in which the menopause has historically and culturally been viewed influences how it is attended to. Consequently, key literature relating to the menopause is included. However, the main focus of this review is literature relating to the taking of HRT during the menopause.

There are differing opinions on whether to review the relevant literature prior to, during, or after data collection and analysis in qualitative research (Field & Morse, 1990). Each has their advantages and disadvantages. In this present study, relevant literature was examined and integrated throughout the research process. This started with the preparation of the research proposal, in order to establish a justification and rationale for the research question and methodology. During this planning phase, a critical examination of relevant research for assumptions, biases and unsubstantiated conclusions was made. This approach, supported by Field and Morse, assists the researcher to become both informed about the subject and how others have approached it, and open to the questions that need to be asked.

Van Manen (1990, p. 76) advises that it is “sound practice to attempt to address the phenomenological meaning of a phenomenon on one’s own first”. However, as he continues, there comes a time when the researcher must test their insights against those of others who have researched and published on the same subject. As well as widening the dimensions of meaning, van Manen further suggests that it is “in this way the work of others turns into a conversational partnership that reveals the limits and possibilities of one’s own interpretive achievements” (p. 76). In the present study

only four qualitative studies were located. These studies include two phenomenological studies relating to the experience of midlife (Brown, 1994) and the menopause (Dickson, 1994), and one grounded theory study by Choi (1993) on choosing whether to take HRT. The publication entitled *Intermission; Women, Menopause and Midlife*, based on a three year Australian study of women's experience of menopause and midlife by Richards, Seibold and Davis (1997), was the last to be accessed. None of these four studies was reviewed until after the phenomenological themes of this present study were developed.

Although throughout this thesis the literature has been integrated, it was not until the writing of the three data chapters that it became part of the dialogue between the data and myself. This dialogue evolved naturally and became my rationale for extending the literature into the data chapters, an approach supported by Rountree and Laing (1996). Therefore the purpose of this chapter is not only to assess key literature relating to the research focus, but to identify the knowledge context within which this study is situated

Structure of Review

The literature examined in both the professional and lay press, relating to the taking of hormonal therapies during the menopause, can be grouped into a number of approaches. Each represents a theoretical view taken by various disciplines when studying the female midlife body. These disciplines are medical, feminist, psychological, social, cultural and, to a smaller degree, anthropological, developmental and transformational. However, it is important to highlight Kaufert's (1990) point here, that membership of some of these disciplines has tended to result in a reluctance to acknowledge the value of the research produced by other disciplines; a tendency that Kaufert views as having hampered understanding of menopause. Consequently, prior to examining key literature representative of the above theoretical views, methodological issues in menopause research will be addressed. Following this examination is a review of literature to be found in the lay press. Highlighted will be an example of publications to which New Zealand women have been exposed. Finally, nursing's contribution to this field is evaluated,

concluding with a discussion of the implications of the literature for the present study.

Methodological Issues In Menopause Research

This decade has seen the emergence of an awareness of how the lack of understanding of philosophical assumptions, that underpin much menopause research, have shaped the questions asked and the methodologies selected to answer those questions (Li, Carlson, Snyder & Holm, 1995). The questions that a researcher asks, and how they go about finding answers to their questions, are influenced by the methods their discipline regards as valid.

Undoubtedly contributing to the interdisciplinary methodological conflicts are the complexities of women's responses to the interplay of all the factors involved, from the biological through to the emotional and social. As Utian (1997, p. 6) states, the complexities of the relationship between "menopause, ageing, disease and behavioural change has been plagued with methodological difficulties". This present review of the literature supports Utian's view.

Usually when different methodologies are discussed, there is the tendency to arrange them on a continuum from good to bad. This is especially apparent between the quantitative and qualitative positions (Darbyshire & Sandelowski, 1997). However, this is not the major concern of Kaufert (1990). This author recommends that the solution to problems resulting from adherence to disciplinary affiliations and methodological choices is to actively seek mutual tolerance of one another's methodologies and conduct collaborative, multiple method research. Kaufert's emphasis is on the use of multiple methods, yet since 1990 little research has been published using more than a single approach. The most recent is the study conducted by Richards, Seibold and Davis (1997) which applied both qualitative and quantitative methods.

Theoretical Approaches To Studying The Menopause

The most commonly cited theories used to explain menopause in the literature are either medical or feminist. Medical theory tends to present menopause as an "oestrogen deficiency" disease requiring hormone replacement therapy (Dietsch, 1995). The perception of menopause as a medical problem is not, as usually supposed, a recent phenomenon. Dean-Jones (1994, p. 108) in a footnote cites evidence of menopause being perceived as a medical problem in Roman society. Feminist theory portrays menopause as a natural age-related experience, that has been medicalised in order to empower physicians to diagnose it and treat it as a medical event (Greer, 1991; Coney, 1994). The feminist suggestion is that where possible menopause should be handled by natural means. However, both groups present themselves, in the literature, as representing the interests of midlife women. The scarcity of research on how women experience, and make sense of the menopause, suggests that neither the medical or feminist positions are evidence-based (Cornford, 1997).

Consequently, what information women want, and how they can access it in order to manage their experience of menopause, is not clearly articulated. This has contributed to the growing dissonance (previously referred to) between women's perceptions of menopause and those of physicians (Lemaire & Lenz, 1995).

Traditionally research on the menopause and hormone therapies has been carried out by male physicians. However, social and behavioural scientists have been studying the menopause from the psycho-sociocultural perspective, particularly in relation to menopausal symptomatology (Flint, 1979). On the other hand anthropologists and evolutionary biologists such as Jones (1979) and Peccei (1995) have explored the purpose and reasons for why human females have a menopause. Other theories presented in the literature, by such authors as Kenton (1995) and Northrup (1995), view menopause as a time of development and transformation. Although attracting an increasing amount of attention, there is little evidence of women perceiving menopause as a transformation (Richards, Seibold & Davis, 1997).

Medical Literature

Undoubtedly the medical model has had great impact on how Western women think about the menopause. In a feminist poststructuralist analysis of the knowledge of menopause, Dickson (1990, p. 27) found that the “expectations in the voices of the women as they spoke about menopause expressed their anticipation of menopause in terms of the scientific and medical discourses”. An examination of the medical literature suggests that four themes tend to dominate: first, an intense absorption in the physiological changes and symptomatology of menopause; secondly, the management of menopause symptoms and prevention of potential health problems within the framework of HRT use; thirdly, the pharmacodynamics of HRT which gives rise to a tension between the advantages and risks of taking HRT; and finally the problem of women’s compliance with prescribed HRT. This section of the review will also include an example of the marketing image of HRT, which appears in medical journals.

The Physiological Unknowns of Menopause

Such authors as Lemaire and Lenz (1995) consider that the physiological mechanisms of menopause may be relatively well understood. However, on closer examination a number of unknowns are apparent; for example, after the menopause women naturally produce very little progesterone, and the reasons for this are not understood. Also poorly understood are the reasons for the elevation, after the menopause, of the plasma gonadotropins, leutinizing hormone (LH) and follicle stimulating hormone (FSH). While medical research tends to ignore this postmenopausal elevation of LH and FSH, perceiving it as something to be corrected, usually through the use of HRT, those writing from the developmental and transformational paradigm have developed a hypothesis for these changes (Borysenko, 1996). A more in-depth exploration of these changes and this hypothesis will be presented later in this review.

The WHO (1996) report states that the event of menopause is known only retrospectively and that no adequate independent biological marker for the event exists. Other than the permanent cessation of menstruation as a result of loss of ovarian follicular activity, vasomotor symptoms of hot flushes and nights sweats are

the only other symptoms considered characteristic of the menopause (WHO, 1996, p. 26), although it is noted by the WHO that hot flushes are not unique to menopausal women. These examples suggest that medicine's understanding of the physiological changes during the menopause is not yet complete.

HRT in the Management of Menopause and as Preventive Therapy

Prior to the discovery and manufacture of oestrogens in the 1960s the medical literature showed little interest in menopause. However, since the availability of oestrogen replacement therapy (ERT) and later hormone replacement therapy (HRT), there has been a phenomenal increase in menopause-related literature. Such publications as *Maturitas* which commenced in 1978, and the more recent development of *Menopause Digest*, have presented medicine's growing interest in menopause and its management with hormone therapy. Although Coney (1994) accuses doctors of falling in love with oestrogen, medicine's interest in and use of hormone therapy is more a reflection of philosophical assumptions about the human body, particularly the female body. For example in *Feminine Forever* Wilson (1966), although appearing to be patronizing through today's eyes, sincerely wanted to save women from the dreadful disease called age. He saw himself more as a knight in shining armour rather than one of Greer's (1991) 'Masters of Menopause'.

The approach to menopause portrayed in the general practitioner literature is primarily concerned with managing it, usually within the HRT frame of reference. However, there are signs that the medical view of menopause is attempting to include aspects other than biological changes. O'Neill (1995), discussing the treatment of menopausal problems, recommends a holistic approach. He does not enlarge upon this recommendation other than to advise physicians to educate the woman about this time of life, examine and confirm her current medical status, maintain compliance (with HRT), and treat her appropriately in a cost-efficient manner.

Another trend to emerge in the nineties is the expanded use of hormone replacement therapies, from treating symptoms of menopause, to that of preventing such diseases as osteoporosis (Eden, 1995), of providing possible cardioprotection (Craig, 1996), and of preventing Alzheimer's disease (Paganini-Hill & Henderson, 1994). In fact

the pendulum has swung so far that such medical specialists as Eden (1995, p. 41) present hormone therapy as “the gold standard for the prevention of menopausal bone loss”. This trend, referred to as the new paradigm for health, is the preventive model. Recommended are screening programmes for all potential diseases, irrespective of causation, introduced in a cost-effective manner. While some preventive programmes, set up within menopause clinics, would also include diet, exercise and smoking cessation advice, the mainstay of treatment is the prescribing of HRT. There is little evidence as to whether women would frequent such clinics seeking this type of service.

Utian (1997, p. 6) considers that programmes based on the preventive model “can spare our institutions and societies from an escalating financial and social burden”. Inferred from this, although not articulated, is that ageing women will be responsible for causing this burden. The fact that women live longer than men is, as Lock (1993, p. 334) suggests, “thrown back at them because they are viewed as a liability to society in their latter years”. Female longevity, as compared to the shorter life span of males, is viewed as an unwelcome trait. Therefore, providing preventive care, including the prescribing of HRT, will save ageing women from becoming a societal burden. Lock suggests that this view is motivated by a vested interest in the potential profit involved in keeping ageing women healthy. On the surface this is a cynical view; however, two news briefs, published in *Pharmacy Today* (1996), support Lock’s view.

Pharmacy Today has been sent free to every community and hospital pharmacy in New Zealand since 1988. Two extracts from the publication follow:

Natural oral oestrogen

As pharmaceutical prices drop and older products lose their patents, drug companies are turning to the HRT market as a major growth area, according to market analysts, Datamonitor. Treatments for menopausal disorders account for only 2% of the global pharmaceutical market, but companies such as Wyeth and Schering AG are positioning themselves as “women’s health companies” because they believe there is scope for further growth in this area.

HRT focus

Novo Nordisk New Zealand has announced the listing of oestrogen-only HRT therapy Estrofem on the Pharmaceutical Schedule from February. "With more than half a million women over the age of 45 in New Zealand it is vital we look for products which encourage compliance and meet women's expectations of improved health care", said Novo Nordisk International's chief executive Mads Ovlisen during a recent visit to New Zealand (Pharmacy Today, March, 1996, p. 29).

These references strengthen Lock's (1993) view that the marketing of HRT has become a lucrative industry. Without doubt the drug companies listed above view ageing women as a rapidly growing and potentially profitable market. The clever marketing strategy of Wyeth and Schering AG in positioning themselves as "women's health companies", through the manufacturing of hormones, totally ignores the health benefits of lifestyle change as part of being healthy. Health for the ageing female is being offered in the form of a pill.

However, Weinstein and Tosteson (1990), after conducting a complex cost-benefit analysis, reached the conclusion that any cost benefits of prescribing HRT as a preventative measure must be considered as tentative only. In 1992 Cheung and Wren reported on a cost-effectiveness analysis of hormone replacement use in the menopause. Their findings suggest that HRT for symptomatic women is cost-effective. However, short-term treatment of asymptomatic women for prevention of osteoporotic fractures and myocardial infarction was found to be an inefficient use of health resources.

The New Zealand report on HRT by The National Advisory Committee on Core Health and Disability Support Services (1993, p. 6) recommends that "any decision to use HRT for the treatment of climacteric symptoms should be made separately from the decision to use HRT long term for the prevention of fractures and coronary heart disease (CHD)". However, the report does recommend the use of HRT for treatment of lower urinary tract dysfunction, and long-term use for prevention of fractures in women who have a high risk of osteoporosis. The Advisory Committee concluded "that it would be inappropriate to recommend to the majority of peri- or post-menopausal women any long term prophylactic drug treatment that had not been

studied extensively in large randomized trials of efficacy and safety (as measured by mortality and morbidity)” (p. 6).

The nineties have seen a shift in the attitudes of doctors towards the menopause and treatment of symptoms. Today menopause is generally recognized as a normal physiological change which often coincides with changing family and work commitments. However, to date there is little research evident that attempts to untangle the complexity of the interplay of hormonal changes, psycho-sociocultural and ageing factors, which produce such varied symptomatology and related long-term health problems (Utian, 1997). The need for qualitative data, as identified by The National Advisory Committee on Core Health and Disability Support Services, (1993) and the WHO report (1996), indicates that attempts are being made to broaden the traditional methodological approach to studying the menopause.

The Dilemma of HRT Use - Advantages and Risks

The voice of medical concern over the lack of sound evidence has slowly grown. Outlines of currently available facts to assist therapeutic decisions on postmenopausal HRT and reduction of cardiovascular risk have been published by Posthuma, Westendorp and Vandenbroucke (1994), and Newnham (1995). Although acknowledging there may be long-term cardioprotective advantages in hormone therapy, these authors advise that present evidence does not support universal preventive hormone therapy in CHD.

The expanding list of disease prevention criteria, for which HRT is being prescribed, highlights the alarming lack of studies examining the interactions between introduced hormonal factors and other medications women may be prescribed. This is evidenced by Myers and Sherman in their study cited in the GP Weekly (October, 1994). While these researchers suggest that oestrogen may slow the metabolism of steroids and/or have an anti-inflammatory effect in women with asthma, they found the “current lack of studies of the interactions between hormonal factors and medications in women with asthma alarming” (p. 21).

Although a similar situation exists in relation to women and coronary heart disease (CHD), there is the added controversial issue of gender bias in the management of

CHD. Craig (1996), while suggesting that HRT may protect against CHD, and may be effective in the management of hypercholesterolaemia in postmenopausal women, also suggests that gender bias in the management of CHD may contribute to the worse prognosis scenario for women after a myocardial infarction. Although he views HRT as likely to reduce CHD incidence and mortality in postmenopausal women, he reminds us that “no double-blind placebo-controlled prospective trials of the anti-atherogenic effects of HRT have been performed” (Craig, 1996, p. 22). This is a point which is emphasised by Jonas and Manolio (1996) in their review of the evidence for HRT use in the 65 plus age group, looking both at the studies done and currently occurring, as to whether HRT may provide cardiovascular protection.

Whether such studies would also include the possible biological interactions between female hormonal factors, coronary heart disease, anti-atherogenic and cholesterol-lowering drugs is not mentioned. Mainstream medicine has not adequately investigated gender differences in the ageing process (Dreher, 1997), nor the complex interactions of female hormones with many prescribed medical drugs.

However, an ambitious primary prevention trial, the Women’s Health Initiative (WHI), currently in progress and planned to commence data analysis over 2006-2007, will address many of the concerns discussed. The essential feature of these clinical trials is the use of clinical end-points as opposed to intermediate end-points, which have been used in many clinical trials of preventive therapies for chronic diseases. The problem with intermediate end-points is that “these are typically biological risk factors such as lipids for coronary heart disease” and do not, as Johnson (1997, p. 85) suggests, “necessarily predict a change in occurrence of the actual clinical disease”. Johnson further points out that because most cancers do not have good biological markers, intermediate marker end-points are not feasible. In addition, an arm of the (WHI) trial will investigate whether HRT has an adverse effect on breast cancer incidence.

In New Zealand a two-year randomized trial which will examine the use of oestrogen for preventing osteoporosis in postmenopausal women, who are at least 10 years post-menopausal, commenced this year (Mackay, 1997). Until such time as the results of the (WHI) study and others similar to the NZ trial are out, the long term

use of hormone therapies as preventive therapy in midlife women should be viewed with the utmost caution.

Another issue identified in the medical literature is the ongoing uncertainty as to the links between taking HRT and cancer. Studies supporting both sides of the argument can be found. However, the area of most uncertainty is over the long-term use of HRT. While Roberts and Hardy (1992) state that no increase in the incidence of breast cancer is apparent in HRT use of up to 5 years, they suggest that it may with long-term use. They state reassuringly that "while it appears the incidence of breast cancer may increase with long-term HRT, women who get this cancer while on oestrogen are less likely to die from it" (p. 57), suggesting that the virulence of breast cancer while on HRT is less than in the woman who does not take HRT. Where a woman has a history of breast cancer, these authors, in general, support current advice that use of oestrogens should be avoided.

More recently Bergkvist and Persson (1997, p. 26), in a review of published studies of the relationship between HRT and breast cancer, state:

Overall, short-term use of HRT for relieving menopausal symptoms is not linked to an increase in the risk of breast cancer. Any possible increase in the risk of breast cancer with long-term hormone therapy use also seems to be moderate. A plausible 30% increase in relative risk of breast cancer translates into an increase in life-time risk of breast cancer from 10 to 13% if a woman were to take HRT until death.

These figures are referred to as reassuring even when HRT is used long-term. It is assumed that the authors are referring to "until death" as death from means other than breast cancer.

Beral, Banks, Reeves and Wallis (1997) suggest that there is a link between taking HRT and failure to detect breast cancer. This suggestion is based on their findings of an increase in the number of breast cancer cases diagnosed in the interval between mammographic screens. The increase in incidence is thought to be due to the fact that taking HRT makes the breast tissue denser, more like its premenopausal state, and consequently makes mammography more difficult to read.

Acknowledging that there are possible negative effects of oestrogen treatment, Bergkvist and Persson (1997, p. 26) consider that on balancing these negative effects with the beneficial effects on the skeleton and cardiovascular system, "the odds favour the use of HRT in postmenopausal women". However, a collaborative re-analysis of data from 51 epidemiological studies of 52,705 women with breast cancer and 108,411 women without breast cancer by the Collaborative Group on Hormonal Factors in Breast Cancer, published in the *Lancet* (1997), does suggest an increased relative risk of breast cancer. The main findings are that there is an increased risk of breast cancer in women using HRT and that this risk increases with duration of use. This risk is thought to be reduced on ceasing HRT and to disappear after about five years. Although this re-analysis includes a large number of women, only 12% of them had been exposed to progestogens. There is to date too little information on the use of progestogens with oestrogen.

Commenting on this re-analysis at the Second Australasian Menopause Society Congress held by the Australasian Menopause Society (1998), Professor Speroff, stated.

The lack of agreement, uniformity, and consistency in approximately 50 case-control and cohort studies indicate that the use of postmenopausal hormone therapy cannot be associated with a major impact on the risk of breast cancer, otherwise there would be agreement among the studies. ... In our view, it is appropriate to emphasize the benefits of postmenopausal hormone therapy, point out the continuing concern regarding the relationship between oestrogen use and breast cancer (particularly long-term use), and to emphasize the absence of definitive evidence linking such therapy to an increased risk of breast cancer (Book of Abstracts).

How are general practitioners handling the uncertainty and treating their midlife female patients? Vines (1993) notes the medical trend of some doctors handing the choice over to the woman. She considers this as throwing the HRT decision back into the market place. In this situation of medical uncertainty, how realistic is it to expect the lay woman to know what is the best for her present and long-term health? The National Advisory Committee on Core Health and Disability Support Services (1993) report on HRT, referred to in Chapter One, considers it unlikely that women

will weigh the various short and long-term effects of HRT equally.

Medicine's Problem with Women's Compliance

The fourth theme identified in the medical literature is that of women's compliance or adherence to hormone replacement regimes. Considering the uncertainties about the long-term effects of HRT, as expressed in much of the medical literature, the treatment goal of improving a woman's compliance (Coope & Marsh, 1992; O'Neill, 1995) and in particular long-term use (Baber, 1996; MacLennan, 1997) does appear contradictory.

Concern about noncompliance with medical therapy is not new. First recognized by Hippocrates in 200 BC (Roberts, 1997), it continues to vex medicine. The WHO report - *Research on the Menopause* (1996), states that the HRT continuation rate after 8-12 months is only 30-40%. Noncompliance is defined by the WHO (1996) as failing to have prescriptions filled and not continuing to take HRT after 8-12 months.

The patient-related factors most commonly identified by women for stopping HRT were bleeding problems, feeling unwell, and anxiety about unnecessary treatment or cancer (Coope & Marsh, 1992). Other factors influencing poor uptake and discontinuation of therapy, referred to by Roberts (1997), were a lack of adequate knowledge amongst women, not consulting their doctor when a problem occurs, likelihood of weight gain, expectations of HRT not met, and forgetting to renew their prescriptions. The doctor-related factor seen as contributing most to a woman's poor compliance is the variation of opinion amongst general practitioners, particularly about the long-term use of HRT (Wilkes & Meade, 1991). Other authors, such as Baber (1996), suggest that compliance is a matter of finding the ideal regime for each woman. Once that is determined, then long-term use and adherence to HRT will be achieved.

In attempting to find answers as to why there are such high rates of medical non-compliance with hormonal therapies, two research inquiries have surveyed women's knowledge of and attitudes towards hormone replacement therapy (Roberts, 1991; Sinclair, Bond & Taylor, 1993). These authors make recommendations based on their findings, that they consider will improve compliance. These recommendations

focus mainly on the need for further health education of midlife women, and for cooperation between the medical profession and the media, in order to correct any mistaken or biased information in relation to hormone replacement therapy.

Roberts (1991), in her survey of sixty-four women found that the influence of the media, as a source of information about HRT, was widespread as illustrated by 61% identifying television, magazines and newspapers as their main source of information. Also noted was the striking desire of the women surveyed for further information. Whereas Sinclair, Bond and Taylor (1993, p. 365), using a sample of 1500 women, found that despite the majority of the women agreeing with the view that "menopause is brought on by diminished hormone levels, and should be viewed as a medical condition and treated as such, and also that a woman who experiences distressing menopausal symptoms should take hormone replacement therapy", only 9% of the women in their study were currently taking HRT. The women's reasons for this disparity were that they had not considered taking HRT for themselves and had not discussed it with their doctors. Based on these findings, the authors recommend that doctors must be made aware of their role in advising women about the problems associated with the menopause and the risks and benefits of HRT.

Increasingly the medical literature, as evidenced by the above studies, is emphasising the role of the general practitioner in informing women about the menopause and its management. However, also included in most medical journals, accessed by the doctor in general practice, are advertisements from pharmaceutical companies which manufacture various hormone replacement products. A perusal of some of the advertisements reveals the use of attractive, smiling and powerful midlife women enjoying life. The underlying message is that HRT will bring this about in midlife menopausal patients.

The Marketing Image of HRT

An examination of the fine print, that sometimes accompanies these advertisements, portrays another potentially worrying side to the taking of HRT that does not fit the image of the women in the advertisements. An example is Wyeth Ayerst's advertisement for Prempak-C in the *New Zealand Patient Management* (January, 1996, p. 70-71). Under the heading "warnings and precautions", the following is an

example of what appears in the small print, which suggests that the physician should be alert to a number of potential effects of HRT. Potential effects include the development of thrombotic disorders (i.e. thrombophlebitis, cerebrovascular disorders, pulmonary embolism). Women with an intact uterus should be monitored two to three times a year for signs of endometrial hyperplasia or cancer. Certain women may develop excessive uterine bleeding. Prempack-C may cause fluid retention which might affect other conditions such as asthma, epilepsy, migraine and cardiac or renal dysfunction. There is a risk of gallbladder disease. Combination products (oestrogen and progestogen) appear to be associated with an increased incidence of depression. Women who use Prempak-C are strongly advised not to smoke due to the increased risk of serious cardiovascular side effects. Finally, according to the advertisement, there is no conclusive evidence that oestrogens increase the risk of breast cancer in postmenopausal women.

The incongruence that is apparent between the visual impact of Ayerst's advertisement and the accompanying small print is reflective of the contradictions and resulting uncertainties to be found in the medical literature. It is of little surprise that delivery of medical care to the midlife woman is anything but homogeneous.

While most medical researchers have focused on the biological aspects of menopause and concentrated on hormone replacement therapies, there are those in medicine who acknowledge that there are also psychological and social factors involved in women's lives that influence menopause (Flint & Samil, 1990). Likewise, there are those in the social and behavioural sciences who recognize the medical aspects. There is an identified need for interdisciplinary collaborative research and, as illustrated by the study of Flint and Samil, research on the cultural and subcultural meanings of the menopause. The recognition of a need for a new model in menopause research, that encompasses the biological and social sciences, was first made by Engel, a nurse, in 1977 (cited in Flint & Samil).

This examination of the medical literature in relation to the use of hormone therapy during the menopause highlights a number of problematic areas. First, medicine has focused intensely on the physiological and symptomatological aspects of menopause that has largely excluded the social context in which the menopausal woman lives.

Secondly, hormone therapies have been linked to the management of menopause to the extent that menopause and HRT have become almost synonymous in Western society. Thirdly, there has been an increased use of HRT, not only for menopausal symptom relief, but as preventive therapy for a number of female midlife health problems. It is in this area of use that medical research portrays a quagmire of conflicting findings. On the one hand, HRT use is portrayed as the gold standard of preventive therapy for osteoporosis; and on the other, it is portrayed as related to a possible increased incidence of breast cancer. While health professionals wait hopefully for the “definitive” results of the Women’s Health Initiative study, how do they weigh up the potential health gains and possible adverse effects on quality of life of midlife female patients? The fourth problem area identified is that of medicine’s reluctance to acknowledge the validity of knowledge generated by other disciplines. This blindness has led, I believe, to the medical profession’s increasing dependency on prescribed HRT to relieve not only symptoms of menopause, but to prevent certain diseases from occurring that midlife women may or may not develop.

Feminist Literature

The late 1970s and early 1980s saw a rising chorus of feminist literature challenging the negative (Millette & Hawkins, 1983) and predominantly physiological view of medicine in respect of attitudes towards women’s health. Millette and Hawkins identify the book, *Our Bodies, Ourselves*, by the Boston Women’s Health Book Collective (1979) as exemplifying “women’s desire to assert control over their own bodies and to have complete understanding of how that body functions” (1983, p. 38). Continuing this trend of empowering women, by informing them about their bodies, were such authors as Reitz (1985), who continues to write on the menopause into this decade, Fuchs (1977), and Seaman and Seaman (1978). Seaman and Seaman, two of the early writers to take a naturalistic approach to menopause, were advocates of the use of ginseng for relieving such menopausal symptoms as hot flushes.

In New Zealand, it was not until 1984 that any publication on the menopause, written for women by a woman, appeared. *Menopause* from the New Zealand Women’s Health Series was written by Raewyn Mackenzie, who through her work running

courses for women experiencing the menopause, recognized and responded to the need for informative lay literature. In 1991, Penguin first published Sandra Coney's *The Menopause Industry* and New Zealand feminist literature entered the international scene. In an in-depth examination of menopause Coney portrays the medical establishment as exploiters of healthy midlife women. This book also sets out to inform women by attempting to remove the medical view of menopause as a disease that must be treated, and explores what is known about midlife health. Coney remains a strong voice on these issues in New Zealand society.

The commencement of this decade heralded another burst of feminist literature, perhaps due to the fact that many of the earlier feminists were now experiencing their own menopause and challenging medical understandings of the menopause. Leading that challenge, of the way medicine viewed the midlife female body and the research methods they used, came Greer (1991). A basic tenet of feminism as presented by Greer was "that women must define their own experience" (p. 18). Through telling their stories women would be released from being "prisoners of stereotype". In her exploration of the literary work of women, Greer found a relative silence on the matter of menopause. Greer (1991, p. 20) suggests that if this silence is a "denial of a male construction of a female event, it is only proper; if it is denial of the event itself, it is neurotic. If HRT is the behavioural expression of that kind of denial it cannot be justified". These statements by Greer give the impression that women have stood passively by while the debate on hormone replacement therapy has taken place.

Countering this view Lock (1993) refers to the paper entitled *Taking Hormones and Women's Health* put out by the National Women's Health Network in Washington, D.C. in 1989, as evidence that women have been part of the hormone replacement therapy debate. Key points made in this paper which highlight the blind spots and assumptions of research on the menopause (cited in Lock, 1993, p. 340 - 341) are worth summarizing here. First, there has been a tendency for researchers to ignore the fact that the ovary and other sites such as the adrenal glands and fatty tissue continue to secrete hormones long after the menopause. Secondly, progestogen was combined with oestrogen to lessen the risk of uterine cancer. However, progestogens have not been in use long enough for sufficient evidence to accrue as to risks or benefits, or about its interaction with oestrogen. The fact that the female body

naturally produces very little progesterone after menopause is not understood. Thirdly, oral contraceptive pills, used in the 1970s, were found to be associated with an increased risk of cardiovascular disease. Fourthly, many women who are now taking HRT were exposed when younger to high-dose birth control pills. The effects of a lifetime of exposing the body to prescribed hormones is unknown. Fifthly, women are not well informed of the side effects they may experience when taking HRT. Consequently many women tend to start and then stop taking medication. This poor compliance with medical regimes may influence the results of epidemiological studies. Finally, it is poor public health practice to prescribe drugs of unknown safety and effectiveness (HRT) to prevent chronic disease conditions. These points remain as true as when they were first published almost one decade ago.

Authors such as McCrea (1983), although applauding the feminists in the health movement for demystifying menopause and making it a topic for discussion, accuse them of inadvertently contributing to ageism. The main focus of feminists has been on the medicalization of childbirth and menstruation, and they have “extrapolated their analysis to menopause without adequate appreciation of the problems of ageing women” (1983, p. 120). McCrea suggests that the feminists by emphasising menopause as “natural and unproblematic”, the minority of women who do need some medical attention may experience guilt for suffering where others claim no problems.

The feminist view of the medical profession as exerting a form of social control over women with dangerous drugs - hormone replacement therapies (McCrea, 1983) suggests that few feminists would take such drugs. Interestingly, Choi (1993) found in her grounded theory study that women who identified themselves as feminists were almost twice as likely to use HRT as those who did not consider themselves feminists.

Criticism of what has been coined as the medicalization of menopause is not just an issue for feminists. In fact, rivaling the feminists in their criticism of the medical view of the female body are many of those researching and writing within the psychosocial, and cultural models

Psychosocial, Cultural and Anthropological Literature

Since the early 1970s, social and behavioural scientists have studied the menopause cross-culturally (Flint & Samil, 1990). In 1987 Bell stated that “the complicated roots and paradoxical consequences of defining human experiences as medical problems and giving medical personnel the task of treating them” (p. 535), have been the focus of numerous sociologists. While such authors as Bell have sought to explore the intellectual roots of the medicalization of menopause, others have examined the politics of menopause (McCrea, 1983; Lock, 1993; Klein & Dumble, 1994). The often contradictory position taken by medicine, of acknowledging menopause as a natural phenomenon, and then defining it in biological terms as a deficiency disease to be chemically managed, has not been overlooked by these authors.

Ripper (1994) claims that the emergence of a hormonal model of women’s reproductive system represents a paradigm shift within Western medical knowledge, from an organistic model (one focused on organs) towards a bio-chemical model of women’s (but not men’s) reproductive system. A woman’s reproductive organs have long been said to cause and explain her limited status and capacity. The shift to a bio-chemical model of women’s reproductive system, has substantiated that belief whilst locating the disabling factor in hormones rather than organs.

Although much of the psychosocial research invalidates many of the negative stereotypes, menopause is still a commonly used explanation for many psychosomatic complaints, in both the lay and medical literature (Defey, Storch, Cardozo, Diaz & Fernandez, 1996, p. 1455). Citing Voda (1992), these authors agree that for many women their “biology has become their destiny”. However, Collins (1997, p. 97) in a longitudinal study conducted in Stockholm, found that “hormonal factors play a relatively minor role in menopausal symptomatology, and the psychosocial factors, lifestyle as well as attitude to menopause and work roles, are far more important for women’s health”. In particular, attitudes to ageing were found to influence symptom reporting. Where age was perceived as positive, there was less frequent reporting of menopausal symptoms. Based on these findings Collins suggests that as far as women are concerned, attitudes to ageing need to change.

However, there are those scientists, both from medical and social disciplines, who have recognized the restrictions of viewing menopause from one discipline only, and have sought to encompass the views of other disciplines. Flint and Samil (1990), physical anthropologist and medical researcher respectively, propose a biopsychocultural approach to the study of the menopause, demonstrating the usefulness of this approach by conducting a joint research project of the cultural and subcultural meanings of the menopause. Respondents in their study were Central Javanese and Minangkabau women (from the western coastal area of Sumatra), with a mix from urban and rural areas. One of the lessons noted by the researchers was that their concern about the negative symptoms attached to menopause resulted in not enough attention being paid to the positive feelings experienced by these women. Flint and Samil (1990, p. 145) conclude that in order to understand why Central Javanese and Minangkabau women report so few "oestrogen-dependent symptoms, we need to understand what menopause means to these women".

The observation that midlife women from diverse cultures experience menopause differently is of great interest to social scientists. In a search as to why this is so, differences in diet have been identified as possible reasons (Wilcox, 1997). A recent advertising campaign by Blackmores on TVNZ (September/October, 1998) points out that Japanese midlife women have less symptomatology than their Western counterparts. The reason suggested is that the Japanese woman's diet is rich in soy protein; therefore, if Western women take their product (which is rich in soy protein), they too would have less problems with menopause. This is contrary to the findings of Rosenberger (1986), who, in a survey of a provincial city, found that Japanese women do experience problems with menopause, but they tend to put up with any discomfort. Rosenberger suggests that this is due to how Japanese doctors manage the midlife woman. The following illustrates this:

The argument goes that the woman dwells on her loneliness and worries about her children, and husband who is often absent until late evening. The result may be a myriad of nonspecific complaints. From ages 35 to 60 years, these complaints are labeled as symptoms of menopause or the "sickness of luxury" (Rosenberger, 1986, p. 19-20).

No wonder as one informant in Rosenberger's study stated "I just put up with the discomfort" (p. 23).

In New Zealand Maori culture, a woman's status increases with age. This recognition is reflected in the roles that are given to women who are postmenopausal.

Madden (1997, p. 28) states that:

the role of welcoming the visitors and inviting the presence of the wairua (spirit) is therefore very much a spiritual concern. The women who are chosen to perform the karanga (call or summons) are generally postmenopausal. This means that they do not carry the additional 'dangerous powers' attached to the tapu (sacred) time of menstruation, which might act to dissipate the spirituality of this time on the marae (meeting place).

A number of conflicting explanations are offered as to why the postmenopausal woman is called to this role. One suggested in Madden (1997, p. 28) is that to ensure respect of the 'wairua' of the 'karanga', "women must be in harmony within themselves and with the environment, and at menstruation time, the physical self requires extra nurturing to achieve that balance or harmony". The 'karanga' is a very specialised responsibility, that must be undertaken by a woman who is not distracted by menstrual discomfort or tiredness. Within this culture, there is a physical, mental, emotional and spiritual 'place' for the postmenopausal woman to live that acknowledges her wisdom and knowledge. Whether this increase in a Maori woman's status can be related to an increase or decrease in menopausal symptoms is not known. However, interest in how women of different cultures experience menopause is growing as evidenced by the title of the 3rd Australasian Menopause Society Congress to be held in June 1999 - "Menopause in Different Cultures".

The topic of menopause, as portrayed in the literature, is riddled with complexities and contradictions. Yet the views of menopause examined so far make no attempt to ask the question, 'why did the menopause develop in human females?' Apart from one species of toothed whales (*Globicephala macrorhynchus*), human females are unique in experiencing a total cessation of reproductive capacity well before the end of their average life expectancy (Peccei, 1995). So for what purpose did this cessation of menses evolve?

The why, how and when of menopause development is one of the more challenging issues facing anthropologists and evolutionary biologists today. In a hypothesis about the origin and evolution of menopause, Peccei (1995, p. 83) presents the results of a mathematical model which suggests that “reproductive senescence can be advantageous, even when maximum potential lifespan is only 50 years, if the premature cessation of reproduction allows females to moderately increase the survival and fertility of their existing subadult offspring”. It is further suggested that if the increasing dependence of offspring was due to “encephalization and altriciality” menopause played a major part in the development of human intelligence. The Oxford Dictionary (1993) defines encephalization as “an evolutionary increase in the complexity or relative size of the brain” (p. 813), and altriciality as “helplessness at birth” (p. 61). Thus when the female was freed from reproducing, through the cessation of menses, she was more able to respond to the dependency of her offspring and, through complex biological and social interactions over time, this brought about an evolutionary change in the brain. Although this model lacks tangible evidence as to the trait of menopause in early *Homosapiens*, it raises questions that challenge the view of menopause as an oestrogen deficient disease. It also challenges us to consider the possible consequences of masking an evolutionary change by altering female hormone levels through the use of long-term hormone replacement therapy.

Few writers refer to the menopause as having any positive outcomes. The research on women’s attitudes towards menopause has tended to emphasise the negative aspects with little attention given to any positive outcomes. One of the earliest exceptions is Margaret Mead, referred to in Borysenko (1996), who talked about the midlife years as a time when women came into “postmenopausal zest”. In more recent times menopause has been positively portrayed by Reitz (1985), as a time of “transformation” by McCain (1991), as a “passage to power” by Kenton (1995) and as a “biopsychosocial and spiritual” event by Northrup (1995) and Borysenko (1996).

Developmental and Transformational Literature

In an attempt to assist women to define and share their own experiences of menopause, to accept ageing and the wisdom of their lives, Taylor and Sumrall

(1991) wrote the *Women of the 14th Moon*. This rich anthology of essays, poems and fantasies on the meaning of menopause embraces the physical, emotional, spiritual and communal elements experienced by the contributors. Mankowitz, a contributor to this anthology captures the metaphysical approach presented in the following comment.

Each woman's experience of the menopause will be different, but if we can assimilate the shadows of the past and accept the realities of ageing, it may be found that the menopause, though a difficult and demanding passage of adulthood, can also be a time of psychological integration and growth, increased strength and specifically *feminine* wisdom (Mankowitz, 1991, p. 23).

Taking the concept of wisdom as an evolving characteristic of menopause such authors as Northrup (1995) and Borysenko (1996) have presented an hypothesis for the development of feminine wisdom in the midlife woman.

Isselbacher, Brahnwald, Wilson, Martin, Fauci and Kasper (1994) state that "after the menopause, plasma gonadotropins, leutinizing hormone (LH) and follicle stimulating hormone (FSH) levels rise, plateau 5 to 10 years later, and remain fairly constant until the eighth to ninth decade of life when the levels may fall" (p. 2017). These changes are poorly understood. However, Northrup (1995) has presented the theory that these elevated levels of LH and FSH have a purpose that is different from their premenopausal function.

According to Northrup, during the years of ovulation (premenopause), LH and FSH are high only near ovulation. Postmenopausally they are elevated all the time, and there is some preliminary evidence to suggest that LH and FSH may act as neurotransmitters. Northrup hypothesizes that these neuropeptides may eventually turn out to be the "hormones of wisdom". Considering that a number of cultures, Native American, African, Aboriginal, European and Icelandic (Borysenko, 1996), and New Zealand Maori (Madden, 1997), value their postmenopausal women for their intuitive wisdom, these biological changes may underline the development of these abilities, where there is a social outlet for their expression. This is an hypothesis that warrants further research, particularly in the area of cross cultural differences in the biological and social changes that occur during the menopause.

Perhaps as Borysenko (1996, p. 151) states, “modern society has lost an appreciation of the special value of postmenopausal women, whose clarity, vision, and fierceness are potentially great gifts to society.”

This brief examination of the literature, representational of the main theoretical approaches applied in studying the menopause, illustrates the methodological difficulties referred to earlier by Utian (1997), that have plagued menopause research. The way in which the menopause is viewed influences how it is attended to, from a biological event that is to be controlled by hormone therapies, to a natural and social transition, or to something greater, depending on the woman’s culture. The major hormonal changes of a woman’s body continue as Lumby (1997, p. 124) states “to inform a large part of the research and practice of medicine”. The emphasis given to the medical view of menopause and HRT in this review reflects the dominance and the volume of research in this area.

Although many women have been exposed to some of the literature discussed, particularly from the feminist, social and transformational perspectives, the mass media remains one of the main sources of information on the menopause and HRT.

The Lay Press

Studies exploring women’s views of menopause and HRT confirm that the media is an important source of information (Roberts, 1991), if not greater than that of the medical profession, as found in the four country study of Oddens, Boulet, Lehert & Visser (1992). Television, magazines or newspapers were identified as the main sources from which women obtained information about hormone replacement therapy.

Often the press are accused of misrepresenting medical information and presenting an unbalanced view, particularly in relation to HRT use and an increase in cancer risk. Such headings as *Hormone Heresy*, *Oestrogen’s Deadly Truth (Part 2)* by Sellman (1996), also available through the Internet, suggests that the introduced synthetic hormones of HRT, as well as environmental pollutants, are presently

wreaking havoc with a woman's hormones. *HRT on Trial* by Ballantyne (1997) which appeared in *The Times Magazine* on November 29th, 1997, states that while HRT offers a new lease of life for many menopausal women, for others it has been the cause of death. This is illustrated by the picture of a British death certificate for an Irene Brankin identifying pulmonary embolism (operation) and hormone replacement therapy as the cause of accidental death. Other articles such as *The Oestrogen Dilemma* by Wallis (1995), and *The Big Change* by Sarney (1996) attempt a balanced and more in-depth look at the controversy around HRT.

The press has portrayed HRT use, in midlife women, as being many things from the "elixir of womanhood" to the cause of breast cancer. Although their aim is to sell newspapers and magazines, often by being controversial, in many ways the press mirrors the conflict and uncertainty that is to be found in the medical literature.

However, no examination of the lay literature would be complete without referring to the growing interest and use of natural progesterone, by midlife women, as an alternative to HRT. John Lee's (1996) book *What Your Doctor May Not Tell You About Menopause* has caught the attention of many midlife women, as evidenced by the increase in prescriptions from zero to forty per month, in one small suburban pharmacy alone (personal communication with Balmoral Pharmacy, Napier). Lee's stated aim is to empower women to question their doctors intelligently, suggesting that if they read his book they are likely to be better informed on the subject of progesterone than their doctors are. His references to doctors confusing progesterone with synthetic progestins are not reassuring.

A strong advocate of Lee is Kenton (1995) who refers to his work with natural progesterone extensively throughout her book *Passage to Power*. Thus women reading Lee and Kenton, and others such as Taylor and Sumrall (1991), Andrews (1993), and Borysenko (1996), usually to be found in Women's Book Shops, are introduced to views of menopause and ways of managing it that conflict with those of medicine. In many ways the decision making dilemmas that face the midlife women have not been fully explored. The role of the lay press in influencing each woman's decision on how to manage their own menopause cannot be underestimated.

Nursing's Contribution to the Literature

Munhall (1994) draws attention to the fact that in spite of the extensive research undertaken by nurse researchers, to gain understanding about the menopause, they were not consulted by Gail Sheehy (1994) in her best seller, *The Silent Passage*. Munhall suggests that it is because nurse researchers have been so rigidly bound by methods that they have been unable to find a place in mainstream literature. This is supported by the fact that all publications by nurses, located for this review, were found in either professional nursing journals or unpublished academic studies held in universities. So what have nurses contributed to our understanding of the menopause and taking of hormone replacement therapy?

The literature confirms that nurses have been researching and writing about the menopause over the last two decades, but their voices have not been widely heard. Nurses have critiqued many aspects from the political (McCrea, 1983) to the social construction of menopause as a deficiency disease (Barbre, 1993). They have written about the menopause from the medical (McKeon, 1994), feminist (Dickson, 1990) and social (MacPherson, 1981) perspectives. Nurses such as Logothetis (1991) and Choi (1993) have explored women's decisions about taking hormone therapy, while others have written guides on HRT use for other nurses (Moore & Noonan, 1996) and published jointly with medical practitioners (Smith & Hughes, 1998).

Li, Carlson, Snyder and Holm (1995), have written with the aim of raising nurses' consciousness of the philosophical assumptions that underpin much of the research carried out in this area, and how a particular view shapes not only research questions, but methodology and interpretation of findings. Other authors (Scharbo-DeHaan & Brucker, 1991, p. 15) present menopause as "both a challenge and opportunity for certified nurse-midwives" to deliver care to women during this transition. Scharbo-DeHaan and Brucker base this position on the premise that the nurse-midwife is familiar with the "normal variations associated with decreasing oestradiol levels". This raises two interesting issues; first, the view of menopause as an opportunity for expanding the midwifery role, and secondly, basing that claim on a physiological rationale, that of women's changing hormone levels.

However, few nurses have researched within the qualitative paradigm. Only three studies were located and these were by Choi (1993), Brown (1994) and Dickson (1994). The research of Brown and Dickson, designed to give a voice to women's experiences of menopause, used phenomenology as their research methodology. Both studies identify a number of themes that capture the deep personal nature of the experience of menopause. Brown describes the themes of power, in terms of relationships - personal and in the workplace; of living in an unpredictable body and of being in and out of control. Dickson brings insight to the experience of hot flushes, ageing, overcoming the silence of menopause, and touches on women deciding whether to take HRT. Apparent in Dickson's study is that the women wanted someone to listen seriously to them. The message from both authors is that the meaning of the experience of menopause, for each individual woman, is what nurses need to help women understand.

Choi (1993), in a grounded theory study, found that women felt unprepared for the menopausal transition, that preparation for this change was problematic because of its association with ageing and the unpredictable experience of menopause. Women who chose to use HRT often did so in response to uncomfortable menopausal symptoms. Those women who took HRT as preventive therapy, experienced much conflict and uncertainty. Choi also found that most of the women made a definitive decision about HRT by the time they were postmenopausal.

In summarizing the many views expressed in the nursing literature, it is apparent that nurses agree that their role is to educate and to support the woman through the menopause transition. In order to do this, nurses, as health educators, must be informed about the current research so that they can give correct and unbiased information (Kelly, 1993).

Considering the breadth and depth of the nursing literature, although small in comparison to that of medicine, why has nursing's contributions to menopause discourses been so invisible? Is the answer to be found in what Munhall (1994) refers to as our preoccupation with methodological issues and a reluctance to enter mainstream literature, particularly the lay press, or is it because nurses have often been the silent partners in the delivery of care to midlife women? A visit to a local

health centre, to access the material given to menopausal women by practice nurses, suggests that there is some truth in the latter. All the material, both written and audiovisual, used by the nurses to inform their midlife female patients about the menopause and HRT use, was produced by the drug companies. Evidence from nursing research was not utilized. It is therefore essential that if the knowledge generated by nursing research is to contribute to evidence-based nursing practice and is to be heard in the public arena, nurse researchers must disseminate and facilitate the utilization of nursing research on the menopause and HRT.

This concludes the review of the literature that reflects the paradigms that underpin our knowledge of the menopause and taking of hormone replacement therapy. The rationale for literature selection was guided by these paradigms.

Summary and Implications For This Study

The implications of the methodological issues raised here reveal how our understanding of menopause has been compartmentalized into disciplinary areas. The philosophical underpinnings of each discipline direct the research questions asked, the methods applied, and the interpretation of the findings. This has also resulted in conflicting definitions of the menopause from an “oestrogen deficient” disease, to a “natural” change. How each discipline has defined the menopause has given direction to how the menopause is to be handled, from prescribed hormone therapy, to a transition to be worked through on a social and emotional level. The major voices in the menopause/HRT discourse, particularly those of medicine and the feminist health activists, have tended to present themselves as representing the interests of women.

The literature reviewed reinforces the current perceptions of menopause which are dominated by the medical view. Medicine’s tendency to find more and more uses for hormone therapy has resulted in HRT not only being used to allay troublesome menopausal symptoms, but as preventive therapy for osteoporosis, cardiovascular diseases and, recently, Alzheimers. The expansion of HRT use has been expertly marketed and financially supported by manufacturing pharmaceutical companies.

The debate that surrounds the long-term use of prescribed hormone therapy continues. In the meantime, some medical practitioners encourage the use of hormone therapies, both short and long-term, while others wait for the results of the Women's Health Initiative study. Increasingly the individual woman is being encouraged to make the decision that is right for her, whether to take HRT or not. The fact that the quantitative data now available in relation to HRT use and any increased/decreased risk of cancer lacks uniformity and consistency makes this a problematic area for both the midlife woman and her medical practitioner.

Menopause as a developmental and/or transformational event is not a widely held view, because of the negative image of ageing in Western society. Little research has sought to find out why menopause evolved in human females, and whether the function of progesterone, LH and FSH are different after menopause. The linking of these biological changes to social roles offers a fruitful area for further research, as would inquiry into why women from different cultures experience menopause differently.

This review suggests that much is known about parts of the menopause but somewhere along the line the whole picture of menopause, as a lived experience, has been lost. In an attempt to bring understanding and insight into this experience only a few nurses, through the use of qualitative methodologies, have sought to explore menopause as a body experience. However, in spite of the research, both quantitative and qualitative, conducted by nurses on the menopause, their voices in the medical and public arena remain a whisper.

In a search of the literature no qualitative studies, examining the experience of taking HRT during the menopause, were located despite the increasing dominance of HRT in menopause research. In Western society the words menopause and HRT have become almost synonymous. The silence in the literature on the experience of taking HRT during the menopause identifies a need for further research, supporting the aim of the present study, to explore the experience of women taking HRT during the menopause within a qualitative paradigm.

CHAPTER THREE

RESEARCH METHODOLOGY AND DESIGN

Every methodology has certain advantages and disadvantages, strengths and weaknesses, as well as the potential for certain kinds of bias. Each yields certain kinds of information but does not yield other kinds. Just as the kind of fish one catches depends on the net that is used, and the net that is employed is designed to catch the fish one values, so the kind of data one collects depends on one's methodology, and the methodology is selected to gather the kind of data one values. (Rohner, 1977, p. 126).

In the previous chapter I reviewed the academic and lay work of others relating to the menopause and taking of hormone replacement therapy. From this overview, it is clear that most of the research in this area has been carried out within the empirico-analytic paradigm. Consequently more is known about the physiological mechanisms of the menopause and taking of HRT. However, how women interpret the experience of taking HRT during the menopause has been afforded little space in the research literature.

The main purpose of this chapter is to describe and discuss the rationale for selection of the research methodology and design of this study. The chapter is divided into two parts. The first presents the case for hermeneutic phenomenology in this study of midlife women taking HRT during the menopause, and its implications for nursing. Part two describes the design, data collection, data analysis and structure for presentation of the research findings. Considerations relating to the research participants, ethical issues, background details and the context in which the data were collected are included. Also described in this chapter are my assumptions and their relationship to the study focus and processes.

PART ONE

The Case For Hermeneutic Phenomenology In Studying The Experience Of Midlife Women Taking Hormone Replacement Therapy During The Menopause

The premise of this discussion is that hermeneutic phenomenology is an appropriate and timely approach to the study of midlife women taking hormone replacement therapy, during the life experience of the menopause. The human science of hermeneutic phenomenology studies persons (van Manen, 1990) and flows out of the Heideggerian view of the person (Leonard, 1989). The term hermeneutic phenomenology consists of two methodologies, hermeneutics (interpretive methodology) and phenomenology (descriptive methodology) thus implying a contradiction. Van Manen states that this contradiction can be resolved “if one acknowledges that the (phenomenological) ‘facts’ of lived experience are always already meaningfully (hermeneutically) experienced. Moreover, even the ‘facts’ of lived experience need to be captured in language (the human science text) and this is inevitably an interpretive process” (1990, p. 180-181).

Before embarking on this study, the phenomenological question ‘what does it mean to be a person?’ demanded to be answered. I will explore this question by briefly discussing the concepts of the Heideggerian phenomenologic view of the person, particularly in relation to women experiencing menopause and taking HRT. Also included in this section are my assumptions and views of what it means to be a human being. Van Manen (1990), with reference to the researcher, states that to “make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories” (p. 47) is more appropriate than to suspend everything that we know about the phenomenon. The explication of my beliefs also serves to make clear to those reading this study the influence of my understandings.

Benner and Wrubel (1989, p. 41-50) provide a concise, and for this study, relevant summary of Heidegger’s phenomenological view of the person as a self-interpreting being. They identify four aspects of our humanness: embodied intelligence, background meaning, concern, and the situation.

The Phenomenological View of the Person: The Self-interpreting Being

Embodied intelligence

The first aspect of the person identified by Benner and Wrubel (1989) is embodied intelligence. It is embodiment which enables us to live in the world and understand it in relation to ourselves. This also means that not only are we “beings with a mind-body unity but also that we have the capacity to be in a situation in meaningful ways” (p. 43). Through our capacity to recognize our world and live in it, we learn culturally appropriate ways of being in our world - thus acquiring a body that knows how to conduct itself - a habitual cultural body. As Benner and Wrubel (1989, p. 44) state, “developmentally, we begin with the body’s innate capacity to be in the world and go on to the ways that the body learns cultural meanings, the use of tools, and skilled behaviour”. For example, the issues of menstrual blood in most cultures are rich with meaning which is reflected in culturally determined behaviours of women. In the Western world, Laws (1990, p. 49) in her study found that in the public setting, “it would be highly discrediting in most situations for a woman to refer to her own menopausal symptoms”

Over time the meanings and skills acquired that are part of our habitual cultural body become so taken-for-granted that most become invisible (Benner & Wrubel). However, as both Dreyfus (1991) and Leonard (1989) remind us, it is only through body “disturbance” or “breakdown” that we develop insight into the taken-for-granted understanding of ourselves. For example, when the midlife woman experiences a change in the rhythms and behaviour of her body manifested in hot flushes and the cessation of menstruation, her body loses its essential embodied, taken-for-granted quality. The meanings the person may give to experiences are described under the headings of Background Meaning and Concern.

Background meaning

Background meaning is given to a person at birth by their culture and determines what is important for that person (Benner & Wrubel, 1989). To illustrate this, these authors

give the example of personal control as a cultural background meaning. They suggest that the background meaning of personal control “is tied to what it means to be a person in our culture” (Benner & Wrubel, 1989, p. 47). In relation to the midlife Western woman experiencing the menopause, not only are culturally determined meanings of ageing closely linked with menopause, but there may be an associated sense of losing control over one’s body.

Concern

The third assumption of the phenomenological view of the person is concern. While embodied understanding and background meaning describe how the person can be in the world and grasp meaning, concern accounts for why they do things (Benner & Wrubel, 1989, p. 42). This “third aspect of our humanness is that things matter to us. We have the capacity to care, and our caring causes us to be involved in and defined by our concerns”. Thus the world is understood in the light of our concerns. An example which has implications for medical professionals and drug companies is the compliance of women taking hormone replacement therapy. Traditionally, why people do things has been answered by mechanistic theories of motivation (Benner & Wrubel). The reoccurring theme of how to improve women’s compliance in taking HRT during this decade (Coope & Marsh, 1992; Berman, Epstein & Lydick, 1996 and MacLennan, 1996) suggests that these theories do not address the qualitative concerns of the women. Concern, as a dimension of the phenomenological view of the person, offers new insights into understanding why people do things.

Some of our concerns cannot be directly expressed, but they are revealed in our actions and responses in particular situations (Chesla, 1995). Thus exploring the narratives of women taking HRT during the menopause enables interpretation of what is salient to this experience.

The situation

We inhabit our worlds in an involved way, becoming constituted and solicited by our worlds, a point that is often missed (Benner & Wrubel, 1989). Chesla (1995, p. 66) states that:

Humans become situated within their worlds by being raised up and living within a complex of understandings about the world and ways of being and acting in the world that are available in that particular time in history, in the culture, and in the family in which we find ourselves.

We live in a real world; however, over time, real-world contexts change and the old understandings of self are no longer relevant. Although we may attempt to prepare ourselves for future change, we can never fully grasp what is to come. According to Benner and Wrubel (1989, p. 49-50).

No amount of mental rehearsal can prepare one fully for such changes, because we cannot reflectively encounter all the taken-for-granted aspects of our being. It is only in the changed context that the hitherto unnoticed background meanings, habitual body understanding, and concern are seen to no longer allow for smooth functioning.

For example, the midlife woman knows that the menopause will come, but no amount of thinking about it can prepare her for the experience of the body changes. The experience of menopause involves the whole woman, and can result in the loss of many taken-for-granted aspects of her being. In elucidating this lived experience, it is appropriate that a research method grounded in the taken-for-granted nature of everyday experience be applied.

Implications for the Researcher

In the phenomenological view, all persons are embodied, “thus our practices are based on shared, embodied, perceptual capacities” (Leonard, 1989, p. 48). This view has implications for every part of this study, from the development of the research question, to the interpretation and presentation of the findings. In this section I discuss the implications of the phenomenological view of the person for myself as researcher.

The inclusion of my relationship as researcher to the phenomenon and the research participants does not comply with the usual customs of scientific reporting. However, entering into the world of another, through the process of phenomenological inquiry,

required that I did not conceal myself behind the anonymous term 'researcher'. To have done so would have been to deny the very qualities that made my entrance into the world of the research participants possible - our commonality as self-interpreting embodied beings who are midlife women.

Another important point is that scientific reports on matters relating to the body can create distance. Lawler (1997, p. 39) states that "third person passive prose creates distance, removes reference to the personal and subjective, and disallows the articulation of matters at the core of nursing practice". Therefore, to establish a perspective as a phenomenological researcher in this present study, I need to articulate what may appear to be superfluous, that I also have innate capacities that enable me to experience an embodied self, to live-in and be-in a world that has meaning. I expected my cultural habitual body, in a taken-for-granted way, to conduct itself appropriately when entering the homes of the research participants. However, as I became a researcher there were new ways of being-in-the-world to be acquired. Consequently some of my understandings of myself as embodied did not work for me. There were new skills to be learned: the handling of a tape-recorder, while establishing rapport and trust; learning to develop an in-depth interview that asked the questions that reaped data rich in the phenomenon being studied; and learning to interpret the data and write the findings in a meaningful way.

It has become apparent to me that my concerns as a midlife woman and a nurse led me to study the experience of taking HRT during the menopause. This awareness did not come until I started listening to the women's stories, and experienced, as Martin (1989) in her study of menopause did, the shoe-horning of the research participants' stories into parts of mine. Chesla (1995) suggests that to have experience in the phenomenon under study may be a help rather than a hindrance. Such understanding is seen as aiding the researcher to formulate questions in ways that bring out the significant aspects of the experience, and to present a truly empathic, shared account of what the informants tell the researcher.

When we choose a topic that interests us, it often relates in some way to our own life (Rountree & Laing, 1996, p. 13). I found this to be both a strength and a weakness. It

was a strength in that I was viewed by the research participants as being like them - a midlife woman. And it was a weakness in that our commonality had the potential to bias my interpretations of the data. However, once I committed myself to this topic I started to analyze my own attitudes towards menopause, and as a product of my generation faced up to the fact that menopause is inextricably interwoven with the process of ageing, and thus subject to stereotyping (Greer, 1991). This process developed into a reflective journey which peeled away layers of embarrassed silence within myself. I prepared myself for becoming a researcher in this hermeneutic phenomenological study by exploring my pre-understandings, beliefs, biases and assumptions. This involved reading, reflecting, listening and talking with other women.

Chesla (1995) states that "because we are always living in the world of meaning that we are trying to understand, there can be no absolute external standard by which we, or others, can judge the truth of our interpretations" (p. 68). Because of this world of meaning, Chesla suggests that "we can never leap outside of our everyday reality to understand either ourselves or others" (p.68). Consequently, hermeneutics challenged my preunderstandings not only of the research participants, but of myself. This process involved self-reflection, confirming meanings with research participants and working with a research supervisor, which enabled me to identify when preunderstandings facilitated interpretations and when they set up blind spots and partialities (Chesla).

As the researcher, I brought preunderstandings to this study, many of which were formed by my situatedness in the world of nursing. Although I was aware of the impact of the medical paradigm on this world, I believe, as Leonard (1989, p. 48) states, "it is nursing, more than medicine, that seeks to help the patient reclaim the sense of embodiment that allows for their taken-for-granted, unselfconscious transactions in the world". The degree to which the empirico-analytic paradigm in science had shaped many of my own understandings of menopause only became apparent to me when I reflected upon, not only the women's stories, but my own.

When a human experience involves a female body change in Western society, and is discussed predominantly in scientific and medical terms, nurses need to examine the foundations of that view in shaping nursing knowledge and practice. Research questions and methodologies that will provide a means of gaining new insights and understanding are required. Phenomenological inquiry offers us new insights into this human experience.

Nursing and Phenomenology

Annells (1996) points out that phenomenology forms the philosophical foundations of such nurse theorists as Paterson and Zderad, Parse, and Rogers. Also the work of Benner (1984); Oiler, (1986); Madjar (1991) and Beck (1992) has demonstrated the appropriateness of phenomenology as a research methodology for exploring many of the questions nurses ask. This is because nurses seek to understand people in health and illness situations. Congruent with this is the “simple phenomenological precept to always try to understand someone from his or her situation, from the way he or she experiences the situation” (Van Manen, 1998, p. 8).

This view has influenced not only the practice of many nurses, but increasingly other health professionals are recognizing the need to have understanding and be involved in the deeply personal and unique manner in which people experience and live with their problems (van Manen). Van Manen (1998, p. 7) highlights the argument that it is nursing that is especially involved in “helping the patient, the elderly, the disabled, or the person who for reasons of circumstance is out of step with the body to recover a livable relation with his or her psycho-physical being”. Understanding of this process comes through the application of phenomenological inquiry, thus supporting the view that it has much to offer nursing as a humanistic discipline (Jasper, 1994).

Contentious issues

It is beyond the scope of this thesis to fully explore issues raised by Crotty (1996) concerning how nurse researchers are interpreting Heideggerian phenomenology and criticisms by Holmes (1996), questioning its appropriateness as a research method for

nursing. However, as these two publications appeared in the nursing literature while this present study was in progress, it is appropriate that any implications be commented on

The first issue relates to Crotty's position that a new approach calling itself phenomenology is emerging in nursing. Central to Crotty's criticism of the nurse phenomenologists is that they appear to be confused about the nature and relationship of experience and phenomenon, as evidenced by these terms being used interchangeably. According to Crotty (1996, p. 3), the aim of mainstream phenomenology is to "illuminate, precisely as human phenomena, the feelings that people experience" and to "elucidate, first and foremost, the phenomena to which people are attaching meaning". Van Manen (1990, p. 184) defines phenomenology as the science of phenomenon, in that it makes a distinction between the appearance and essence of the phenomenon. This means that phenomenology always asks the question, what is the nature or meaning of something? In this study I have aimed to elucidate the phenomenon of menopause, seeking the nature or meaning of menopause and the taking of HRT, as interpreted by the research participants.

Also part of Crotty's criticism is the way in which nurse phenomenologists tend "to focus on the subjective, rather than on the objectivity to be found in the subjective" (1996, p. 55). However, Dreyfus in his commentary on Heidegger's *Being and Time*, states

there are no interpretation-free facts for the phenomenologist to describe, neither objective facts nor subjective ones like a system of beliefs, so the phenomenologist must interpret and organize the phenomena to reveal the understanding of being in which he already dwells, which lets anything show up as anything" (1991, p. 31).

My experience in undertaking this study supports Dreyfus' position. I am also reminded by Phillips (1993, p. 166) that "nurse researchers must realize that the mystery of a lived experience is continuously revealed in innovative ways, and, though previously unknown to the researcher or research participant, may become manifest during the mutual process of the research".

Phillips' comment is not a license to wander up the garden path methodologically speaking, but challenges nurse researchers to be open to how human lives are revealed. It would be a tragedy if we became bogged down in methodological correctness of a time past, at the expense of bringing illumination on aspects of human experience in sickness and health.

Dreyfus states that when phenomenology is correctly understood it "turns out to be hermeneutic, that is, interpretative" (1991, p. 32). He further comments that because human beings are self-interpreting, this shows that "interpretation is the proper method for studying human beings" (p. 34). However, self-interpreting is not simply idiosyncratic, but we individually interpret according to our social reality of concerns, gender and culture for example.

There are many interpretations of phenomenology; Heidegger himself formed a break away group based on different understandings. As important as these discussions are, in the development of phenomenology as a research method, they can divert us from being able to recognize good phenomenological description that informs nursing practice.

The second contentious issue questions the appropriateness of phenomenology as a research method used by nurses. Holmes (1996) suggests that Heideggerian phenomenology is at odds with the values of nursing, because of Heidegger's membership to the Nazi Party. Therefore, because of this association, Holmes (1996, p. 479) states that phenomenology is "not only unsuitable as a means of understanding and elaborating nursing knowledge, but also actively counter-productive to the conventional aspirations of nurses". Outside of nursing, debate relating to Heidegger's political association is not new, as evidenced by the work of Steiner (1978), Bourdieu (1991) and Babich (1992). To situate Heidegger purely in the political arena is wrong (Bourdieu). Perhaps we are at this time in history too near and too far: too near in that the consequences of Nazism continue to affect our consciousness, and too far, in that it seems remote or has been suppressed in some from remembrance (Steiner).

Heideggerian phenomenology offers both a philosophy and research methodology that value human experience. Through the use of phenomenology, nurse researchers have revealed new insights, as evidenced by the work of Benner (1984); Oiler, (1986); Madjar (1991) and Beck (1992) that has enriched nursing practice. I know that my reading of the work of nurse researchers who have used Heideggerian phenomenology has informed not only my practice, but enabled me to see more clearly into some of the unlit places of human experience.

A number of other issues are raised by Crotty and Holmes which this brief discussion does not fully address. However, my aim was to acknowledge their criticisms and comment on any implications for this present study. I believe that the clear articulation of the philosophical underpinnings discussed earlier in this chapter and the upholding of the primacy of the data, together wove the methodological fishing net that directed every aspect of this study. Throughout the data collection, data analysis and writing, I was guided by van Manen's (1990, p. 177) question "what makes this thing what it is (and without which it would not be what it is)?" What makes the experience of taking HRT during the menopause what it is and without which it would not be what it is?

Over the last two decades a number of nurse scholars (Paterson & Zderad, 1976; Donaldson & Crowley, 1978; Watson, 1985; Benner & Wrubel, 1989) have highlighted the limitations of the empirico-analytic paradigm in serving nursing. Unfortunately this has led to what Darbyshire (1997, p. 138), in conversation with Sandelowski, refers to as "an imaginary polarity with the positivists as the bad guys, and the qualitative people as inherently good". Consequently many qualitative researchers start by defending their method. Sandelowski, continuing the conversation, suggests that it is not qualitative research that needs defending, but why we have chosen a particular design to answer the question asked.

In relation to the present study, the silence in the research on the experience of taking hormone replacement therapy during the menopause, and the apparent dilemma that many midlife Western women are experiencing, indicates the need for phenomenological research. The question *what is the experience of women taking*

hormone replacement therapy during the menopause, is a phenomenological question, and thus requires the use of this methodology to answer it.

This concludes the discussion of the philosophical underpinnings of this study and the development of the case for hermeneutic phenomenology in studying the experience of women taking hormone replacement therapy during the menopause. I have endeavoured to present my rationale for selecting this research approach, seeking to elucidate the phenomenon of menopause as experienced by women taking HRT. Part Two will describe how this study was carried out.

PART TWO

The Research Process

Orienting to the Phenomenon

When planning a phenomenological study, the question ‘how to carry it out?’ is not the first question asked. Rather, ‘why am I involved with this phenomenon?’ comes first (Colaizzi in Drew, 1989). The idea of researching menopause and HRT was first put to me by Dr Valerie Fleming. She knew I was looking for a research topic for a Master’s Thesis. Initially I rejected the idea because the idea embarrassed me, but there was also something that aroused my curiosity. This led to reading around the topic and listening to what was being said and, more importantly, not being said. I tentatively put the idea of conducting a study about the experience of taking hormone replacement therapy to friends and colleagues. Each time the response was a resounding “It is about time someone told our story”. Although they described their symptoms, it was the underlying apprehension about losing control over their bodies and their lives that permeated their comments. Here lay my directions for how to carry out this study. Consequently, both the research question and the methodology arose from and were guided by women living through the experience, and by the lack of qualitative research studying women taking HRT during the menopause.

The phenomenological question:

What is the experience of women taking hormone replacement therapy during the menopause?

The objectives for this study were:

1. To understand the meaning women, who take HRT during the menopause, give to this experience.
2. To identify their reasons for commencing HRT, and their future expectations.
3. To identify their reasons for adhering or not to HRT regimes.
4. To contribute to the evidence which informs the practice of health professionals working with midlife women.

Description of the Research Process

Guiding the writing style of this thesis are not only the philosophical underpinnings as laid down in Part One of this Chapter, but my response to the stories of the women. The experience of carrying out this study became a journey of self-discovery. Sweet (1989) referring to his work with clients captures what I experienced during the collection of data:

to seek to understand another without judgment, resistance, or identification brings its own dilemma. To understand the other is to understand myself better, differently. Really to hear the other might mean that the change that must occur, is in me. I can no longer be like I am ... Because I am much more like my clients than different from them, I hear myself when I truly hear them (Sweet, 1989, p. 76).

The process of data collection and analysis, although presented under separate headings, did not happen exclusively of one another. Van Manen states that “these two acts are not really separable and they should be seen as part of the same process” (1990, p. 63). It is only for purposes of clarity that they are presented as separate.

Accessing the Research Participants

Accessing the research participants involved advertising in two community papers which are free to all residents over a wide geographical area. The advertisement (Appendix B) invited women to either attend a morning meeting at a central education institution, or to reply to a P.O. Box number. The first option gave those interested the opportunity to meet with me and collect the information sheet (Appendix C) and consent form (Appendix A) if they wished to continue. In all, only twelve women responded; four attended the meeting, five replied by letter, one was contacted through one of the participants (after data collection had started), and two, who were personally known to me, were declined.

The ten participants came from a radius of 200 kilometres; this meant that considerable time was spent in travel, sometimes resulting in a lapse of months between interviews. In order to keep in touch with the women, I sent out a newsletter at intervals informing them of how the study was going and where I was up to.

Criteria for Research Participants

The criteria for acceptance into this study, as stated in the research proposal, required that the women had been taking HRT for one to two years. This timeframe was selected to include and slightly extend beyond that period where most women stop taking HRT - after 8 to 12 months (WHO, 1996). However, there were insufficient women volunteering who met this criterion. Consequently, the one to two year timeframe for having been on HRT was removed, and the criteria were adjusted as follows to be inclusive of women who were prepared to become participants:

- were menopausal and taking HRT /or had experienced a surgical menopause and were taking HRT
- had no medical history of chronic disease
- were not known in anyway to the researcher (myself)
- were prepared to commit to two to four one-hour interviews and to keep a written log over a two month period.

Data Collection

For this study, each volunteer participant was interviewed from two to three times over a fourteen-month period. An exception was one woman who, due to changing family matters, could take part in only one interview. Each interview was from forty-five to ninety minutes in length. The process of data collection continued until the women had no more to say on the subject, and I became aware of reoccurring themes in their stories.

The interviews were audio-taped and transcribed by a word processor. The exceptions to this were: tapes of two interviews (from one participant) were discarded due to electrical interference, one interview was stopped when the participant became distressed, and one interview was conducted without being audio-taped because of the participant's request. Consequently, less data were collected from two of the participants than from the others. I checked the transcripts by replaying the tapes and concurrently reading the transcripts. The second means of data collection involved asking each participant to keep a journal over a two month period. Only four participants made use of this. The return of the tapes and journals (after completion of the thesis process) was offered and accepted by all participants.

Prior to the commencement of the first interview the participants read the information sheet and signed the consent form. While the form included consent to have the interview audio-taped, it also made clear that they could have the audio-tape turned off at any time. This was rarely requested.

The setting of the interviews was mostly in the homes of the participants. However, one interview was at a participant's place of work in a private office, and one took place in my home. The first interview opened with the question, "why did you become a participant in this study?", then moved onto details about when they started the menopause and the taking of hormone replacement therapy. Once these preliminaries were completed, I asked each woman to tell me about her menopause and experience of taking hormone replacement therapy. It was at this stage that I learned two

valuable lessons. The first was that the menopause is an integral part of each woman's life. Their responses were everywhere, traveling through every aspect of their lives. I initially viewed this inability to keep them to what I perceived as the topic as being solely due to my inexperience as a researcher. However, this changed once I abandoned my carefully prepared questions, relaxed and listened more intensely to the women and responded to them with "tell me more about that", and "what was that like for you?" The second lesson was that most of these women had a deep longing to talk to a willing listener. The amount of data collected was at times overwhelming in its volume and breadth. Consequently more data were collected from those women who were most articulate.

Subsequent interviews were used to clarify and reflect upon the previous interviews and to move closer to understanding. As rapport developed, interviews became hermeneutic; first, because they gathered stories and recollections of experiences and secondly, because they became reflective acts between the research participant and myself (van Manen, 1990). It was at this stage that we, the research participants and myself, became collaborators in this study.

Collection of the data was greatly influenced by the fact that I was viewed by the women as being like them, a midlife woman. It was our similarities that enabled the data collection process to progress smoothly. This is supported by two experiences: first, the need of each woman to know my age and menopausal status before sharing their experiences; secondly, a participant informed me of a conversation about the study (with her husband) where she said "I wouldn't be telling a 20 year old about these things".

Data Analysis

All the data gathered from the verbatim transcribed interviews, journals and fieldnotes were analysed. This process, from the first interview, involved reading, reflecting, interpreting and writing, seeking understanding of this phenomenon as experienced by the women. Each interview was read as a whole, then line by line - wholistic and

sententious (van Manen, 1990). Statements which seemed to best answer the research question were highlighted. Then each interview was compared with others, moving constantly between them. It was here that I looked for essential themes to shape my interpretations.

According to van Manen (1990), there is a need, for purposes of clarity, to distinguish between incidental themes and essential themes. He also states that this task is “the most difficult and controversial element of phenomenological human science” (1990, p. 106). Essential themes apprehended in this present study stood the test of being asked, “is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon?” (van Manen, 1990, p. 107). For the purposes of giving structure to these essential themes, subthemes and supporting components were identified.

Supporting these themes are excerpts from the women’s narratives which best capture the heart of the theme, thus giving substance to the writing. It was these themes that I took back to half of the participants and to two ‘critical’ friends for the purposes of clarification and credibility. This activity evoked in my two ‘critics’ a flow of their own stories that in many ways mirrored those of the research participants. On completion of the data chapters, several participants, my thesis supervisors, critical friends both academic and lay read them. Their confirming feedback on this phenomenological description contributed to the validating circle of inquiry.

Transformations

Phenomenological studies are concerned with transformations of experience into knowledge. Thus I could only include in this study women who had experienced taking HRT during the menopause. The richness of the data collected is therefore not only dependent upon the articulation skills of the women, but on my own interviewing skills to bring out their knowing. Reinharz (1983) identifies five steps in the phenomenological transformation of experience to knowledge. I have situated these steps within the context of this study.

1. Each woman's experience was transformed into actions and language which became available to her through the interactions she had with me. As the phenomenological researcher, I created a situation in which her experience became available to her in language. This became the first transformation.
2. I then transformed what each woman saw and heard into an understanding of the original experience. Because I can never experience her experience, I relied on data she produced about that experience, and I developed my own understanding, which became the second transformation.
3. I subsequently transformed this understanding into themes which I believe capture the essence of the experience - the third transformation.
4. Using these emerging themes I transformed them into a written document which captures the aspects or qualities that made the experience what it is. This is the fourth transformation. Throughout all these transformations there are things which can be lost and gained.
5. Finally you as the reader of this thesis transform the findings into something meaningful for you.

Although these steps identified by Reinharz were helpful in this study, step five suggests that I am saying, "I've done the study, here are the findings, you make of it what you will". However, the qualitative researcher has a responsibility to point out what important issues may have been uncovered, and to ask of the clinicians, 'how is this working in your practice?' (Darbyshire & Sandelowski, 1997). The responsibility to give clear directions to the intended audience of this study had methodological implications not only for what was written, but for how it was written.

Writing and Rewriting as Method

Van Manen (1990, p. 124) states that writing is the phenomenologist's method. "It is the minded act of writing that orients itself pedagogically to a notion that is a feature of lived experience". It is through the construction of a text that van Manen suggests we come to know what we know (a body of knowledge), and through this process that we learn what we are capable of saying (our knowing body). Therefore, according to this author, the object of the research process is to create a phenomenological text.

Under the heading Data Analysis, I referred to the process of identifying the essential themes, the thematic dimension which gives structure to the text and guides understanding. However, van Manen (1997, p. 345) identifies two dimensions of phenomenological inquiry, the thematic and the expressive dimensions. He succinctly states: "When we turn from the thematic meaning to expressive meaning, then the question we ask turns from 'What does the text speak about?' to 'How does the text speak?' This poses the challenge to the researcher of creating a text that speaks both to the cognitive and intuitive capabilities of the reader.

Therefore my aim was to create a text that embraced both these dimensions. The process of writing the data was experienced as an ongoing dialogue with the data and the literature, rewriting, discarding, and growing. There were times of writing when I needed to close my eyes and write from the 'inside out'. These were 'moments' of transformation, as if I had walked into an unlit place and the light had come on. A 'good' phenomenological text, according to van Manen (1997, p. 345), "has the effect of making us suddenly 'see' something in a manner that enriches our understanding of everyday life experience." Thus, in the creating of this phenomenological text, I set out to bring insight and to enrich understanding of the menopause and of taking HRT as experienced by the research participants.

Trustworthiness of the Study Findings

Essential to the evaluation of a study is an examination of those aspects which may limit the confidence that can be placed in the findings. However, there is disagreement as to how the researcher should go about ensuring the confirmability of qualitative research. Lincoln and Guba (1985) emphasise the importance of understanding the naturalistic inquiry paradigm as the key. Patton (1990) suggests that credible qualitative studies must address three issues: the techniques and methods used for data collection and analysis; the qualifications and experience of the researcher; and the “paradigm orientation and assumptions (which) undergird the study” (p. 461).

The problems of rigor in qualitative research were also described by Sandelowski (1986). Offering a framework for evaluating such studies, she suggested a number of strategies including truth value, applicability, and consistency. The first is achieved when the description of the experience is perceived as accurate by the research participants. The second, applicability, referred to as fittingness by LoBiondo-Wood and Haber (1994), is achieved when the study findings “shed light on or ‘fit into’ contexts outside the study situation” (Leonard 1989, p. 53). Consistency, the third strategy, refers to the auditability or clear audit trail ensuring that the reader can follow the thinking of the researcher (LoBiondo-Wood & Haber). Leonard (1989, p. 53) states that consistency is met “by the presentation of sufficient data from the text analogues to enable the research reader to participate in the consensual validation of the data”.

In order to validate the findings of this study, I used member checking, mindful of the fact that this technique is a variable in itself, and as such may influence the data (Sandelowski, 1993). For example, some research participants may feel uncomfortable on reading their transcripts and wish to make changes. The use of member checking, in the present study, involved discussing my interpretations/summaries of the previous interview with the informant, taking the emerging essential themes and supporting subthemes for checking, and finally having a number of the informants read the completed data chapters. This resulted in minor

changes related to the use of some words in my interpretations of their narratives. Sometimes the participants would say after reading the summaries, “that word doesn’t mean anything to me”. Together we sought the word or phrase that they felt more truly interpreted what they were saying. This happened rarely, and their confirming response to the phenomenological text was reassuring for me. However, I am mindful of the societal tendency to want to please and not to challenge in the researcher and participant relationship. The fact that they also perceived me as being more like them made this a more trustworthy process.

Overall, my guiding ethos for all parts of this study was to be true to the text (Benner, 1994). Adherence to this ethos has relevance for the trustworthiness of a study and is supported by Denzin and Lincoln (1994, p. 488) who state that qualitative research:

“is carried out in ways that are sensitive to the nature of human and cultural social contexts, and is commonly guided by the ethic to remain loyal or true to the phenomena under study, rather than to any particular set of methodological techniques or principles”.

Evidence of adherence to this ethos is apparent when the researcher’s view of the research focus is challenged. Benner (1994, p. 101), referring to the ethical stance of the interpretive researcher, suggests that; “If the interpreter’s own views have not been challenged, extended, or turned around, the quality of the account is questioned and the danger of just reading in preconceptions must be considered”. Very few of my assumptions relating to the research focus were confirmed. For example, I expected that the medical paradigm would play a part in shaping the women’s understanding of the experience, but I was unprepared for the degree to which it did and the dilemma it caused in many of the participants. Also I was not prepared for the contradictions that were part of the experience of menopause; an event that is both universal and individual, inevitable yet unexpected, normal yet an aberration.

The research process described in this chapter acknowledges the elements of trustworthiness and is open to scrutiny.

Ethical Considerations

This study was carried out in accordance with the ethical guidelines set out in the Massey University booklet *Experimentation Involving Human or Animal Subjects*, August 1994. Approval was also sought from and given by the Hawke's Bay Crown Health Enterprise Ethics Committee as the study took place within their boundaries. The following ethical issues were addressed:

1. Confidentiality

Confidentiality for the participants was ensured by the use of code names. The audio-tape transcriber signed a non-disclosure form and took measures to keep all details of the interviews confidential (Appendix E). All data collected in the form of fieldnotes, logs, tapes or typed transcripts were kept in a separate locked cabinet. Access to these was limited to the thesis supervisor and myself. The final report has been screened to ensure the anonymity of the women. After completion of the thesis process, the tapes and the journals will be returned to the participants or if not wanted, they will be destroyed.

2. Anonymity

It was essential for the collection of the data that the women felt safe and able to share their experiences with me. Thus every effort was made to ensure the women's anonymity, and that of any third party as a result of their participation in this study.

3. Participants' right to decline

Once each woman volunteered to become a research participant in this study, she signed the consent form which stated she was free to withdraw from the study at any time, or to decline to answer any particular questions in the study. She also had the right to request that the audio tape be turned off at any time (Appendix A).

4. Ethical courtesies

Although each woman volunteered to be a participant in this study, it was because she had been prescribed HRT that in part made her eligible. As a courtesy to medical

colleagues, prior to seeking participants, one hundred and twenty letters were sent out to medical practitioners (within this study's proposed geographical boundaries), informing them about this study and offering a summary of the findings (Appendix D). Only three responded, offering assistance with accessing research participants and expressing interest in receiving a summary of the findings. They were all female general practitioners. However, one general practitioner expressed concern that she did not want any of her patients, who may be participating in this study, to become fearful about the risks of taking HRT. Suggesting that I may expose them to information that may affect their compliance with HRT regimes. I responded with a letter outlining how this study would be conducted and that it had been approved by two Ethics Committees. A brief description of what this qualitative study involved was included, emphasising that the focus was on the research participants' experience of taking HRT during the menopause.

5. Health risks

The fact that I am a nurse, and that the research participants were informed of this in the Information Sheet, the following proviso was made. Based on professional knowledge, should I at any time identify that the health of any participant was at risk, as a result of HRT and how they were using it, I would advise them to visit their medical or other health practitioner or to seek a second opinion as considered appropriate.

Intended Audience of this Study

The aim was to write this study in a style accessible not only to clinical nurses and other health professionals, but to the educated outsiders who seek to inform themselves about the menopause and issues around the taking of HRT. Although this is a Master's thesis and must meet the requirements demanded of academia, I have sought to balance these with a user friendly approach. By attempting this, I aim to narrow the gap between this study and clinical practice. This was but one step towards meeting what I perceive to be an ethical responsibility of researchers, making

the findings of one's research accessible to those working in the clinical setting. Other steps in relation to clinical practice will be expanded upon in the final chapter.

The Study Participants

The age of the ten study participants ranged from 47 to 65 years. The duration of taking HRT ranged from two up to fifteen years. Three women had experienced a surgical menopause. The participants came from a cluster of provincial cities, towns and villages. Five participants identified as New Zealanders, two as Maori, one Dutch, and two English. Occupational status included, a laboratory technician, cook, caregiver, office manager, beautician, taxi driver, cleaner, retired, and homemaker. Nine of the women were married and one was separated.

Relevant to the above, the question "why do people choose to become research participants?" comes to mind. In the research literature this is unexplored territory. Partly in response to this question, and to protect the identity of the ten women who have been assigned pseudonyms, I let the women tell you in their own words why they became part of this study. Their reasons ranged from curiosity, being taken along by a friend, wanting to help another woman doing research, to wanting to help both themselves and others.

Alex - You feel as though you are on your own - you feel as though you are the only person in the world that's ... I mean you know you're not, but you feel as though you are the only person and nobody seems to understand what you are talking about. You go to the Doctor. The Doctor says "Oh yes, well here's a few pills" and you think to yourself, "well surely somebody must know that I'm not 100% but I'm not ill. You know, I'm not the person I used to be a year ago or six months, or two years ago, you know. Well, somebody, somebody must know something, somewhere". So I thought, and B... said to me, my husband said "Go along, chat. See what happens. They might come up with something. If they don't, they don't".

Del, Roz and Eve- *Curiosity.*

Elizabeth - *I'm part of the first generation to be on it (HRT). To pass my experiences on for the benefit of others ... sharing part of my process as a woman.*

Eve - *Why I came forward for this project. Been down the whole hormone replacement therapy for quite some time and I'm all for it, and, just curious I think and wanted to know what was going on, and so I came along.*

Lynn - *Well, I felt after 20 years I had a lot of experience of the menopause. Very valuable experiences as I felt and I have met up with lots of other people and people have come to me and asked me what I've done and asked my advice and that sort of thing, you know. I felt well, if I could be of any help.*

Mary - *Lynn told me about your study and that you were looking for more women, So I thought I would like to help.*

Pat - *I think the first, the first reaction I got was "Oh, here's a woman doing study". Not what it was about. The fact that you were actually studying and writing a thesis. Because I've been doing that myself, you know, doing study. I've sort of been doing papers at University for years. And I thought "Oh obviously this woman is doing a thesis. And when I fitted the criteria I thought, Oh well, yes, I will".*

Penny - *Well quite frankly I didn't. My friend (Eve) rang up and asked me to go with her. She said "you're on patches". I said, "Oh yes, yes, I'll go along". That's how it started.*

Tina - *Because I saw your ad in the paper. Because before that I never really thought about it. I read about it, but that somebody would do a study about it or a thesis - never ever thought about it. So I thought, "Oh well, why not". It will help me and it will help other women.*

These ten women gave me their time, their stories and their hospitality. I, in return, gave them voice, and together we became collaborators in this study. Hutchinson, Wilson and Skodol Wilson (1994) writing about the benefits of being a research participant state: "The act of interviewing, with the rhythms of speaking, listening, and responding, promotes a connection between interviewer and participant. The interview gives the research participant a voice" (p. 162). It was through the act of writing this hermeneutic phenomenological study that I fulfilled my commitment to the research participants collectively.

SUMMARY

This Chapter is presented in two parts: part one explored the rationale for selecting hermeneutic phenomenology in studying the experience of midlife women taking HRT during the menopause. This discussion touched on how phenomenology has influenced the work of nurse theorists and researchers. Also outlined were the implications of the issues raised by Crotty (1996) and Holmes (1996), for this study. Part two described how I carried out the study, and concluded with the research participants telling why they became part of the study.

The next three chapters present my hermeneutic phenomenological descriptions and interpretations of the experience of taking HRT during the menopause. The participant's words are presented as they were recorded with minor adjustments/explanations to facilitate understanding. Consequently, the supporting statements from the interviews are not always written in grammatically correct sentences.

The central over-riding theme of this study is *universal change-individual responses*. This is made up of three essential themes: *living-with-a-changing-body*, *being-on-hormone-replacement-therapy* and *relationships-past-and-present*. Each of these essential themes, supported by subthemes and components is the focus of the following three chapters. Chapter Four introduces the three themes and then explores the first, *living-with-a-changing-body*. Chapter Five presents the data supporting the second theme, *being-on-hormone-replacement-therapy*. Chapter Six, although the last essential theme, groups the data which threaded through every interview, the women's *relationships-past-and-present*.

CHAPTER FOUR

UNIVERSAL CHANGE - INDIVIDUAL RESPONSES

Lived experience is the starting point and end point of phenomenological research. The aim of phenomenology is to transform lived experience into a textual expression of its essence - in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience (van Manen, 1990, p. 36).

The central argument developed in Part One of the previous chapter is that the phenomenon of menopause and the taking of hormone replacement therapy need to be understood in terms of how they are experienced, and what they mean. Hermeneutic phenomenological research reveals to us “the significance in the taken-for-granted” (van Manen, 1990, p.8), and takes those seemingly everyday happenings and offers us “the plausible insights that brings us in more direct contact with the world” (p. 9). Insights are made possible by five transformations (Reinharz, 1983) as discussed in the previous chapter. Based on these understandings, I present the following three chapters as my written transformations of the women’s narratives.

Through the writing process, I have endeavoured to capture the essence of the original experience. Van Manen (1990, p. ix) reinforces this approach, stating “interpretive phenomenological research and theorizing cannot be separated from the textual practice of writing”. Chapters Four, Five and Six each focus on one of the three essential themes, *living-with-a-changing-body*, *being-on-hormone-replacement-therapy* and *relationships-past-and-present*. In these chapters the three essential themes are emphasized in italics, while the subthemes head each related section as they are presented. Throughout the discussion of the themes and subthemes, components which emerged as an integral part of the experience are identified and integrated into the discussion. This manner of presentation has been selected so as to whisper to you my interpretations, and not to intrude upon yours. The fifth and final transformation is, as Reinharz (1983) states, the reader’s interpretation, and so I invite you to transform this report into something that is meaningful for you.

It is important at this point, before presenting the data chapters, that I offer my explanation as to why there are such differences in length between the three essential themes and their respective subthemes. For example, Chapter Five, which explores the essential theme *being-on-hormone-replacement-therapy*, is very much longer than the other two themes, and in turn is dominated by the subtheme medical discourses. Such matters can cause some ‘angst’ to the novice qualitative researcher. However, as previously referred to in Chapter Three, the apprehension of the essential themes (including their subthemes and components) is for the purposes of clarity. While on the one hand themes provide a framework upon which to hang the interpretations of both the research participants and the researcher, on the other, they can present an artificial image of lived experience. Lives are not made up of evenly clustered experiences and this is reflected in the size of the themes.

This chapter and the following two present my interpretations of the data at this time. They are limited by both my own interpretive abilities and the set timeframe of academic course requirements. I know that, as I grow in life experience and understanding of research processes, the data will reveal more insights. So, in this sense, the work of data analysis and writing for the qualitative researcher is never complete.

Themes

Although the menopause is universal for human females, the responses of each woman were individual and very personal. *Universal change - individual responses* is the central over-riding theme that captures the conflicting quality of the woman’s experience.

The experiences of the ten women in this study of menopause, and why they were moved to taking HRT, flow from their embodied intelligence, background meaning, concerns and situation. They knew the menopause would come, but the timing and the experience of the changes were unexpected. These changes involved something that had been a deep integral part of their lives and identity, the monthly period, which

had either become erratic or ceased suddenly. Other changes experienced were the hot flushes that for some women caused embarrassment during the day and deprived them of sleep at night. These deeply personal body experiences disturbed the taken-for-granted body, leaving some with an overwhelming sense of loss of control over their bodies, their lives, and their relationships. *Living-with-a-changing-body* is the first essential theme that explores the phenomenon of menopause and will be developed in this chapter.

The second essential theme explores the experiences of the women taking hormone replacement therapy. Dominating this experience was the impact of medical discourses in shaping many of the women's knowledge and understanding of menopause and its management. The narratives revealed that some women were taking HRT without ever having made a conscious decision to do so, but more as a response to being told it would help them. Others considered it carefully. The women's reasons for taking HRT and expectations of therapy were as individual as their responses to it. However, once on HRT, some women adhered strictly to medical prescriptions, while others were moved to give their bodies a break. This behaviour can be understood in light of each woman's concerns. Thus the second essential theme *being-on-hormone-replacement-therapy* will be presented in Chapter Five.

Throughout the narratives, from which these two essential themes emerged, the women's stories wandered, embracing their relationships with husbands, daughters and mothers. The women's experience of their changing bodies, and their husband's response to those changes, either positively or negatively influenced their identity as women. Where there were daughters experiencing their own "hormonal upheavals", the onset of menses, at the same time as their mother's menopause there were some repercussions. For the participants, the few remembered stories of their mother's menopause were now viewed differently in light of their own experiences. In some instances, the participants' recollections of how mother was became markers of what was to be expected for themselves. Some stories touched on how father was with mother, and reached through time to be mirrored in the women's own relationships

with today's husbands. These *relationships-past-and-present* form the third essential theme, which will be explored in Chapter Six.

The structure for presenting the three essential themes of this study evolved from the data. However, the order in which the essential themes are presented reflects my attempt, as researcher, to give form to the women's stories and enhance understanding. The women did not tell their stories of menopause and of taking hormone replacement therapy in a linear fashion, but told me about their lives. Martin (1987), in her book *The Woman in the Body*, refers to the difficulty her research assistants had of keeping older women on the subject of the interview: "they wanted to wander from menopause to talk about many other aspects of their lives" (p. 176). She concludes that it was because menopause was experienced as "a part of all the other events happening in their lives" (p. 176). Bervig-Valentine (1997) takes this idea further, stating that women tell their stories differently to men, often telling the end of the story first, and always describing the circumstances in which events occur. My experiences as interviewer in this study confirm these authors' observations. In order to find out what the phenomenon of menopause means, how it, and the taking of HRT are experienced, I explored these experiences through the phenomenological view of the women as self-interpreting beings.

LIVING-WITH-A-CHANGING-BODY

The body that knows how to conduct itself - the habitual cultural body - starts to lose its taken-for-grantedness at the onset of the menopause. Some women experienced a serious rupture in their ability to negotiate their world, while others felt that without outside stressful life events they probably could have coped. As the women told their stories, recurring refrains were heard in their words. From these refrains four sub themes emerged, relating to *living-with-a-changing-body*. They are inevitable-unexpectedness, loss-of-control-over-the-body, deciding-what-to-do and needing-to-really-talk.

Inevitable-unexpectedness

Every woman in the study knew that sometime the menopause would come. Cessation of the monthly rhythm of menses and the beginning of hot flushes were a part of what they expected. However, the timing and the experience were unexpected. Medically, a woman is defined as menopausal when she has reached 12 months past her last menstrual period (WHO, 1996). This definition did not fit the women's knowing that they were menopausal. According to Reitz (1985), a woman "knows" when she is menopausal. In the present study, after three months most women knew the menopause had arrived and they were in it. Alex's narrative captures this:

What alerted me was hot flushes. When I say hot flushes it was perspiration that just drowns you. You'd also, going to bed at night time, your bed would be soaked and you'd think. Gosh, I've got to get out of here ... So naturally, with that, you are definitely going to be in menopause, it's not going to be sort of the start of it - you're in it. (Laughter). You know. So that's about it, it just sort of seems to come on you, but it's when you look at it later that you feel as though it's been there for a while but nobody has ever put a name to it (Alex: Int. 1, p. 2).

Alex is acknowledging that she has been in this state for a while but she didn't stop and think about it, and then something happened; the signals got louder to the point where she could no longer ignore them. So the body as a 'knower' knows of the presence of the menopause, but it is only when the changes disrupt the taken-for-grantedness of the body that what is known, is named. This idea is supported by Benner and Wrubel (1989, p. 42): "our bodies as well as our minds are knowers, and this embodied knowledge enables us to move through situations and encounter situations in terms of meaning and in rapid, nonreflective ways".

For most of the women experiencing a natural menopause, the first visible body changes were seen as being triggered by stresses outside of the body and not by their biological clocks. Life events such as troubles with teenage daughters, marriage of a daughter, the illness of a parent or in-laws, moving countries, and the death of a husband were perceived as the triggers of the onset of menopause. Most women have

experienced a change in the menstrual cycle when under stress so this linking is to be expected (Witkin, 1991).

While it is well accepted that a women's oestrogen-secreting system is sensitive to psychological factors, it is not such a widely held view that the "biochemical changes at menopause and those of stress are likely to interact and exacerbate each other" (Ballinger, 1990, p. 95). Menopause does occur during a life stage where stresses include such events as the death of spouses and parents, retirement, and problems with teenage children. Ballinger considers that these factors play a part in triggering the commencement of menopause. However, a study conducted by the Society for Research on Women in New Zealand (1988) of the experience of women in midlife in Christchurch, contradicts Ballinger's view that there is an association between commencement of menopause and life stresses. This survey found no association between menopausal stage and life stresses.

Another theory relating to the timing of the onset of menopause suggests that most women enter the menopause at about the same time as their mothers did (Northrup 1995), and that there is a genetic trigger. However, in this present study most of the women perceived the onset of menopause as being triggered by a major life event rather than an inherited trait. Thus life events as triggers is the first component of inevitable-unexpectedness. This is revealed by Eve and Tina in the following narratives.

*I just stopped having periods sort of thing for a couple of months sort of thing, and I just of, because I lost a husband and I thought maybe it was because of that - the shock of that - sort of thing ...
I wouldn't really face it that I was really (menopausal) yes I was going through all these mood changes and everything like that
(Eve: Int. 1, p. 2).*

*When we first came to New Zealand about January of last year, well because I thought my period was due and it just didn't come and I thought, well because we've moved countries and doing something completely different, my daughter was getting married, and I thought, well it's the stress, so period just stays away. And then after two months and I thought, No, something's not right so I thought, I'll have an hormone test - have the oestrogen levels tested
(Tina: Int. 1, p. 1).*

Three women had experienced a hysterectomy and partial/total oophorectomies. None of them knew themselves as menopausal because of the surgery. The menopause was something that would happen later. Penny, who had a hysterectomy and bilateral oophorectomy when she was 45 years old, thought the menopause would come at the usual time around 50. She did not experience any sense of a presence of something before it revealed itself through body changes, as Alex did.

I thought it would be when I was about 50. And I was 45 when I had the hysterectomy. It never entered my head that I was going to have the change of life then. Never entered my head. Nobody told me. So I thought I'd be 50. It was a shock to find I had it straight away. That was the menopause - the operation practically. For some unknown reason it never entered my head. (When did you actually realise?) Oh once I started having the hot flushes. Well slowly really. I just hadn't thought of it like that. Just because they removed everything - I didn't realise that was the menopause then and there. I still thought it would be years later. So stupid (Penny: Int. 3, p. 16).

All these women, when they experienced a disturbance in the smooth functioning of their bodies, no longer had a nonreflective grasp of the situation in terms of meaning for self. When we lose the “essential embodied, taken-for-granted quality”, the body “becomes something one reflects on consciously” (Benner & Wrubel, 1989, p. 43). It is the disturbance that leads us to notice things (Dreyfus, 1991), and when we notice we can reflect upon the experience in order to name it. Naming-the-changes is the second component of inevitable-unexpectedness.

Most of the women felt that at the time the body changes started, there was a lot going on in their lives, leaving little opportunity for conscious reflection. It was only in reflecting on the past that they were able to articulate what the menopause means for them. Each of the women, through her capacity to be in situations in meaningful ways, has found different meanings - meanings as they are lived out. Thus finding meaning is the third supporting component of inevitable-unexpectedness. While each woman's story is unique to her, loss of the ability to bear children, and ageing, are inextricably woven into the fabric of meaning given to menopause.

Alex still experiences a deep hurt, because menopause means that her body is unable to bear a child. She does not want a child, but she grieves the loss of her body's ability to bear - the things you cannot have you desire. When a woman defines herself strongly in terms of her role as mother, menopause takes on a meaning of the end of something valued.

Oh yeah, you cry. Of course you cry. The thought of going through the menopause though has many things. You know, I had heard about it but when they (Doctors) say, when they tell you you are going through the menopause you stop and think to yourself "I'm not going to have a child any more". Not that I wanted any more children. No. But that is a disappointment. You do look at it and think. ... menopause is a traumatic thing. To me it's a traumatic thing. And no, I can't have children. I didn't want children but once you say you can't have them it's like a bag of sweets. When you can't get hold of them you want them (Alex: Int. 1, p. 12).

For some women, the loss of the ability to have children is expressed as a deep pain, as poetized by Janet McCann (in Taylor & Sumrall, 1991, p. 144). In this poem, McCann refers to holding the hand of her five year old son "her last one".

and there is this ache like a cloud
 an old pain
 that will not say itself
 and when we walk into the house
 hand in hand
 my body hangs on me
 like an old red dress.

Here, the threads of loss of the ability to bear children and ageing knit together as part of the meaning of menopause.

For the participants, ageing was not always seen in terms of a changed appearance, but more in what they could not do. No longer could they tackle everything; they had to consider their bodies. Eve shares her realization that she had to slow down, that no longer could she do everything.

... a couple of years ago I realised I'm not getting any younger - I'm getting quite old. I realised I had to start taking notice of that too and slow down because I do have to slow down. I can't keep

running around the block any more like I used to once (Eve: Int. 2, p. 4).

The constant ‘little messages’ about getting older from the news media and from workmates affected Alex, although she tried not to take them on board. She felt stigmatized and sometimes consumed by the loss of her younger self.

It's a stigma. It's a real stigma. That you're, that you are getting old. You know. This is the, well, there is no return now. You haven't got any return. How are you going to turn back to 25 year old or a 35 year old? I wish they could. It would be rather nice (Alex: Int. 3, p. 9).

Menopause as a developmental stage, a part of life, was another meaning given. Elizabeth, a teacher, while teaching a form II class on body changes realized this. “*Here I am thinking they're at the beginning and I've gone past the end ... it's just another stage of life*” (Elizabeth: Int. 3, p. 8).

The narratives of the three women who experienced a surgical menopause are similar yet different. While there was a sense of loss, there was also a relief that they didn't have to worry about periods again. Mary felt she had ‘lost her womanhood, but gained dignity’. Roz, who required a hysterectomy for cervical cancer, viewed the menopause as something that would happen after surgery and that the whole thing was a relief.

I think right from the onset of having to have a hysterectomy I've been very aware that it would be likely that I would have menopause afterwards, whereas as a younger, healthier woman, I had the awful dread that my periods were going to go on until I was about 65 because I'd had a very early onset menstruation and I thought I was very likely to go for a longer period too you see, so I was actually quite grateful, I think. Oh, well, that's all over and done with. No it doesn't worry me in the least (Roz: Int. 1, p. 7)

Inevitable-unexpectedness captures two types of knowing; the first is consciously knowing that the menopause will inevitably come, and the second is the knowing that comes from the lived experience. It is the unexpectedness of the experience and the background meanings provided by a woman's culture that resulted for some in a

degree of denial, that the menopause was not going to happen until it did happen. Background meanings impacted on Alex and influenced what was important for her. The menopause was something she did not wish to anticipate and denied until it was upon her. The cultural meanings given to the menopause and to ageing are intertwined and reflected in the words of Alex.

You're not going to turn 50. Ever. You know. Or you're not going to be on the change of life. I mean that doesn't happen until it arrives. I mean, it's like nobody has any illness until you've got it and when you've got it you think, Oh my God, I can get it. And then, of course, all of a sudden you've got this thing, but you think well, why me. You know. I'm old now. I must be 50. I must be going on 60 and the next step is the rest home (Alex: Int. 3, p. 7-8).

The subtheme inevitable-unexpectedness and the three supporting components life-events-as-triggers, naming-the-changes and finding-meaning were but one part of the experience of *living-with-a-changing-body*. Deeply concerning for some women was the loss of control over their bodies and the meaning that held for them.

Loss-of-control-over-the-body

The adult female is expected to control and conceal the functions of her body, especially in relation to menstrual periods. As Laws (1990, p. 42) states "one cannot isolate 'meanings' of menstruation in our culture apart from the idea that it is something which must be hidden". Consequently, living with a body where the monthly periods became erratic and hot flushes made public something that was deeply personal, some women experienced a deep sense of loss of control over their bodies. This left two of the women in this study with a pervading sense of having lost themselves somewhere. Witkin (1991, p. 45) suggests that "times of body change are times of stress, because we may feel our sense of control threatened. We can't turn them off." The subtheme loss-of-control-over-the-body has four components: changing-rhythms, body-embarrassment, unexpected-feelings-and-emotions, and comparing-the-present-body-with-the-past-body.

The changing rhythms of their periods, were not experienced as great ruptures but, once named as being due to the menopause, brought relief for most women. Del's words allude to a new found sense of freedom.

It was good. It was really good not having to put up with that hassle anymore but I thought it was just temporary. You know, how sometimes you don't have a period and then you do and then you don't. And I just stopped completely one Christmas and didn't see it again until I went on the hormonal replacement (Del: Int. 1, p. 3).

Lynn recalls also a great sense of relief, but this was to be short lived as the nature of her periods became erratic.

I felt oh hooray, I won't be having periods any longer, (laughter) but I've never wished, I never thought I would ever wish to have my periods back - be normal again, until I'd gone through all the menopause problems. I felt, oh gosh, it's starting a bit early. I did feel I was a bit early in starting. A lot of people don't start until they're in their fifties. (When did you realise it was the menopause. When did you actually name it? The menopause, in your mind). Well, I suppose towards the end of the three months - getting toward two and a half to three months because I knew darn well I wasn't pregnant. ... And then my periods came back again and I seemed to get back to normal. I thought, oh well, that's just a flip of the pan and I didn't sort of think any more about it. I can't remember how long it was before I lost them again (Lynn: Int. 3, p. 2-3).

There is a sense of menopause being a time that is not normal for a woman. It is only since Lynn has been on HRT that she has experienced the return of periods. Having periods again will be explored in the next chapter under the essential theme of *being-on-hormone-replacement-therapy*.

The body change that was experienced as disruptive for most of the participants was hot flushes or hot sweats. Those participants whose jobs involved meeting people spoke of the embarrassment they experienced, because they were unable to control these changes. An integral part of being a person in our culture is to be able to control your body (Benner and Wrubel, 1989). Roz and Tina describe their experiences with hot flushes.

It was becoming a real problem at work, more than anything else. I felt dreadful in the middle of a meeting to be sitting there sort of bathed in sweat and having everybody look at you, going, what the hell's wrong with her. You know. (Roz: Int. 1, p. 1).

It was just this hot and then you were talking to customers and then could feel. Oh I'm getting so hot and in the summertime it was dreadful. ... But it was never that I was thoroughly wet. It was more embarrassing, when you looked at people and you could feel that rush of heat coming up your neck. Yes, because you could be in the middle of a conversation and then you could feel all this and you'd think. Ohhh. It probably wasn't at all because then I went to the mirror sometimes and I felt as if I was bright red. And you aren't really. No. And it's only you that notices it because you feel it, but you don't really see it (Tina: Int. 1, p. 10).

The hot flush makes something that is deeply personal and not to be talked about, public. Even when the hot flush is not visible to others, because Tina senses it, she is embarrassed.

Penny did not observe the rules, that in most situations a woman does not refer to her own menopausal symptoms (Laws, 1990), and as a consequence she experienced silence. The presence of silence usually denotes something taboo.

I do know that a few times I had massive hot flushes in front of people, so for me I would be embarrassed, so I would say I'm having a hot flush and there would always be dead silence. And that made it worse (laughter) (Penny: Int. 3, p. 3).

When alone, the hot flush does not cause embarrassment - it is only when it occurs in the presence of others. Alex uses humor and while she jokes, underneath she wants to hide herself away.

So if you are going through the menopause you make a joke of it anyway. You know. I'm having power surges, you know, and things like this. Well everybody laughs at that. Good God, you're perspiring like a, you know, anything really, but oh yeah, I'm having a power surge. And just throw it away. (You don't want to, underneath it is different?) Yes, it is. It definitely does. You feel as though you are shriveling up. And you put on a good face sometimes and, you know, you sing or you try to pretend you're singing, and all the time (whisper) thank God I'm out of that now, I don't know how I can relax a bit. And so in front of people you do

feel as though you've sort of put on a brave face or put on a face
(Alex: Int. 1, p. 18).

The body awareness expressed in the words of Roz, Tina, Penny and Alex cannot be separated from their perceptions of how the world perceives them. Consequently, they experience embarrassment because they are revealing a loss of control over their bodies. The third component of loss-of-control-over-the-body is unexpected-feelings-and-emotions.

In the minds of many women and doctors, there is an association between the menopause and deterioration in a women's mental capacity, her ability to reason, and her feeling of well-being (Llewellyn-Jones & Abraham, 1988). Research does not, however, offer a definitive answer as to whether there is a link between menopause and depression. An editorial which appeared in the *Menopause Digest* (1996, p. 6-7), written by Dr J. Studd, states that depression is twice as common in women than men, yet acknowledges that there is no evidence that depression is a result of low oestrogen levels. In spite of this, he recommends the prescribing of oestrogen over antidepressants. On the other hand, Carter and Fink (1994, p. 82) suggest that women may blame feelings of depression on the menopause because "these feelings may be precipitated by the serious and legitimate losses centering on the 40-60 year period". The Manitoba Project, in a re-examination of the link between menopause and depression, suggests that the social losses of midlife coupled with a woman's health, rather than hormonal changes, may trigger her depression (Kaufert, Gilbert & Tate, 1992).

However, many women do experience a range of emotions during the menopause. The following stories of three of the women in this present study revealed that this was for them a time of unexpected-feelings-and-emotions. Their narratives portray a wide range of experiences. Tina shares her feelings:

I wanted to divorce my husband. I wanted to get rid of him. I wanted to go out on my own to do the things that I wanted to do, as I felt my family had grown up, so there was really no point in staying together for the sake of that. I thought I could do it on my own as well (Tina: Int. 1, p. 4).

There is an inchoate longing in Tina's words that wants to give expression to itself, to break out and be true to itself. On the other hand Lynn experienced an overwhelming sense of having lost herself.

I think I'd lost myself. I really had. Because I really wasn't the person I used to be. ... I mean it wasn't until later on that I realised that I hadn't been behaving like my normal self, you know. ... didn't have confidence to talk to anybody. I just didn't feel I could speak to anybody without condemning them, or being, you know, being very negative about things .../... Yes well, I had no confidence in myself (Lynn: Int. 1, p. 10).

In her third interview, Lynn returns to these feelings and reveals that she was trying to find a way of getting the body she knew back on track, and thus reclaim her normal self.

I was trying to find some way out of it. Some way of sort of ... (When you say out of it, what is it?). Well out of these awful feelings I was having. Not knowing and trying to find myself again. And to put my body back on the right track again. Really, I suppose. ... In my mind. My whole self on the right track really. I suppose it was mostly emotional and mentally to get back onto the right track because I knew my body couldn't get any younger. But yes, so I wasn't too bothered about that. It was just the way I was feeling and I just couldn't handle the way, the way I was any more (Lynn: Int. 3, p. 12).

These feelings ruptured Lynn's ability to negotiate her world. She had experienced a deep loss-of-control-over-the-body and felt she could no longer handle the way she was. While she fought to return to her old self, her being wanted to be something else. The same sense of loss of the familiar self is echoed in the words of Alex.

I feel as though somehow or other that I'm not myself. I'm not me any more. Now whether it's the menopause, whether it's the tablets that are stopping me, I have no idea (Alex: Int. 2, p. 5).

Both Lynn and Alex experienced a sense of having lost themselves. Authors from the popular press such as Estes (1993) and Kenton (1995) would consider the cluster of experiences described by Lynn and Alex as examples of soul loss. Kenton describes this as "the sense that we cannot see who we are, that somehow we have lost a crucial

part of ourselves which provides us with creativity, with vitality or with a sense of meaning in our lives” (1995, p. 218). Both Estes and Kenton refer to classical Jungian psychology which emphasizes that soul loss occurs around the time of menopause, between the ages of 35 and 50. Throughout her life a woman does her duty to her family and community, but her inner voice that says she would rather be doing something else is ignored. Thus over time her soul voice shrinks until she can barely hear the words. Although Kenton emphasizes that there are many different experiences of soul loss, each woman is faced with the same challenge of healing “the internal split that has occurred between herself and her own feminine nature” (1995, p. 219).

Although the anecdotes of Tina, Lynn and Alex express emotions different from one another, the dominant threads running through them reflect the unexpectedness of the feelings and the lack of a meaningful context. Benner and Wrubel (1989), referring to Heidegger’s work, state that “a person is a self-interpreting being, that is, the person does not come into the world predefined but becomes defined in the course of living a life” (p.41) and “people as embodied intelligences are able to live in the world and recognize it as their world, a world of meaning” (p.44). When embodied intelligence is ruptured by body changes and we cannot recognize what we have become, we are no longer situated in a meaningful context. There develops an overwhelming sense of having lost oneself as is seen in Lynn’s story.

Within modern Western culture there are no special rituals that make sense of these experiences and enable women to give positive expression to that which desires to show itself. The menopause and our responses to it are to be concealed; we are expected to carry on with our lives as usual. This is not so in all cultures; in certain societies restrictions are lifted and post-menopausal women become engaged in activities which give them considerable power in the community (Hall & Jacobs, 1994). These authors refer to Maori and Kung! women, who take up extended roles once they reach the menopause. For example, Maori women become the formal mourners at tangi (funerals). Hall and Jacobs also observe that “women in traditional societies (such as Kung! women) do not usually experience any symptoms, other than cessation of bleeding, at menopause” (1994, p. 156). The reasons for these differences

between women from traditional societies and Western women are not as yet truly understood and need further research.

The idea of the menopause as a time when old unfinished business surfaces again is supported by Hall and Jacobs (1994). Particular reference is made to sexual abuse. On the other hand, Northrup (1995) states that during the time of the menopause “we may find ourselves grieving for losses never fully grieved” (p.437). Kelsea in Taylor and Sumrall (1991, p. 151) succinctly captures this experience in the following, “At menopause life can turn into one long pre-menstrual experience. Hormones slap you up against the doors of your unfinished business” In the present study, Elizabeth, who had had a traumatic childhood, found that during the menopause years unfinished business from this earlier time surfaced. She sought counseling and started what she called her “healing work”. Elizabeth read the following poem to me over the telephone one day and then gave me a copy for inclusion in this study. The journey from blackness to new beginnings can be heard in Elizabeth’s words.

Shame

*That blackness that has permeated my soul for years,
It is like you have possessed and tormented me as far back as I can
remember.
You are not me, you are not my Being.
You have tricked me into believing that you were.
I am now starting to feel you leave, the
oppressiveness of not even knowing that you
were there and what you meant.
It has been a trick, a cruel untruth.
You have let me believe that you were me,
the pain and humiliation you have created
by damaging my soul and living there so long.
And to think you were never mine, I took it on
not knowing there was anything else.
I now know you don't belong to me and can break your tenure.
By asking for God's help and believing that my soul was always in the Light
and never in the Dark.
To follow the path of a wholesome spiritual being,
and that my journey is to be one of Love, Light and Joy,
I bid you farewell so I can start my journey
anew of whom I truly am.*

The menopause is seen by Northrup (1995) as a “time of moving into the wisdom years” (p. 437). The work that Elizabeth is doing reveals that she is moving towards wisdom by discovering a new understanding of herself.

When talking about the menopause, we frequently use words that depict something is changing or that the woman is going through a transition, yet we do not, in our culture, clearly identify what it is a transition to. And sadly, because of the negativity that surrounds menopause and ageing, many women experience difficulty in accommodating their changing bodies.

How the participants perceive their changing bodies and cope with them varies, but always there is a comparing-of-the-present-body-with-the-past-body. These perceptions are voiced in terms of what they in the past could do, and how they looked. Some participants moved easily into the present body feeling “I’m still attractive”, while others not at-home in, or accepting of, the new body, referred more frequently to how the body was in past times. Alex’s experiences illustrate the latter:

In the last six months I’ve really felt as though I was old, but I didn’t want to be told that I was old. I know I’m getting older. I know that life is sort of, you know, if I can’t live life to the full I’m going to lose it. But I don’t want to be told I’m old. I still want, I want my youth. I mean I don’t look in the mirror now. I’m big! I know I’m big. But I over-indulge on peanuts. But I don’t actually look in the mirror. I look to do my hair but I don’t look at anything else. I never see it (Alex: Int. 1, p. 11).

For Alex the present body as seen in the mirror is so altered that she cannot see the “me” she knew. Brown (1994, p. 77), in her study of midlife women, refers to a “searching for the self that was”. This is perceived by Brown as part of reflecting on the changes experienced at midlife “in search for the self that was and a coming to terms with the self that is” (p. 77).

For Alex and Lynn, who experienced particularly troublesome body changes over a prolonged period, there was an overwhelming sense of having lost an integral part of themselves. For Lynn this realization came afterwards, and was experienced as loss of

ability to interact with others. *"I was a nobody. I was just a nobody. I'd lost all my self-confidence. I couldn't even speak to anybody"* (Lynn: Int. 3, p. 8).

In phenomenology the body is seen as embracing two distinct layers, the habitual body and the present body. The habitual or past body acquires ways of relating to the world; it gives structure to one's situation. Thus the body with its two layers forms the meeting place of past, present and future (Langer, 1989, p. 32). The stories of Alex, Lynn and Elizabeth suggest that, when the flow between past and present experiences becomes difficult or painful the self becomes lost.

Deciding-what-to-do

A key element of the phenomenological view of the person is concern. It is what concerns us that accounts for why we do things and why we make particular choices (Benner and Wrubel, 1989). Mostly these concerns are not readily conscious and are revealed through our actions in response to situations (Chesla, 1995). It was the narratives of the women reflecting upon their experiences that suggested what mattered to them and why particular decisions were made. Deciding-what-to-do is the third subtheme of this chapter which focuses on *living-with-a-changing-body*. In the section which follows I will discuss why some women decided to initially cope with things themselves, and why others sought medical help.

Lynn, a strong advocate of the natural way, initially tried a number of natural remedies such as 'Golden Seal', a herbal treatment (not usually taken for menopausal problems) to deal with her erratic periods and hot sweats. This appeared to help her, but there came a time when everything became too much. She was experiencing great difficulty in negotiating her life and her relationships. So she sought medical help.

Well having gone, as I said, through the whole gamut and nothing seemed to be working and my moods were so terrible, I was almost unbearable to live with I think, Steve (husband) said he was getting to the end of his tether after all this time, and he didn't tell me until I asked him afterwards. But I felt myself I was moody, I was up and down like a yo-yo And then having these awful, - yeah - hot flushes. They were coming every quarter of an hour so I was constantly in a sweat the whole time. I mean I'd just suddenly go

out and another wave would come and it seemed to me every quarter of an hour. It went from being sort of two and three a day and it gradually increased and increased until it was - and I just went to the doctor and said look you're going to have to do something. I cannot go on like this. But I know a lot of it was stress (Lynn: Int. 2, p. 5-6).

Lynn has experienced an ongoing battle between wanting to handle the menopause naturally (using diet, exercise and herbal remedies) and seeking medical help in order to gain some control over her body. I will return to these conflicting concerns in the next chapter when discussing the subtheme watchful-wariness of the body.

For some women deciding-what-to-do was an ongoing experience, as was the case for Pat. Initially she thought the menopause a breeze, as the stopping of periods did not cause her concern. However, with the onset of hot flushes her concerns changed, moving her to seek medical assistance.

And I thought, Oh well, if this is the menopause, what's the problem. Why do all these women moan about all the problems they go through. Because that's all that happened. My periods just stopped. No other symptoms. I thought, this is a breeze. And that was fine for about four or five months I suppose and then I started getting these hot sweats. Couldn't sleep. Used to get very bad tempered. At the time I didn't realise that this is what it was. Because it wasn't, it didn't happen all the time. ... mainly the reason that made me go to the doctor was not being able to sleep and the hot, hot flushes (Pat: Int. 1, p. 4).

Later during this first interview, while talking about her mother, Pat brought up a deeper concern that was a part of why she sought medical help.

... one of the other reasons I went to the Doctor about the menopause was I remember her (mother) telling me about my Grandma. Now when my Grandma went through the menopause she lost all her hair. Every patch of body hair, she lost. She went completely bald. She lost her eye lashes, eye brows. You know. She lost all her hair. It did grow back, when it grew back it was pure white. She used to be my colouring and I am very much like my Grandma and my Grandma was like me, you know, fairly well built and one of these big bosomy Grandma's that sort of enveloped you in a hug. And that was one thing that worried me. Because I've heard these things skip generations. I thought, Oh, I hope that's

not going to happen to me and I broached the subject with my doctor (Pat: Int. 1, p. 4).

Pat was deeply concerned about her likelihood of also experiencing total hair loss because of her physical likeness to her Grandmother. It is these two concerns of total hair loss and the disruptive nature of the hot flushes that moved her to seek medical solutions.

Another example of the power of an image that reaches through several generations to create concern and direct deciding-what-to-do is illustrated in the experience of Elizabeth.

Because my grandmother developed a hunched back. My mother is an asthmatic, so she of course, has sort of got a hunched back and she made the comment then that it appears to be in our family and suggested ages ago that I take calcium tablets or do something about it ... so that's my main reason (Elizabeth: Int. 3, p. 3).

Although we are daughters of generations of silent women and know little about what happened to women, (especially those of our foremothers), the stories that are remembered shape our concerns and are recalled when we enter our menopause. Most families have myths about menstruation and menopause that are handed down. I can recall from my own childhood the hushed tones between my grandmother and her sister when talking about how some woman was at “that age” and had gone “queer” because she was going through “the change”. Through my child eyes I would gaze at this woman to see what had changed. Then in my teens, the mother of a girlfriend suddenly disappeared because of “woman’s problems”. Nobody would talk about it, but years later I found that she had been admitted to a Psychiatric Unit. These are some of the stories that escaped the silence around me, and fitted alongside the stories of the women in the present study.

Needing-to-really-talk

Our lives are filled with talk, so in what sense does real talk differ from this everyday talk? Van Manen (1990) refers to an incident where his mother, on leaving from a visit, says to him “we haven’t really talked” and he knew exactly what she meant. Van

Manen's anecdote implies a two way process, that when one really talks, another really listens. Harris (1996) suggests that our everyday patterns of listening are thin, in that we pay little attention to much of it. Then a certain tone captures our attention and our thick listening is activated. Thus the strong desire of needing-to-really-talk expressed by some of the women suggests that there were few listeners willing to become thick listeners. However, we are reminded by van Manen that, from a phenomenological view, to get closer to understanding real talk is not to treat it as a problem to be solved "but as a question of meaning to be inquired into" (1990, p. 24).

The need of the women, whose stories are reported here, to really talk about what was happening to them was partly met by becoming research participants. This, for me, was an experience that invoked an unforeseen insight. Qualitative research requires thick data, that which is rich in the phenomenon being studied. The process of gathering this requires a level of listening - thick listening. So the research method met the need of the participants to really talk and be heard.

During my last meeting with Alex, she told me that she had talked to no-one as she had talked to me because I wanted to hear her stories (Fieldnotes, 23/12/96). Alex had found her attempts to really talk blocked by the fact that no one wanted to talk and listen deeply about the menopause. She illustrates this.

You chat to people to try and find more information and they say. Oh yes, you're bound to feel like that. But I suppose they (doctors) are a little bit nonchalant about it because they're probably not going through it either themselves, or if they have gone through menopause it's not the same. You don't talk about it. It's a closed door. And I don't want it to be a closed door (laughter). Because I still feel that we should talk about it. We've got to talk about it (Alex: Int. 1, p. 16).

Needing-to-really-talk means to Alex talking to someone who wants to hear what she has to say. Someone who is experiencing or has experienced the menopause. Reitz (1985) refers to this need as the "search for talk". The experience of really talking means that the teller can give words to their experiences and thus name them. This illustrates the first phenomenological transformation of experience to knowledge as identified by Reinharz (1983), previously referred to in Chapter Three. As a

phenomenological researcher, I create a situation in which the research participants' experiences become available to them in language.

The need to share, to communicate with others about what was happening to her, was also expressed by Mary. Really-talking for Mary involved more than sharing a common experience, but also touching and communicating on a deep almost prayerful level together.

I think we ought to start a little discussion with people in my situation. More so now - I feel there is a need to share their experiences and how they're feeling ... Really talk. Yes. Hold hands together and sort of pray together (Mary: Int. 3, p. 1).

Really-talking and being listened to involves the sharing of our stories and has the potential to heal. Bervig-Valentine (1997) states that the telling of our stories is as important to us as food and water. Stories not only clarify how we feel, helping us to make sense of life, but they act as a catharsis, and most importantly they connect us to one another.

SUMMARY

The stories in this chapter revealed hidden meanings which affected the women's perceptions of their own bodies, lives, and relationships. Within these stories, strains of deep concerns were heard, and thus insights into why certain choices were made became more clear. The impact of having to carry on with life in a culture that does not provide positive images of the menopause was lonely for a number of women. Through the women's narratives, I heard words that are commonly used to name the menopause, depicting that something was changing or in transition, but what the change was to is not clearly identified in Western culture. Clearly, some participants felt deep loneliness during menopause, surrounded by people who did not want to know. In many ways the process of participating in the research became a channel through which some could meet this need. At times the women's stories slipped into parts of mine and there was a synergy of meaning that I needed to express in the form of the following poetic image.

Menopause: Living-with-a-changing body

We know yet we don't want to know before it comes.
 We know it will come, yet the experience of it is unexpected.
 Our world hangs unwanted meanings upon us of ageing,
 and our bodies in the mirror confirm.
 We are daughters of generations of silent women,
 but when our time comes we remember the stories that escaped the
 silence.
 We live in a culture that does not want to hear when we crave to
 really talk.
 And should unfinished business from years ago arise ahhh
 There is no place to accommodate a changing woman.

Van Manen (1996) refers to the power of phenomenological texts where “words may give rise to a poetic image that can move us, inform us pathically and thus leave an effect on us” (p. 5). Thus was my experience as I reflected upon the women’s words describing their changing bodies. I experienced an understanding that was in van Manen words “somehow prediscursive and precognitive and thus less accessible to conceptual and intellectual thought” (1996, p. 5).

This chapter has focused upon the theme that captures the experiences of the women during the onset of the menopause and prior to taking hormone replacement therapy - *living-with-a-changing-body*. I have endeavoured to go beneath the notion of what the menopause is and reveal a “reflective determination and explication of meaning” (van Manen, 1990, p. 77). The essence of *living-with-a-changing-body* during this time was explored, identifying themes and supporting components.

CHAPTER FIVE

BEING-ON-HORMONE-REPLACEMENT-THERAPY

I definitely needed that replacement. I couldn't do without it now. There was a lot of goings on I suppose that I didn't really realise that I was going through, if you know what I mean. There was other things happening in my life. I was busy running a business, I was busy getting a teenager [sic], I was also having another romance. A pretty busy life. (Eve: Int. 1, p. 4).

In the previous chapter, narratives of the women told about their experiences of living with a changing body. Within these stories, concerns about changes of menopause and how they were being experienced emerged. This chapter continues to unfold the stories, as the women experienced *being-on-hormone-replacement-therapy*.

There are five subthemes related to the women's experiences of being on HRT. The first focuses on medical discourses. This subtheme explores the impact of the medical view on the women's reasons for commencing HRT and their expectations of it. For some participants, the experience of receiving conflicting medical information resulted in an ongoing search for the "right doctor". At the same time of data collection, changes were made in prescription costs of HRT. Therefore the impact of ongoing costs emerged as a component of medical discourses.

The second subtheme, rituals-of-taking, revealed how the women incorporated the taking of HRT into their daily lives. Having-periods-again is the third subtheme which affected the seven women who had a natural menopause. For most, this became one of the most troublesome experiences of being-on-hormone-replacement-therapy, especially for those who could not anticipate when a period would occur or for how long it would last. The fourth subtheme, watchful-wariness-of-the-body, is supported by the component taking-a-break from HRT, a practice that varied amongst a number of the participants.

The fifth and final subtheme is being-in-control and being-controlled. Hormone replacement therapy, while bringing a sense of being in control of one's body and life, also brought an accompanying sense of being controlled for some participants. These five subthemes support the second essential theme of *being-on-hormone-replacement-therapy*.

Medical discourses

The Penguin Dictionary of Sociology (1994, p. 119) defines discourse as "a domain of language-use that is unified by common assumptions". Thus this first subtheme describes the discourses of medicine - ways of talking and thinking about menopause and hormone replacement therapy as experienced by the research participants. However, as this dictionary points out, while discourses may overlap or reinforce each other, they may also conflict. This was very apparent in the women's narratives. Another relevant aspect to the Penguin definition of discourse is that discourses may have a similar effect to that of ideology. "That is, a discourse, as a ready-made way of thinking, can rule out alternative ways of thinking and hence preserve a particular distribution of power" (p. 120).

Undoubtedly the medical discourse influenced the attitudes of the women in this study towards the menopause and how it should be handled. However, while some women unquestioningly accepted medical decisions, others expressed a desire to break from medical treatment and cope with the menopause themselves. This latter aspect will be developed further under the subtheme watchful-wariness of the body.

The responses of general practitioners to the participants experiencing symptoms of menopause were, as the women reported them, as individual as the responses of the women themselves to the menopause and medical treatment. Where the women experienced conflicting medical information or disagreement between doctors, their level of unease increased. Also the experience of having a different doctor each time they went to a medical centre was unsettling for some women. These practitioners were labeled the "supermarket doctors" by one woman. The participants preferred to have continuity when discussing such personal matters as the menopause and how to

cope. However, one of the participants had changed general practitioners, seeking that “right” doctor, six times since the onset of the menopause.

The processes by which the women came to be on HRT varied. However they all had reasons for taking HRT and expectations of what it would do. Thus going-on-HRT - reasons-and-expectations is the first component of medical discourses. As the women recalled their dialogues with the doctors, we hear in their words the medical view of the menopause as a deficiency condition requiring medical intervention. Also heard are the promises portrayed in the pharmaceutical advertisements of not only being in control, but of looking and feeling younger.

Alex, when asked what were her expectations of taking HRT, replied.

To make me feel better in myself. If they are going to make me, I suppose, feel younger (laughter). Yes, I suppose it is really. You don't think of these things until somebody asks you the questions. But you know deep inside you that this is what you're thinking. You know. But, no, hopefully it's going to make me feel younger. I know it won't make me look younger but it's going to make me feel young (Alex: Int. 1, p.13).

Elizabeth, whose underlying concern was to prevent a family trait, a hunched back, from developing did not seek medical assistance until she experienced a lack of energy and was generally not feeling well. Elizabeth continues:

So by February 1987 I had gone two years without a period which meant that, at the age of 42, I hadn't menstruated for two years, which meant then that I had gone through it at a very early age. And then it must be about three years ago, which makes it what, 1993, I went to a doctor, I went to a woman doctor and I said to her that I felt lacking in energy and I didn't feel too good at times, and she said then, you know, asked me my details about the menopause and she said that I had probably denied and deprived myself for eight years of vitality in the sense that because I had gone through the menopause at such an early age. And looking back on it, in 86 or 87 when it was when I came back to this place. I think I went and had some check ups with a consultant and he said yes, that I had definitely ... my ovaries had shrunk. I was definitely menopausal. And he suggested then that I take HRT and I said no on the basis of my having to get period [sic]. Because I'd never had a hysterectomy and I realized that I was going to have to

go back and use tampons and that was the off-putting thought ...but when I went to my GP (the woman doctor referred to above) she sort of laid out the pros and cons. That was when I decided to go on it (Elizabeth: Int. 3, p. 3.).

There were so many other things (personal problems) and I thought well if I can help myself in a physical sense it would help me emotionally as well. But I knew that I had to emotionally clear lots of things because, you know, one counteracts the other (Int. 3, p. 4).

When taking HRT was first suggested by the consultant, the thought of having periods again was so off-putting that Elizabeth refused. However, when her general practitioner used the words 'denied and deprived', she felt that by helping her physical body she would then have the energy to cope with her emotional life problems. The thought that periods would return now seemed of less importance. What concerned her was her difficulty in handling her emotional life, and thus her expectations of HRT were that it would help her physically and consequently support her emotionally.

It was not until a new doctor took over the practice that another participant was introduced to HRT. She had experienced an early menopause at 43 and had lived with ongoing hot flushes for eight years. Del uses the words, "I was put on" suggesting that she had little to do with the decision to take HRT. Del explains.

It really wasn't until my doctor passed away and another doctor took over the practice that I was put on the HRT. ... Well I went for an introductory visit to the new doctor at the same surgery where I had always gone for well over 20 years and I guess through looking through the files, or my files, ..., she asked if I knew anything about HRT and I said no and she gave me a pamphlet to read and she said ... how did I feel about going on a course of the HRT and, I'm open to anything. I'll try anything. And so, and I said yes. You know, I'll have a go, so she said she would give me a course, I think it was for three months, at that period (time), and that's where it started. But of course, I had already stopped menstruating before that - about eight years before that (Del: Int: 1, p. 2-3).

When Del talks about her expectations of HRT, it is in terms of replacing that which the body can no longer make. The impact of the words of the pamphlet published by the drug company are heard in her narrative.

I guess I needed what I wasn't getting, what my body wasn't making. So it had to be replaced. You know, orally. So I decided well, I guess if you're not going to get enough of it from your daily diet or whatever then it's like a supplement of what you're not getting (Del: Int. 1, p. 5).

The marketing material produced by drug companies providing HRT not only influenced how some participants thought about the menopause, but also influenced what type of HRT was prescribed. In Pat's recollection of the doctor's words we hear this influence.

Well I basically told him that, you know, I was having these hot flushes. And I was getting a lot of headaches and couldn't sleep. "Oh, it's your hormones" he says. He's one of these doctors, I don't think he's really sympathetic to women's issues. I mean, he's always very pleasant but he's ... I'm never made to feel as if I'm, you know, a silly woman. But he's one of these guys that "oh it's your hormones". And he, he suggested that I try, he said well I can put you on HRT just to see, you know, see how you go. He said it might not work. We'll have to, we might have to try different kinds, different dosages, because he says, sometimes. I mean, he was very good, he did, ... he did a lot of explaining, explain a lot to me. That some women need different dosages and different kinds of drugs and that possibly the first one he gave me wouldn't work. And we would see how we go. So he, he actually gave me, he must have had some samples from the Reps because he actually gave me a pack. I think it was a month's supply. And a little booklet with them, that obviously came from the rep. He said, well you know, try these, come back and we'll see how you go. And they were good. Whether it was luck or not I don't know but we seemed to hit on the right one straight away (Pat: Int. 1, p. 5).

As Vines (1993, p. 7) states, "a tendency to 'hormonal imbalance' is a defining characteristic of women today - particularly premenstrual women and ageing women". The symptoms of headaches and sleeplessness are not unique to the menopause. In fact, according to a World Health Report (1996, p. 13), "an adequate independent biological marker for the event does not exist". However, there are still those within the medical profession who identify health problems that midlife women experience as being entirely due to the hormonal state of menopause.

There has been research exploring how women make the decision whether or not to use HRT. As previously mentioned, Choi (1993) found in her study that most of the

women made a definitive decision about HRT by the time they were postmenopausal. This was not the experience of most of the women who could be classified as postmenopausal in the present study. As the stories illustrate, going on HRT was not always a carefully thought through decision. Alex, now reflecting back on how she came to be on HRT, realizes this.

I mean, now I've just jumped into taking the pills before I knew what I was doing, you know, and I really wished I'd known more about the pills first before I did actually take them. And then I'd have a choice of whether I really wanted them or whether I didn't (Alex: Int. 2, p. 18).

The process was very different for Roz. Her general practitioner of many years respected her ability to understand and provided her with medical information. Roz had had a hysterectomy and total oophorectomy, and had initially tried medical non-hormonal treatment to control her drenching hot flushes. Roz describes the process of how she made the decision to take HRT.

We tried, as I said, we'd tried the non-hormonal treatment and it wasn't helping at all really so he, he was very good though, he gave me quite a lot of literature to read and ... Some of it was quite heavy reading. I think that a lot of people would have looked at it and thought "I don't think I'd bother wading my way through this". A lot of statistics and you know, typical medical type book. But it was very good and you know, I thought he was very good to sort of, consider his patients enough to do that type of thing rather than just saying, oh well, we'll try you on HRT. You know. And he gave me the option. He said, you must make the decision and ... because we do have an incidence, I've had two sisters with breast cancer. So there is a strong incidence of breast cancer in the family. So he said, well you know, you have to make an informed decision by yourself whether you want to do this. And so I, you know, I thought about it quite carefully at the time. I didn't rush into a decision by any means. And, so he told me to try it and I certainly have found it beneficial (Roz: Int. 1, p. 3.)

Roz and her doctor treated the decision to go onto HRT as hers. With her experience of cervical cancer and family history of breast cancer it was made clear that it would be her decision. Vines (1993), refers to the medical trend of "letting the woman decide" as throwing the responsibility back to the market place. The reports provided for Roz to base her decision upon were described by her as medical and statistical.

Reports based upon qualitative data were not provided for her. When asked what her expectations of HRT were, Roz responded.

I don't expect what a lot of people have mentioned to me but ... (What are those things?) Oh your skin and your hair and you know, outwardly, physically, but, I didn't actually have the expectations to start with. All I was interested to see was whether it was going to control the hot flushes and so I could keep that part of my life in order as such. And it's done that extremely well (Roz: Int. 1, p.8.)

Roz was one of the few participants whose doctor had discussed with her how long it would be necessary to take HRT. He explained. “*You know you may be looking at doing this until you are 60 - 64 roughly. You know, you have to be aware that this is quite a long term commitment*” (Roz: Int. 1, p. 9). However, for the other participants, they did not know how long they were meant to be taking HRT, and when asked responded, “Oh, I haven't thought about that, I'll ask the doctor next time”. There was a silence, a taken-for-grantedness that this was in the hands of the doctor. As van Manen (1990) states, “nothing is so silent as that which is taken-for-granted or self-evident” (p. 112).

Not all participants experienced doctors who were advocates of or prepared to prescribe HRT. Since the onset of the menopause some 20 years ago Lynn had been to six doctors seeking help. The following anecdotes capture Lynn's experience of medical discourses.

The first doctor, he wouldn't give me anything. And he talked to me about hormone therapy and I really, had read up quite a lot about it myself, and I didn't ... I was a bit scared about the cancer sort of side of it and I didn't want to go on to it because I didn't believe in drugs if I could possibly avoid them (Lynn: Int. 1, p. 4).

Well, at first it was to try to get them to put me on, to give me some miracle cure, but although I didn't want the HRT I wanted them to give it to me. So I was split in half really. I wanted something to help me but I wasn't really too happy about all of it. The doctors just refused to give it to me (Lynn: Int. 1, p. 22.)

Lynn sought something that medical science could not give her - a natural means of overcoming the life-disrupting body changes she experienced.

The third doctor who prescribed natural remedies helped Lynn for a while, but when the body changes became more disruptive she went back to him.

So I went back and I said I just can't go on like this any longer and that's when .. and he knew I was just going to sit there until he gave me what I wanted (Lynn: Int. 1, p. 9).

I had to try the HRT as the natural things didn't seem to work. And he didn't agree. And he said, well if you do you know, your periods will come back. And I said I never thought I'd see the day when I'd be glad to have my periods back but I'd rather have my periods back than go through what I've been going through over the last number of years. So he got in touch with (the specialist) at the time and he rang him up and he had a chat to him and, cause he hadn't sort of had much to do with the menopause, so that was good. It seemed to work a little bit with the sweats but it didn't change my moods. It didn't help that time at all. I thought, well, I'm not supposed to have oestrogen naturally, you get the progesterone as well, so why not have the progesterone too. So I talked to him about that. He said OK, all right let's try it (Lynn: Int. 1, p. 9).

All these stories show how the experience of going-on-HRT - reasons-and-expectations, differs from woman to woman. Also heard in the stories are the different views the doctors have on prescribing HRT. Conflicting information, the second component of medical discourses, was part of Lynn's frequent changing of doctors. In the end she didn't know where to get help. Lynn explains.

I didn't know where to get the help from. And of course I didn't get it from one and then all, they have all got different opinions, they have all got different sort of access to experiences and I thought, Oh well I'd better try a different one (Lynn: Int. 1, p. 22).

Logothetis (1993, p. 124) states that "when women are exposed to such conflicting recommendations, the question of the impact on their ability to make informed decisions about HRT immediately arises". The impact of conflicting information is apparent in the words of Alex. Her story describes how she was prescribed HRT and her ongoing dilemma of what will happen if she continues and what will happen if she stops.

When the doctor first put you on hormone replacement therapy, what was the kind of discussion that took place? *None. Just a sort of try these, they'll correct it. (Correct what?). Well, correct, well as far as I understood it, just your hot flushes or ... your periods or whatever. I really didn't know much about it. The only thing, I do know about it is the fact that I either die of heart attack if I don't take them, at 70, or I die of cancer because of having them. (Alex: Int. 1, 9). ... Who do I go to? What do I do? Do I carry on and get cancer? Do I go off them, you know, and get heart problems? (Alex: Int. 1, p. 11).*

Alex, when asked whether she had discussed these feelings with her doctor, replied:

I've never come across one that you can talk to. You come against people and you start talking to people because they're not even interested half the time. I mean a doctor is a doctor and wants to give you a few pills anyway. And you know this. Oh, say I know this. Not you know this, I know this. You say you don't want pills and they say well I think you'd better take them. So then the Government turns round and says well, we can't afford to give them to you now after you've got used to them. ... I don't like taking pills, but then I think to myself, Ohh, I'm going batty, so I must have something (Alex: Int. 2, p.12).

Those women who did not respond to the different brands of HRT as medically anticipated were prescribed other medications or treatments. Alex was told she would be a good candidate for a hysterectomy. However, Alex did not want this. *"I know it would be all over if I went for a hysterectomy, but I don't want one"* (Int. 1, p. 3). When asked why she didn't want one, Alex replied.

Because I don't believe in being cut around for no particular reason. And when you've got a ...when you go through the menopause I do agree to the fact that you know, it's going to end sooner or later ... and all I get told is that you're a good candidate to having a, for like the hysterectomy (Alex: Int. 2, p. 3).

Underneath Alex believes her problems will eventually self correct, and does not want to commit herself to the finality of surgery. Where moods continued to be an ongoing problem and did not respond to HRT, anti-depressants were prescribed. For the two women who did take these for a short time, the experience was not a successful one. In Alex's case she started to doubt her ability to know her body, and put her responses to HRT and Prozac down to her own imagination. *"And I don't know*

whether it's the Prozac, the hormone pills or whether it's my own imagination because I'm on the pills" (Int. 2, p. 9). As discussed later in this chapter, where a participant did not respond as medically anticipated, she tended to become caught up in an ongoing mix of medications and treatments, each with its own complex implications. Coney (1994, p. 257-258) suggests that this situation is "one of the hidden dangers of HRT. ... The first intervention - the HRT - has led to more interventions, more drugs, and more tests. The effects of multiple medications are not well known".

Today millions of women face the decision whether or not to use HRT. The women in the present study revealed that this is not just a medical decision nor is it a definitive one. For some women this decision can become the source of an ongoing dilemma, fuelled by conflicting medical views and the women's concerns.

Finding the right doctor was also part of the experience of medical discourses. A number of research participants at some time asked me whether I knew of a good doctor. I adhered to the ethical standards as set out in the research proposal: that should I, as the researcher, at anytime identify that the health of any participant was at risk, as a result of HRT and how they were using it, only then would I advise the participant to seek the advice of their medical or other health practitioner or a second opinion as appropriate. Thus I considered it not appropriate as a researcher to recommend individual doctors. Through the women's stories it was apparent that women do check out which doctor is the most helpful and tell others. Alex illustrates.

So I'm just debating, I mean I keep being told that go and see another doctor, go and see another doctor but you don't know whether it's worth going to see another doctor. Whether you are going to be any better off. You know. Better the devil you know. I mean she's nice. And you get ... when you've got a doctor, I think you have got to put your trust in your doctor. The doctor then, you can't flit from him to her to him to her because I don't feel it's doing you any good. Because they don't know who you are, what you are, where you've been, where you haven't been, what you've had wrong with you. And that's something I don't agree with. I feel if you go to that doctor you should really stay there. Because they can understand you better, sometimes. I don't say it always works that way (laughter) (Alex: Int. 2, p. 13).

Not only did the medical concepts impact on the women, but the nature of the relationship between the doctor and the women influenced the way the women thought about themselves and the menopause. Once on HRT, the women experienced ongoing medical discourses involved in the obtaining of prescriptions, and undergoing regular medical checkups. The decision to take HRT meant these medical discourses will continue into an indefinite future.

In this present study the medical costs of obtaining a prescription for HRT was not a major concern for most of the women. However, for one participant on a reduced retirement income, costs became a concern when she received a letter from the pharmaceutical company which manufactured the HRT she was on. The letter advised her that, due to the withdrawal of subsidies on the cost of hormone replacement therapy patches by PHARMAC (the Government pharmaceutical purchasing agency), she “may have to pay an additional monthly charge of approximately \$12.00 over and above the standard prescription fee” (dated 2 December 1996). However, if she had certain medical conditions, her doctor would be able to organize that she be exempted from paying this additional charge. The impact was such that when her prescription finished she decided, after approximately four years of being on HRT and at 61 years of age, she would now stop using the patches. Penny experienced a return of the drenching hot flushes and, fearful that the ‘moods’ would also return, went back onto the patches. In an effort to cut costs, Penny also sustained the extra cost of getting her doctor to check out whether she had one of the following exempted conditions, high blood pressure which is adversely affected by oestrogen tablet treatment, high levels of triglycerides in the blood, or liver problems.

Penny continues the story.

Just for \$12.00 I went off it for a week. It was amazing. I decided I'd pay the \$12.00 (Penny: Int. 3, p. 15).

By the end of the week - I thought why am I like this? And I thought, well my God, it's going to get worse and worse. So I went straight back on the patches thank you. I just couldn't go through that again (Penny: Int. 3, p. 8).

What lies at the core of this experience? It wasn't just the ongoing financial costs; it was the discovery for Penny that she could not do without the HRT patches. Life without HRT was unlivable and with HRT increasingly expensive. The return of the body problems experienced prior to the use of HRT will be explored further in this chapter under the sub-theme watchful-wariness of the body.

The impact of medical discourses on midlife women and their decisions about HRT is considerable. There is a vulnerability to certain words that depict body deficiency, deprivation, and ageing. A conversation with an acquaintance (Raewyn is her pseudonym) illustrated this. The impact of the doctor's words were such that she wrote them down. Raewyn continues.

Approximately August 1996 - went to doctor for another reason and had blood sample taken for cholesterol. Doctor mentioned we may as well check for 'other things' at the same time and a tick was put in the box to check on 'time of life.' This led to a very short conversation about how I considered I was going through menopause - at that stage getting slight night sweats but had had suspicions for approximately three years with "things different". We then had a short discussion on HRT and my doctor (and he's lovely) passed a comment to the fact that he finds the women who go on HRT are 'WITH IT, ACTIVE AND MODERN AND HAVE A STRONG DESIRE TO STAY WITHIN THIS WORLD' (emphasis Raewyn's). (Fieldnotes).

This medical discourse created a dilemma for Raewyn. After viewing a video and the literature provided by the doctor, she is in a place where she doesn't know what to do. Prior to this dialogue she had been living with her body changes and had not found them sufficiently disruptive to approach her doctor for help. Raewyn shares her dilemma.

He gave me a video and literature to read - all very pro-HRT - and I'm sure would give me the time to discuss any queries I might have if I required it. He was really very good and explained what was happening to the body but that comment (above) really stuck - my immediate reaction was 'help - I'm going to be old - mentally and physically if I don't go on it. I think perhaps an unwise choice of words on his part - but then he may be right. Who knows. (Raewyn: fieldnotes).

As Raewyn interpreted them, the words of the doctor suggest that HRT is the only means by which the midlife woman can stay in this world as an active modern woman. Not to take it would threaten her ability to be a full participant - she would risk becoming mentally and physically old. This view is the antithesis of a common theme found in women's literature, that menopause is a time of transition - an opportunity for transformation (McCain, 1991). McCain expresses the fear that by changing menopause from a life stage into a medical disease, "we shall lose more than we shall gain" (p. 97). The view of menopause as a time when something is gained rather than lost has little support in Western culture.

Rituals-of-taking

Woven into the experience of *being-on-hormone-replacement-therapy* and flowing from the previous subtheme is the second, rituals-of-taking. Whether the women were taking pills or using patches, they had incorporated them into their daily routines. When their routines were broken, they tended to forget to take their HRT. Sometimes a husband was part of the ritual as in Alex's case.

Never missed a day because my husband makes sure that I don't. Because otherwise I would. (If your husband was away on holiday or not here, do you think - what would you do?). I don't know. Because he puts them on the table for me in the morning and I've got so used to that, or if I'm not at work that morning he'd bring them into my bedroom and that's the first thing I have, is those. Cause when I used to be on the pill (contraceptive) when I was younger he used to have to give them to me at night time because I used to forget it. Because I'm not a pill taker. And I had to get used to taking pills, and ... these if he didn't put them in front of me I'd probably wouldn't bother with them. But I think I would now because I've got so used to them that I think probably things might happen or I might not be, I'm supposed to feel better on these here hormones (Alex: Int. 2, p. 15).

Part of Alex's concern about taking pills was based on her belief that taking pills means you are ill. She also had the ongoing dilemma of taking HRT to prevent heart disease, while fearing it might cause cancer. When asked what she thought would happen if she did forget replied. "*I don't know. I don't know. I really don't. I dread the thought that if I stopped taking them without the doctor's permission ... I don't know what would happen*" (Alex: Int. 2, p. 15). The authority of the medical

discourses dominates Alex's concerns about taking pills, but it doesn't make her concerns go away. Also deep down there is a recognition that in spite of her dislike of taking pills and her dilemma, she has got "used" to them and a whisper of an apprehension is heard that something might happen if she stopped taking HRT. This is something that was hinted at by Penny when she had to decide between financial costs and doing without HRT patches; she realized she could not live without the HRT patches.

Having-periods-again

One of the most negative experiences of *being-on-hormone-replacement-therapy* was the return of periods. Although these were referred to as "induced bleeds" by some of the participants' doctors, they were in the minds of the women "periods". For the seven participants who experienced a natural menopause, the return of periods was a nuisance. Their doctors had explained that their periods would return, but what returned was different to the premenopausal period. Having lived some thirty to thirty-five years with a monthly cycle, their bodies usually knew when a period was coming. However, for most of the women, the anticipated timing of the periods induced by HRT, referred to as "withdrawal bleeding" or "breakthrough bleeding", could only be known by which type of pill they were taking. Their bodies did not experience the familiar premenopausal period sensations they knew. The body that knew when a period was coming is now the body that does not know. Where the body responded, as medically determined to HRT, and the periods could be anticipated, there was a sense of being-in-control. But this was not so for a small group of women, whose bodies responded in an erratic and uncontrollable manner. These women never knew when a period would come, nor for how long it would last. Thus living-with-uncertainty is a component of this subtheme.

Elizabeth, who had regular controlled periods, did, however, experience certain body tensions that told her a period was due. The intensity of these sensations were perceived by her as being related to life stress.

Under my arms, before Christmas last year, I had quite sore [sic] under my arms but I did have a lot of stress. November of last year,

that was when I was doing my course and my daughter was living with me. And I realized that it's probably in the last, or about the 18th day onwards on the pill, that I can feel the build up under my arms. Once my period has come on the pill, it's released and sometimes if I'm really under stress my breasts really hurt. I mean they sort of get sore. In that time, up until the last pill, but they're not as bad at the moment. And the other thing sometimes I can feel is, probably about a week before my period, I can feel my ovaries twitching. I can actually feel pain there. And I get a discharge. Like when, I suppose before when I was menstruating, isn't it, before when I was menstruating (sounds weird), so I've got a discharge back, that I do get occasionally, or prior to my period coming. It's as if perhaps there's still, from the time what would be my ovulation, I still get a discharge (Elizabeth: Int. 3, p. 2).

Elizabeth knew that life stresses influenced how she felt. This was a common thread throughout the interviews. The participants frequently referred to what was happening in their lives, and constantly associated how they experienced the menopause and the negative effects of HRT to life stresses. Ballinger (1990) suggests that there is an interaction between the biochemical changes at menopause and life stress, each exacerbating the other. Therefore it is feasible to suggest that the influence of animal or synthetic hormones - HRT added to the mix, could further exacerbate these interactions. The interweaving of life stresses into their stories bears witness to the fact that the women in this study knew of this relationship, because they had lived it.

The relationship between our lives and how we experience the menopause is also emphasized by Greer (1991), who points out that this connection is consistently ignored by the medical profession. The relationship is apparent in the experience of Pat who had at first responded well to HRT, her periods being controlled, but this changed. However, within the context of Pat's life, her son had returned from overseas, she had moved from a temporary job to a new permanent job, and her husband who had gone through redundancy some years ago remained unemployed. The previous regularly induced HRT bleeds changed their rhythm, as if her body was responding at this time to stronger stresses from her every-day life. Pat shared this during our last interview.

There isn't a pattern. I mean the last time there was only a fortnight. Before that it was something like three weeks. There isn't

a pattern any more. And I told him (the doctor) the last time I went and he said, well keep taking them as you've got them at the moment and see what happens. He didn't seem very concerned. (Can you sense in your body when it's going to come?) No. (Because you usually could with a period?) You could. You know. (But with this you don't.) No. Not really. Nothing that's obvious. No. It just happens (Pat: Int. 2, p. 7).

The dislike of experiencing a return of periods calls up the ongoing dilemma some women experienced as to whether to continue taking HRT. In Eve's story we hear her inner self dialogue. The fear of bone fractures or something unknown happening motivates her to continue with HRT, but in a changed form.

I didn't like it very much at all (the HRT induced periods?). I would say to myself, 'Well, I'm not going to take those tablets', but then I might be sorry mightn't I? I might be asking for more trouble. I might have breaks and goodness knows what going on if I didn't take them apparently. I think I am on the verge of changing what sort of treatment I'm having because I might have to just go on to some sort of form of tablets, perhaps (Eve: Int. 1, p. 6).

Where the periods are continually erratic and heavy, considerable disruption to life is experienced. This inability to control the body means that living-with-uncertainty pervades every facet of life. Alex, who did not respond as medically anticipated to HRT, was situated between the loss of body control which menopause had brought, and loss of body control on HRT. In the following passage Alex talks about “a downer”, a feeling that we can only understand by referring to the situation that is “a downer” for her. Alex continues.

... because you're never sure whether you're going to have a period, whether you're not going to have a period, you think to yourself, OK, I'm fine. And when you don't have a period you think you are fine and then all of a sudden you've got one and then get a 'downer'. You know, you feel as though you're just really down and you think to yourself, now how long is this going to last. Is it going to be a flood. Am I going to have it for two or three days, am I going to have it for 10 days. And you just feel real down. You know, you feel as though life is just sort of passing you by, you can't really do anything. Meaning, when I say you can't really do anything ... if you want to go in the bath, you can't have a nice sit down in the bath or you can't, if you have a shower, you've got to make sure you've got everything on hand and you're still washing

yourself when you come out. (When you say you're having a 'down', is it the physical symptoms of bleeding or are there other things when you're having this down?) Yea. It's the physical symptoms of a ... of a constant bleed that you can't, you've got to pack yourself so well. I mean, it's like having thick nappies on, to go out. You know, so you have to cancel out your, like I cancel out going to fitness because I feel personally, well I couldn't put a pair of trousers on and feel comfortable sitting on them pedal bikes and things like this. You know (Alex: Int. 1. p. 2).

I'm getting them (periods) on and off and it's just so uncomfortable because you think, oh, well, I'd better not do anything this weekend because I've started again. You know. So you really feel as though you want to cancel everything else. (So is this like it's starting to control your life - the bleeding?) Yes. It is. But it is controlling my life. And, I mean, it controls me. Because it controls my sex life, ... because you don't fancy sex anyway. And, you know, I never knew periods could be like this. You know. Make you feel so bad (Alex: Int. 2, p. 2-3).

The claims of the pharmaceutical advertising have not been fulfilled for Alex. Novo Nordisk Pharmaceuticals, in their pamphlet 'Voices of the Menopause', state that "HRT restores the levels of these sex hormones in the body to their premenopausal levels, which is why symptoms, both physical and emotional, are relieved". There is a "promise" that the women will return to the premenopausal state. Alex had been prescribed a variety of HRT brands but had continued to have ongoing problems.

Each experience is embedded with individual meanings, but a common thread running through all these stories is the changed nature of the periods on HRT. It is clear that HRT induced bleeds did not produce the remembered signals of a premenopausal period. Whether these bleeds adhered to the expected rhythm of the HRT or to some other, there were now new rules for periods to be learnt, as all familiar tensions were absent. Where the women, and from their narratives the doctors, talked about the induced bleeds, there was a taken-for-grantedness by the women that the premenopause periods and the periods on HRT would be the same. But it was within the women's stories, both spoken and diaried, that we learn they were not. Premenopausal periods with their well documented accompanying body tensions are a part of being a woman; they are a constant reminder of a woman's fertility. The

women in the present study experienced HRT induced periods differently, and in most cases their bodies were silent, as if the body no longer needed to announce its fertility.

Watchful-wariness

Interwoven into many of these experiences is an underlying anxiety about the body. The women became very watchful of their bodies, checking that they were responding as they should to the HRT. They noted the timing of their periods and whether the duration and amount of blood lost was normal. Without the familiar body tensions associated with pre-menopausal periods, there was a watchful-wariness awaiting the HRT bleed. Mostly it was just an awareness of wetness that told them the period had arrived. Pervading these experiences is the fear of “having an accident” and of making public something that is intensely private. Alex experienced an accident within the privacy of her own home and reflects on the embarrassment she would have felt if it had happened while she was out.

I was sitting in the lounge one day, there was just my husband and I and he said I think you'd better go and change and I hadn't noticed it come though. Just a small patch. Imagine how you'd feel if you was out somewhere (Alex: Int. 2, p. 28).

Watchful-wariness of the body, the fourth subtheme, became one of the repertoire of skills used to protect oneself from the embarrassment of losing control over the body.

The slightest change in the nature of the HRT induced bleeds, even if they remained regular, increased the women's awareness of their bodies. Eve, who had responded well to HRT for approximately a year, started to notice small changes in her periods. These changes increased her level of watchful-wariness of her body.

It's more of like a fresh blood flow. Oh it's a wee bit clotty sometimes. But it's more of a fresh blood flow. Being reminding me, a few times it's been a wee bit heavyish and sort of pains - I've been getting those pains beforehand which I don't like that very much at all. ... And I was just wondering if there might be some activity down at the ovaries or something that's happening down there. I'm sort of waiting to see what's happening (laughter). That's another thing, I must go and get my smear test done again too. They have sent me a note and I must go and do that (Eve: Int. 1, p. 5).

There is the deep unspoken question, 'is there something suspicious going on?' Eve's concerns motivate her to get a cervical smear done and to stop deferring it.

Between the first and second interview, Eve had had her prescription changed to patches and tablets, a combination that did not induce periods. When her body did not fulfill this promise and she experienced erratic periods, she started to wonder about her body, trying to find a reason why this should happen.

Well, I changed my medication. And I literally didn't have a break, I think I should have given it a break. I went straight onto this new medication which is the patches. ... So I don't have to bleed at all. Well, I think about a week, a week and a bit, I was on them. I started to bleed. Just a slight bleed. I didn't stop for three weeks so I took myself off the patches and the tablets. So I thought, Oh well, I've done some damage to myself I did a lot of lifting a while ago ... I was feeling all right. I was just a wee bit sort of apprehensive about why should I be bleeding (Eve: Int. 2, p. 1).

Eve's narrative illustrates both a watchful-wariness and the resulting action of taking-a-break. Taking-a-break is a component of watchful-wariness and will be developed further in this discussion.

Changes other than those relating to periods were also experienced. These made the women very watchful of their bodies, and as in Tina's case she observed her moods in relation to each coloured pill in the HRT cycle. Tina was concerned by her moods. Her husband had told her that for one week every month she was negative and argumentative. Tina illustrates.

But even that is not consistent because I kept track of it last month and it was when I was on to the third blue one, that's when I felt really negative. Now I'm on to the third or the fourth today, and I mean, no I feel as good as gold. And before that it was when I was taking the white ones. That was the last of the set. So I don't - if it has anything to do with ... I mean you look for reasons why you feel this way ... and then you think, oh well I miss my friends. I talk to them on the phone and they tell me things about what has happened there and I think, Oh I wish I was there (Tina: Int. 2, p. 1).

Tina stands on the outside of the situation and reflects in order to understand and know why these moods are occurring. Benner and Wrubel (1989) suggest that whenever one stands outside of a situation, one is in a reflective position. This enables Tina to interpret what she is experiencing and to give it meaning. However, in situations where the body did not respond as medically expected to HRT, a number of the women stopped taking it. Stress is defined here “as the result of the person’s grasp of the meaning of a situation for the self when that meaning conveys challenge, loss, threat, or harm” (Benner & Wrubel, 1989, p. 59). Thus taking-a-break supports the subtheme watchful-wariness of the body and was the response of these women to their anxieties about their bodies and HRT. Benner and Wrubel (1989, p. 48) further suggest that “the person through concern is involved.” The woman, as a self-interpreting being, understands her world in light of her concerns, and what threatens her concerns also threatens the woman. Therefore it is through gathering together the women’s narratives that we move closer to the meaning of the experience of *being-on-hormone-replacement-therapy*.

Tina shared that she was thinking of coming off HRT and trying natural ways of coping. When asked why she was searching for something else, she responded.

Well something that ... maybe the moods that I have for the couple of days - sometimes three or four days ... maybe it has something to do with the HRT. So if I try something else, then I might be ... like I am going to try tomorrow night. I'm going to meditation. See if that would ... I mean anything to make you feel happy and ... just content. So I'm trying. You spoke last time where you had taken yourself off (HRT) a couple of days. Yes. How often do you do that? Oh, I'd do it a couple of times a month. Why do you do that? Because sometimes I think I should not put all that stuff in my body (Tina: Int. 2, p. 6-7).

When initially making her decision to go on HRT Tina carefully considered the material provided by the nurses at the medical centre and sought the most natural one. “... some came from animals and that did not appeal to me at all. So I said I want to have a natural one. Well as natural as possible” (Tina: Int. 1, p. 2). At our last meeting, Tina shared with me two articles by Sherrill Sellman (1996), which her son had located on the Internet, titled ‘Hormone Heresy Oestrogen’s Deadly Truth Part 1

and 2'. The combination of her deep anxiety about putting unnatural things into her body and the message in these articles had led Tina to the decision that when her present HRT prescription ended she was going to talk to a naturopath. What threatened Tina's concerns, threatened her. Leonard (1989, p. 46) states that "to understand a person's behaviour or expressions one has to study the person in context. For it is only in context that what a person values and finds significant shows up".

The frequency of taking a break from HRT for these women is not known. It was something they did every now and then, when they became anxious about the biological or financial implications of taking hormones. However, when the effects of taking a break, an exacerbation of menopausal symptoms, threatened the woman's ability to maintain her life and live comfortably with her body, she resumed HRT. Previously, under the first subtheme medical discourses, I referred to Penny's experience of taking-a-break, due to the increasing financial costs of her HRT prescription. However, when the drenching hot flushes returned, Penny feared that perhaps the other problems she had experienced in the years between her hysterectomy and being prescribed HRT would return. These concerns overcame the financial concern motivating her to resume HRT patches. Penny describes this experience.

And then I wondered if I was going to do the highs and the lows again. Instead of staying even. The even, you still get highs and lows but you cope with it. They're just little ones. Yes. I don't want that either. Thank you. Not living alone and you know you can get depressed enough sometimes without having to have a body that makes you go into depression as well. That's a strange thing to say. (tell me more about that - a body that makes you go into depression). Well I don't understand what I'm saying (Penny: Int. 3, p. 9).

Here Penny recalls a "memory" that had not been thought before. Van Manen (1990, p. 13) challenges us to "discover what lies at the ontological core of our being. So that in the words, or perhaps better, in spite of the words, we find 'memories' that paradoxically we never thought or felt before". Penny expresses the view of her body as being continuous with her person. She reveals a taken-for-grantedness of her body

that, in the words of Benner and Wrubel (1989, p. 53), acknowledges the body as “a way of knowing and as integrated with the mind”. The phenomenological view of the body has profound implications for the care of women during the menopause and will be developed further in the discussion chapter.

How to discontinue HRT, should they wish to, was not discussed between the women and their doctors. The taking of a break was usually done surreptitiously. For those few women who did take breaks longer than a couple of days, the return of the pre HRT problems became intolerable and they resumed HRT. Little literature is available on the experiences of women deciding to stop taking HRT. However, Seaman and Seaman (1978, p. 297), in their research involving oestrogen replacement therapy (ERT), found that while some women who took ERT for a time and then stopped with no aftermath, others experienced only delays of hot flushes not a curing of them. Thus the following questions need to be asked, what happens to a woman’s body when she stops taking HRT, and does HRT merely delay the transition of menopause in some women?

The following narratives illustrate what happened to one of the research participants when she stopped taking HRT for varying periods of time. The return of the pre HRT menopausal problems when stopping HRT had been an ongoing problem for Lynn. In fact Lynn experienced these problems off and on for twenty years. Commencing the menopause at 45 years of age, now at 65 she wonders when it is going to end. Lynn had concerns about the long term effects of HRT. She read widely and was affected by conflicting medical information. Also Lynn believes that menopause is a natural process and she should be able to cope with it naturally. Consequently, over the years she has alternated between HRT and natural remedies, after an initial time of trying to cope with menopause solely by the use of herbal and mineral combinations. The longest time she has taken HRT was for six months. However, when her concerns relating to the effects of HRT troubled her, she would take-a-break from HRT. Sometimes Lynn sought out another doctor trying for a lower dose of HRT. The following is an account from her diary describing what she experienced when she stopped taking HRT.

What happens when I'm not taking HRT? 1st month or 2nd month normally I'm OK except for vaginal drying up - intercourse is painful. Seem to get a lot of headaches - just beginning to tie this in. Also tend to lose good sleep pattern. Wake up in early hours and can't get off again. Fourth to sixth months have sweats when I wake up. This last few weeks I've had to get up and towel off and put on a fresh nightie.... Time to go back on HRT. Can't find the time to go to the doctors so keep putting it off. At last - I've got some again (Lynn: diary).

The relief she experienced when she resumed HRT can be heard in her words. Yet from her interviews and diary we know this will be short lived as she strives to protect her body from perceived harm and takes herself off HRT. When asked why she stopped taking HRT, Lynn responded:

The reasons why I stopped, I suppose, we've been educated to think - the risk of cancer with taking it (HRT) and also I feel that the body should be able to go through its natural evolution without having chemicals pushed into it - because all right natural things perhaps to a certain extent but these were not natural even though they say they're Equine, but still, I mean, what's the horse got that we haven't got. Sort of thing. You know. I mean. Other people say that because it comes from a horse they don't want to take it. And they didn't like the idea of it being taken from a human being really. And me using it. I just didn't want ... I didn't like interfering with the natural course of one's body. (Lynn: Int. 3, p.10).

The medical term used for not adhering to a medical regimen is “poor compliance”. However, such labeling ignores the impact of background meaning and concerns on behaviour. Lynn’s narrative illustrates this. When we view reasons for our behaviour as being part of our ability to understand our world in light of our concerns, the phenomenological view offers new insights into understanding why some women do not continue with HRT as prescribed.

Being-in-control and being-controlled

In this and the previous chapter I have referred to the importance of personal control - being in control of one’s body and life. From the women’s stories it is clear that, in New Zealand culture, personal control is an important part of being an adult. The importance of this is also echoed by Femtran, 3M Pharmaceuticals who promise midlife women that “you stay in control”. There are two underlying assumptions here,

firstly, that menopausal women are out of control and secondly, HRT can manage the menopause by giving self-control.

Benner and Wrubel (1989) suggest that the background meaning of personal control can never be made completely explicit, because of its relationship to what it means to be a person. The disruption and resulting embarrassment of living with a body out of control is explicit in the data. However, as the data were analysed, it became increasingly clear that HRT was seen as giving back control to the women over their bodies and their lives. Being in control meant they could maintain their busy working lives and their relationships. They needed HRT to maintain this control. This “needing” concerned some, as they wondered whether they were “giving in” to or using HRT as a “crutch”. There was a hint of not being able to do without HRT, as heard previously in the stories of Penny and Alex. However, when we further peel away the layers of the women’s experiences, there was more than a sense of control for some participants, there was also a sense of being controlled by HRT. Thus being-in-control and being-controlled is the fifth and final subtheme of *being-on-hormone-replacement-therapy*.

The participants’ descriptions of being-in-control varied. For example, in the following narrative Roz illustrates the need to conceal her hot flushes when in public. She described how she had to do something about them in order to be in control of her body.

I think basically if I hadn't been a working person I think I would have just been prepared to let menopause as such take its natural course. Because it wouldn't have been an embarrassment to me while I was at home and out of the public eye, but it was becoming, (the hot flushes) it was so frequent at work that I just felt that I had to do something (Roz: Int. 1, p. 10).

Roz then approached her doctor, after a non-hormonal medication proved to be ineffective and decided she would start HRT. The promise was fulfilled for Roz and she obtained the control she needed. “*It has let me keep that side of things under control on a moving basis. It was good*” (Roz: Int. 1, p. 10).

Martin's (1987, p. 177) findings support this need to separate work and home when it comes to the embarrassment of revealing the problems of menopause. Martin uses the term hot flashes to describe what the women in this present study referred to as hot flushes.

The general cultural ideology of separation of home and work appears in this material when women are embarrassed at having their menopausal state revealed publicly through hot flashes. As with the hassle of menstruation, women are asked to do what is nearly impossible: keep secret a part of their selves that they cannot help but carry into the public realm and that they often wear blatantly on their faces.

It is important to note that Roz felt that she could have coped if she had not been working. The demands on the lives of this generation of midlife women cannot be overlooked. Many trends have impacted and moulded women's expectations of self to be in control as a wife, a mother, and a career woman. Hormone replacement therapy helps women to maintain the control society asks of them, and to keep hidden the menopausal state from their public face.

An essential part of being in control for some participants was being able "to do it yourself", without having to use HRT. Even after a period of time of taking HRT which had eased their lives, the desire to be in control and not depend upon it would take over. In the following anecdote read to me during the interview from her diary, Pat describes her second attempt to stop taking HRT.

It's a year since I last attempted to stop so decided to give it another go. I have kept one month's supply so that I can go back if necessary. And a week later I started to get hot sweats. Not sure if it's the symptoms recurring or the hot weather. Will carry on and see how things go. Started new job. ... Will persevere without HRT. ... started getting headaches during the middle of last week. Hot sweats still continuing. Will know whether it's the weather or me once the temperature drops. Still not taking HRT but if headaches continue may have to start again (Pat: Int. 2, p. 1-2).

Over a period of one week Pat's problems increased.

Decided to start taking HRT again. Obviously not ready to stop yet. I feel frustrated, thought I would be okay now, been on HRT for two years ... Cooler weather, I don't get as many hot flushes. Was I too hasty in going back on HRT? At that stage I was still - kept thinking I wanted to beat this on my own without having to take tablets. Thinking it could be me and not a physical thing (Pat: Int. 2, p. 2)

Embedded in Pat's experience is a knowing that the problems were not just hormonal but to do with the environment, her life, and how she is situated in it. However, any concerns that Pat did have regarding dependency on HRT were removed by the words of a pharmacist. In the following we hear Pat move away from her concern of using HRT as a crutch, towards accepting that HRT as something she really needs for an indefinite time. Such are the impact of the words used by the pharmacist.

But I was talking to - at one stage when I went to the chemist to get my prescription he gave me a leaflet on the menopause and HRT. And he, he's one of these very chatty chemists and he was saying that - he told me that women who are on this are less likely to have heart attacks and it stops you - it helps prevent osteoporosis. And reading the guff he gave me sort of convinced me I'm not really using it as a crutch. That perhaps it's something that I, you know, I really should carry on taking for a while - until, until whenever (Pat: Int. 2, p. 2).

Such was the influence of the pharmacist that it overwhelmed Pat's concerns about depending upon HRT. Pat now has two more potential health problems, heart disease and osteoporosis, to worry about as well as her concern of being like her grandmother and perhaps experiencing total body hair loss.

When a woman changed and took control of her life relishing in a period-free life filled with energy, those around her could experience some difficulty in coping. Mary, who had a hysterectomy and partial oophorectomy, found that life took off for her after this surgery. She shares her experience.

That's when I was more in control. And no one liked that. Did you like it? Oh yes. I liked it because I was getting somewhere. For me. I seemed to be getting places, doing things. And if my family didn't like it, too bad. It was me. It was my turn (Laughter). Because I had helped my family ever since but if they didn't accept me, then I just

carried on anyway. ... I was wondering why my family were arguing with me. I think it was because I was more powerful. Powerful or more direct with them. As the change took place I couldn't comment couldn't do anything right for that short time and then I got the patches (HRT) and then I sort of calmed down a bit. It was a calming - and now they are all back (the family.) And we're all friends again, including my husband who went the same way as the children. They were involved with their other interests and I wasn't included. Because they just couldn't handle me the way I was. I was traveling all over the place, playing squash here there and everywhere, because I had no problems every month - there was no problem and I was just enjoying life to the full. But that was too fast for them - they liked me like before (Laughter) (Mary: Int. 3, p. 4).

However, this situation changed for Mary; she required surgery for adhesions and the remaining partial ovary was removed. After this, Mary experienced consuming hot flushes and loss of confidence. She also felt that her family sniped at her. *"I felt I was incapable. I couldn't handle them (family) anymore"*. (Int. 3, p. 2). Mary also wrote in her diary that at this time she and her husband were drifting apart *"other people (women) seemed to interest him more"* (Journal, p. 3). Mary sought her doctor and was put on HRT patches, to try them out. When asked what the doctor said to her, Mary responded

He said this might combat the hot flushes you are experiencing - also you'll feel better in yourself. Your partner - you will be more - probably acceptable or, could handle your partner better. Give you more faith in yourself (Mary: Int. 3, p. 2).

In accordance with the management guidelines from The National Advisory Committee on Core Health and Disability Support Services on Hormone Replacement Therapy (1993) and recent medical research (WHO, 1996), Mary's doctor has prescribed appropriate medical treatment for "premature loss of ovarian function" (p. 50). Surgically induced menopause is reported as leading to an early acceleration of bone loss. However, the words Mary recalls do not say this. It is as if the doctor is returning Mary to her pre-menopausal emotional state. This is supported by Roberts (1981) who suggests that when women visited their doctors, "the doctor played a more active part in reconciling women to their traditionally prescribed role" (p. 10). Mary now has returned to the centre of her family. They include her in their lives.

There is no more rushing around, her days focus on matters concerning her husband, her children and grandchildren. Mary is calmer and feels that she has things in control. Control has many subtle faces. The spark of change, that ‘breaking out’, has gone from Mary’s life.

The other side of being-in-control is being-controlled. Where the HRT promise of staying in control was not fulfilled, and ongoing problems were experienced, there was, for one participant, a strong sense of being controlled by the pills. The following narratives taken from two separate interviews with Alex illustrate this.

I always thought I could control myself and while I’m on pills I feel as though the pills are controlling me. I don’t have to control anything. It’s them, so I feel as though the pills are taking charge of my life. I suppose. And that helps me to feel frustrated too. I don’t know whether that’s just me or what it is (Alex: Int. 1, p. 20)

I’m not a scatty person but I do feel, yeah I’m much better without the pills. But that could be because I don’t like taking pills. And I feel that the pills are controlling me. You know, these to me, pills are controlling (Alex: Int. 2, p. 16).

The promise that “you stay in control” has not been a part of Alex’s experience on HRT. And even when she recalls that she felt better without the pills, she continues to take them and searches for reasons within herself as to why she feels they are controlling her. Thus she blames herself for the problems she has experienced. The question, “does HRT have a tendency to cause a physiological and/or psychological dependency in some women?” hovers ominously. According to Bewley and Bewley (1992), the oestrogen in HRT could be a “habit-forming drug”.

SUMMARY

In this chapter the experience of *being-on-hormone-replacement-therapy* reveals itself as a complex tapestry of lived threads that run through the lives of the women. Embracing the phenomenological view of a woman as a self-interpreting being has led to new ways of understanding this experience. Through exploring the deep concerns of the participants as revealed in their stories, new insights into why certain choices

were made have emerged. Why the women chose to take HRT, their reasons and expectations and why some took a break, or sought a different doctor became apparent. Undoubtedly the medical view shaped much of the women's knowledge of menopause and its management. The women's stories illustrated their vulnerability to those words that implied that not to take HRT was to risk becoming less - less of a woman. However, I cannot generalize, because within the medical view are many different and sometimes conflicting views, a situation that added to the dilemma of some participants.

The decision whether to take HRT or not is considered to be an important one for today's midlife woman. It is certainly of great interest to pharmaceutical companies manufacturing HRT and to doctors who desire "treatment compliance". The 1996 World Health Organisation report on the menopause refers to the difficulty in identifying women's preferences. This WHO report further suggests that most women are more concerned about relieving the symptoms of the menopause than exposing themselves to possible long-term risks of taking HRT. However, as the discussion shows, the present study does not support this position and identifies two important issues. First, the decision to take or not to take HRT is not a definitive decision. Secondly, for some women their desire to cope "naturally" and their need to regain some control over their bodies and their lives through taking HRT is at the heart of an on going dilemma. I suggest that it is at the core of this dilemma, that new insights into understanding how the decision is made and why some women comply with medical regimes and others do not, are to be found.

Although the subthemes identified were part of all the participants' experiences of *being-on-hormone-replacement-therapy*, there was individuality in how they were experienced. When we view the menopause and the taking of HRT within the context of the women's lives, we see a little more clearly into the complex interactions of prescribed hormones, individual female physiology, and life stresses. It is also when the body is acknowledged as a knower and the women's taken-for-granted knowing is revealed, that we move towards a better understanding of some of the reasons for individual human responses.

Throughout Chapters Four and Five, the women's stories have referred to their relationships both past and present. The importance of these relationships to the women, as they sought meaning in the experience of menopause and of *being-on-hormone-replacement-therapy*, form the third essential theme, *relationships-past-and-present*. This theme will be explored in the next chapter

CHAPTER SIX

RELATIONSHIPS-PAST-AND-PRESENT

For an individual, background meaning is provided by the culture, subculture, and family to which that person belongs (Benner & Wrubel 1989, p. 46).

When we explore *relationships-past-and-present* we see the extraordinary social changes that have occurred between the generation of today's midlife women and their mothers. Gray (1993) refers to the nature of women's work as having changed the most dramatically. Women have always worked but it is the shift from work in the home to outside paid work that has changed between the generations. Gray (1993, p. 225) states, "instead of replacing one style of work with another, each generation has simply added its own new focus to the one before". This has resulted in many of today's midlife women trying to cope with both work at home and paid work outside the home. The essence of a busy life is captured in Eve's quote at the beginning of the previous chapter, in which she identifies numerous factors in her full life. Thus the self-identified need for hormone replacement therapy by some of the participants in this study cannot be viewed in isolation from the impact of societal demands on today's midlife women.

In the introduction to the three essential themes of this study, in Chapter Four, I referred to how the experiences of *living-with-a-changing-body* and *being-on-hormone-replacement-therapy* influenced relationships, particularly with daughters and husbands. There were also two other relationships that influenced the shape of the women's understanding and experience of menopause. The first was the one between themselves and their mothers, and to a lesser degree the relationship between their mother and father. It is these relationships that compose the third essential theme of *relationships-past-and-present*.

The first subtheme, *remembering-now-how-mother-was-then*, brings together those few recollections of how the participants' mothers were when they went through the

menopause. The participants' stories also revealed how their own experiences of the menopause brought new understanding of what happened to mother. Where there were memories, they acted as markers as to what was to be expected or considered normal. However, dominating these reflections is the power of the silence that occurred between the generations of women on matters concerning the menopause and the body. Hall and Jacobs (1994) refer to the power of these messages from mother in shaping perceptions of menopause.

The second subtheme relates to the women remembering-how-father-was-with-mother, during the time of menopause. Again, in light of their own experiences, they now understand a little more of that time. This leads into the third subtheme living-with-today's-husbands.

The final subtheme that supports *relationships-past-and-present* is today's-daughters. Those participants who had daughters expressed the intention to prepare them for menopause. Where a difficult menopause was experienced and this coincided with a daughter's hormonal upheavals, there were implications for both in later years. All the stories told were not only woven into today's relationships, but moved backwards and forwards through time, covering three generations of women.

Remembering-now-how-mother-was-then

Interwoven into most of the participants' stories were references to how mother was when she 'went through' the menopause. The women's memories of their mother's menopause changed in light of experiencing their own menopause. From a situation of not wanting to know about their mothers' menopause, they now used those memories to make sense of what was happening to them. This changing understanding of past experience is supported by van Manen who states, "the past changes under the pressures and influences of the present" (1990, p. 104). Two components support this subtheme; comparing-self-with-mother and not-knowing-about-things.

Experiences forgotten that unknowingly left their traces were now remembered and heard for the first time. New understandings of what their mothers experienced have

now developed in light of the women's own body changes. Tina illustrates this experience.

I remember her (mother) saying that she was hot and throwing off the blankets and standing in the window and things like that. But it does not really register then. Now I remember these things that she said then (Tina: Int. 2, p. 6).

There was a realization amongst the women participants that they never really listened, and it is only because they are experiencing menopause that they now remember and understand. This comparing of one's own experiences to those of their mothers also gave a sense of what is 'all right' or 'to be expected'. Tina continues.

Because it does not affect you, you never really listen to what they said then. It's only now that it affects you too, or that you are going through the same stage, that you think, oh that's right, yes, my mother said that too. But my mother-in-law said that too. But you never paid any attention (Tina: Int. 2, p. 6).

In making comparisons, there is sometimes a rationalizing of the differences. Eve compares herself with her mother and sees herself as less emotional:

My mother ran away from her husband. Went overseas somewhere. That's what they told me then. That she was going through the menopause. That happened at the time of the menopause? That happened at the time of her menopause. She was a more emotional sort of a person than I was, yes, so that's what she did and my stepfather chased her all round Australia looking for her to get her back and eventually, I think after 6-7 months she did come back. ... She just thought that she'd wanted a change in life and ran off overseas. (Laughter). Yes. I think after that time too she practically came back with her spirit broken. I think. She just came back and did as she was told literally (Eve: Int. 1, p. 9).

Frequently the women's stories would thread through their memories of their mothers' and their own experiences. The images that the women recalled of their mothers' menopause did not make sense when they first observed them, but now in light of their own experience these recollections of unspoken things are linked to their own.

Mary illustrates.

... my mother never spoke - talked - or my aunt and my mother in-law. They didn't talk about these sorts of things. It was a no no subject. ... My mother and my mother in law they used to hide themselves in bed or my mother would be crying a lot. ... I used to cry a lot too. Because I was sort of unhappy inside (Mary: Int. 3, p. 11).

Where there were no memories of mother during this time, or as in most cases, a silence surrounding issues relating to the body, there was a not-knowing-about-things which embraced not only the menopause, but menstruation, sex and childbirth. In Alex's story, there is an embarrassment in the recollections and the telling. Without her own stories to reflect upon, Alex becomes a listener to those of others, and thus listening becomes a way of knowing (Belenky, Clinchy, Goldberger & Tarule, 1986).

I have nobody in the family to share stories with. What I know from scratch, I mean even childbirth or having children. I was eighteen before I knew where a child came from. My mother told me that when I started a period which was when I was just turning ten, that if a man ever touches you now you have to shout and scream for help. So that's as much as I knew about sex, and that's as much as I knew about periods ... But then she died at 41 so I had no - the way I learnt was by listening to people that I was talking to, you know, you just listen. You have to listen otherwise you never know anything (Alex: Int. 1, p. 8).

Alex's sense of not-knowing-about-things is heard again in the words of Penny. *"I never knew anything about childbirth when I went in (to marriage). Yet my mother had five children. You'd think she could have told me something"* (Int. 3, p. 13). There was a silence between many of the women and their mothers, on those things that related to issues of menstrual blood and sexuality. This is supported by Gray (1993) in the story of Peggy. Peggy's mother never told her anything about sex or periods, but silently placed belts, pins, and towels in her drawer. The silence that surrounded this act was so strong that Peggy never asked her mother what they were for.

The nature of the silence that pervaded these issues prevented curiosity. As heard in the stories of Tina and Mary, they did not want to know about their mother's

menopause when they were young. In fact, this not wanting to know carried over into adulthood. Mary recalls an incident where a workmate gave her a book about the menopause to read and she responded. “*Oh no, I won't need that*” (Int. 3, p. 27). She did not touch that book until she was going through the menopause and then wondered why she hadn't read it before. Readiness to be informed about the menopause came when the participants experienced their own body changes. Thus the nature of the silence that hung between mothers and daughters, and female friends, lacked any curiosity and desire to find out about menopause. It was a silence that shouted “you don't want to know about this”.

How much this silent response to menopause flowed over to the subject of HRT can only be assumed. However, it is important to remember that HRT, for this generation of midlife women, is a new thing. These women have no previous generation to look back at as to how to handle HRT.

Remembering-how-father-was-with-mother

The silence that surrounded how mother experienced the menopause is even more pronounced when it comes to how father was during this time. However, some stories were recalled. Again incidents that made no sense in the past, are now, in light of their own life experiences, understood. Penny recalled how she would not have known anything about her mother's menopause unless her father had spoken to her. Penny continues the story.

Well I wouldn't have noticed anything except my father came to me one day - I'd never heard of the menopause ... 'You've got to be nice to your mother, because she's going through the menopause and sometimes doesn't feel well'. And I thought really, I haven't seen her sick in bed. I think that was it. So I don't know how my mother went through it. Because it was well hidden however she felt. ... But she must have had - it must have been something to do with my father, their relationship for him to come and say that (Penny: Int. 3, p. 12).

The silence of her mother's experience is such a barrier that the young Penny does not ask what does the word 'menopause' means. On a deeper level, she intuitively knows that this condition her father is referring to is not to be asked about.

Sometimes certain behaviours that study participants had witnessed between their parents were seen as being connected to their own experiences. When Mary found that she was arguing more with her husband, she remembered that this was so for her parents. Thus there is a linking of experiences between the generations that helps to make sense of the present. Mary illustrates.

... but when I look back at my mother - my mother and father were arguing a lot. A lot more and fighting. And then I sort of used to visit my mother-in-law and they were doing the same thing and that was through the change. Menopause. And I thought well, when I came to my time, we were fighting too. And I thought, it must be a trend (Mary: Int. 3, p. 12).

Very little is recalled of how father was with mother. Gorman and Whitehead (1989) state that the menopause is treated as a joke or an embarrassment by men (p. 118). One participant, Roz, recalls overhearing her husband's friend referring to a woman as a "menopausal old bitch". "*A lot of men tend to look at it on that basis but then it's a bit like saying, - it's just a male insult more than anything else*" (Roz: Int. 2, p. 9). However, when the women spoke of their husband's response to them, it was not in these terms.

Living-with-today's-husbands

In the burst of books on menopause that have been published in the late 1980s and early 1990s, there is usually a small section covering relationships with husbands and partners. The focus tends to be on the problems caused by moodiness, vaginal dryness, and the women's decreasing libido. However, increasing attention is now being given to the changes that men may be experiencing in their own sexual response and behaviour during midlife, as found in Stoppard's (1994) book. One publication, the *Amarant Book of HRT* by Gorman and Whitehead (1989), includes a chapter specifically for men to read about what is happening to their wives or partners. The approach is that women are usually ignorant about their bodies and cannot manage their menopause without the help of men and HRT. The following illustrates this:

It can't be easy to find yourself living with someone who seems to have turned into a perfect stranger - and sometimes not a very pleasant stranger at that. If it is any comfort, she is probably just as

bothered and bewildered as you are. You'd think women would know all about how their bodies work and the interlink between physical and psychological symptoms. But many don't. It is really very simple (Gorman & Whitehead, 1989, p. 117)

The actions that are recommended by Gorman and Whitehead for husbands or partners are twofold. First, be extra loving and reassuring, showing your partner that you realize her mood swings are nothing to do with you but due to her temporary hormonal imbalance. Secondly, encourage your partner to seek assistance from a doctor. The promise is that once she commences regular oestrogen not only will she shortly return to 'normal' but the risk of fractures, heart attacks and strokes will be reduced. Gorman and Whitehead conclude the chapter with the following statement: "When the benefits are so great, and the drawbacks so small, there seems little point hesitating, does there? And it may save your marriage" (1989, p. 120). There is the underlying assumption in both statements that the problem lies within the woman, and that the solution to her well-being is in medical hands, with a little persuasion from her partner. The question 'what is menopause a change to?' is never asked. The aim is to return the woman to normal, her premenopausal state, the implications being that menopause is an abnormal state for a woman. The fact that a woman's ovaries are meant to stop producing hormones is ignored (Hall & Jacobs, 1994).

The experiences of the women participants were that husbands either left things to them or were part of the decision making to take HRT. Sometimes a husband experienced alarm at what his wife was experiencing. Roz relates an incident where her husband witnessed for the first time one of her drenching sweats.

My husband actually found it quite alarming the first time that he saw me have a hot flush. He thought 'God, what the hell's wrong with her'? You know. He thought there was something really serious, and in that he was quite concerned (Roz: Int. 1, p. 15).

Most of the husbands who were partners of the women in this study knew little about the menopause, but they understood that things were changing for their wives. Those who had deep concern for their wives tended to be part of the decision making process to take HRT, although the final decision was left to the women, as in Roz's case.

He discussed it with me when I was thinking about whether I was going to go and do it or not (take HRT). And he said, well you know, you've got all the literature. You'd know more about it than me. So you do what you think is right. We probably haven't discussed it again since. It's not an issue as such (Roz: Int. 1, p. 15).

Although the reactions of husbands were very important, even the most supportive of their behaviours were not always enough. Alex commented on how fortunate she was to have a husband who listened, but this was not enough. *"I can talk to my husband but it's no good talking to a man that doesn't know"* (Alex: Int. 1, p. 17). Again the importance of having another to talk to who has experienced menopause is emphasised.

Where the women experienced times of vaginal dryness, decreasing libido, and poor sleep due to night sweats, there were implications for their relationships. For most women the taking of hormone replacement therapy improved vaginal lubrication and relieved night sweats. However, for one participant her loss of interest in sex concerned her. Alex shares a personal insight into her situation.

I don't feel sexy ... It's only changed in the last ... see the sexual thing has only been in this last year - or just a little while ago. And it's slowly diminished and my husband is very very patient and he, wants to and I don't. And I can't be bothered. And it sounds terrible. The poor love, he's so patient with me. And the Doctor says, Oh well eventually it will come back. But I said how long have I got to wait? (Alex: Int. 1, p. 15).

Alex continues taking HRT, her husband and herself hoping that the doctor is right and her libido will return. They wait together, Alex thankful that she has a patient husband. However, this was not so for all the participants. As previously mentioned, Mary found that she and her husband were drifting apart and wrote in her journal. *"Other people (women) seemed to interest him more"* (Journal, p. 3).

The view that a woman's behaviour is related to her hormones (Vines, 1993) is also heard in the words of some husbands. Tina, who experienced mood swings while taking HRT, shares her husband's response to her.

Sometimes when I'm irritated at my husband he says. 'Oh a period is due' but I mean he's been saying that for years (Laughter). It's funny that men always blame it on the women's hormones (Tina: Int. 1, p. 3).

Some husbands do not comment and do not share with their wives how they are feeling about things until asked. Lynn, who had a long and difficult menopause experience, knew at the peak of her difficulties that she was hard to live with. But she did not ask her husband until afterwards how it was for him. She recalls:

Well having gone, as I said, through the whole gamut and nothing seemed to be working and my moods were so terrible, I was almost unbearable to live with I think, my husband said he was getting to the end of his tether after all this time, and he didn't tell me until I asked him afterwards. But I felt myself I was moody, I was up and down like a yo-yo (Lynn: Int. 2, p. 5-6).

There is an inward-looking essence to menopause. While acknowledging the patience of a husband, some women spoke about the self-focus they experienced. How the husbands responded to this self-focus was never mentioned. Alex, who saw herself as lucky with a husband and family who cared, still wishes they would think of her more.

I mean I'm lucky, I've got a husband that cares, you know, and the family care. But sometimes you feel as though, Oh God, you know, I wish they'd think a bit more of me but I'm not thinking of them either. I'm not thinking of them, I'm thinking of myself all the time (Alex: Int. 1, p. 7)

The need to attend to self and those things that had been deferred because of family commitments is for some women very strong. Tina, quoted previously in Chapter Four, wanted at times to divorce her husband and go out on her own and do the things she had repressed during the years of nurturing a young family. A similar experience was described by Mary (see previous chapter, subtheme being-in-control and being-controlled) when she took control of her life relishing in her energy and doing her own thing. These narratives give just a glimpse of menopause as something that has a need to express itself in ways that are, as yet, not well accommodated within Western society. Kenton (1995), on the back jacket of her book *Passage to*

Power, describes this inner desire of the menopausal woman to express herself in more creative and assertive ways in the following:

Menopause is a time of celebration when our creativity is no longer bound to our obligation as a member of the human race to propagate the species. Often, for the first time in a woman's life, her creativity can be set free for use in whatever way the whispers of her soul dictate

Some of the experiences that the women described, the anger, the desire to do one's own thing and a decreasing interest in sex, fit into what anthropologists have "identified as an 'idiom of distress' that crosses cultural boundaries yet has specific meanings in different social contexts" (Doyal, 1995, p. 45). The condition is called "nervios" which is seen as a complex physical and psychological response to the contradictory and demanding reality of so many women's daily lives. Reported symptoms are of anger, a very bad temper, yelling at the children, and finding fault with everything. Although not unique to menopause, "nervios" during the menopause is viewed in Peru as an expression of feelings often suppressed earlier in life. In the case of Puente Piedre women, the state of "nervios" gave them the right to leave their homes and to act more independently. Doyal found that these women were "often allowed to distance themselves from their husbands, to avoid both sexual and emotional services that they no longer wished to provide" (p. 46).

Although not so clearly structured within Western Society, there were overtones of "nervios" in the stories of some participants. The narratives of Alex and Tina reveal some of the complex psychosocial characteristics. Alex, who had experienced anger which she had at times directed at her daughter, a decreasing interest in doing housework, and a loss of interest in sex, suggested that menopause had given her an excuse. She illustrates.

Now it can be one of those things, menopause, that you give yourself an excuse ... I think we do. Not everybody. Don't think everybody does but I do think a lot of us do. I do. I'm sure I do. That's the conclusion I've come to. It's given me an excuse for not having sex, I think. It's given me an excuse for getting fat. It's given me an excuse to sort of be lazy. ... I never had an excuse

between the ages of 20 and 50. No excuse at all. (Alex: Int. 3, p. 9-10).

Alex has assumed some of the negative conditioning that has surrounded what happens to older women. According to Benner and Wrubel (1989), our interpretations are shaped by background meaning - a way of understanding our world that is given to us at birth by our culture. This is supported by Barbre (1993), who suggests that our perceptions of menopause do not occur within a vacuum but are culturally constructed. Traces of “nervios” are heard in Alex’s words, but the culture in which she lives has no place or space for her to fully express her feelings. Thus she seeks solutions to overcome how she feels by persevering with HRT and waiting for fulfillment of the medical promise. These stories illustrate that the meanings given to the menopause, by the participants, are tied to the underlying cultural assumptions in Western society about womanhood, ageing, and medicine (Barbre, 1993).

One of the few writers that explores the anger that many menopausal women experience is Reitz (1985). Through the use of case studies Reitz suggests that the anger is accumulative, building up throughout a woman’s life, because women have not been taught to express anger. Sometimes this anger is released and sometimes it is turned inwards and becomes depression. The situations identified as evoking anger were in relation to work and speaking to husbands. Reitz also suggests that much of the midlife woman’s anger comes from the way the culture misperceives her, namely the negative association of ageing and perceptions of being no longer desirable.

In the present study, another situation was identified by some of the women as evoking anger, that of communicating with their daughters. How the daughters experienced these interactions is beyond the scope of this study.

Today’s-daughters

The last component that supports *relationships-past-and-present* is today’s-daughters. Commenting on mother and daughter relationships, Hall and Jacobs (1994) suggest that the taboo of menopause is most apparent between these two generations. The stories of the participants remembering-now-how-mother-was-then confirms this,

but what of today's daughters who have 20 to 30 years before they reach their own menopause?

Eight of the ten women in this study have daughters. The impact of the women's response to the menopause, on their daughters, became apparent through their stories. Two of the study participants expressed concern about how their responses to the menopause may have affected their daughters. However, in their narratives they express a willingness to talk about and share their experience of menopause with their daughters, revealing an openness that was not a part of their up-bringing. Today's-daughters would be told about menopause. One participant expressed the intention to give her journal and tapes (from this study) to her daughter. However, not all had spoken to their daughters at the time of the interviews because, when they meet, life is so full with grandchildren. Meanwhile others freely discuss the menopause. In Roz's case, her daughter expresses disapproval of her mother taking hormone replacement therapy. *"The oldest one, doesn't like the fact that I am using HRT. She's very very much into homeopathic medicine. ... What kinds of things does she say? Just. 'Oh you shouldn't be taking that shit'"* (Roz: Int. 1, p. 7 - 8). Within one generation, the types of conversations that occur between mothers and daughters on menopause and how it is handled have radically changed.

Where the experience of menopause was difficult and the women experienced moods, irritability, and anger which spilled over verbally, daughters were affected. Alex reveals how she tended to direct this anger mainly at her daughter.

I would be getting and feeling as though it was bursting because I was angry inside and couldn't stop myself from being angry ... I used to do it to my daughter more than anybody and she used to just get up and walk away from me and that used to make me worse (Alex: Int. 1, p. 2).

Where the mother's menopause and the daughter's menses coincided there was a period of chaos which Lynn refers to as a time of "hormonal upheaval".

And when I was going through my worst time she (daughter) was coming up 12 - 13 - 14 when she was going through her hardest time with adolescence and I don't recommend that mix at all to

anybody. And she held things against me which, I mean, she didn't realize what I was going through I suppose. She did to a degree but I don't know how much (Lynn: Int. 3, p. 5).

...I'm sure it's all due, that is, due back to this time when we were together. As I say, with this hormonal upheaval. (Laughter). Both going through it (Lynn: Int. 3, p. 7).

In the case of Lynn's daughter, there have been some repercussions. Lynn's daughter sought counseling for personal relationship problems and this has brought up issues from this time, when mother and daughter were locked into their hormonal upheavals.

It is clear in the stories of the women that, in many cases, an image of menopause as something 'taboo' and not to be talked about had been passed from mother to daughter. But between the participants and the daughters who are yet to experience menopause, the silence is being broken down. These women seek opportunities to tell their daughters the whole story. There is a determination to change things for today's daughters. Lynn captures this change.

I don't want to go on and on about it but I feel I've got a responsibility to help them so that they don't go through - I mean they've seen the end result of me, what I've gone through so that should be enough to instigate them to do something beforehand and just watch their lifestyle, not to drink too much and not get over-stressed. (Lynn: Int. 2, p. 19).

Although not consciously expressed in the stories, there is a sense of continuity between the generations; the mothers who have long passed menopause, the women of today who are in the midst of menopause, and today's daughters who have their menopause yet to come. There is a kind of knowing within the silence. The thread that links the generations of women has gradually revealed some of itself, as each generation moves closer to identifying with what Hall and Jacobs refer to as, "the cycle of changes which womanhood embodies" (1994, p. 174). The relationship between mothers and daughters holds the key to this knowing.

The theme today's-daughters completes the hermeneutic phenomenological writing of the data. That this should reveal itself as the last subtheme of the experience of

menopause and of being-on-hormone-replacement-therapy, should not be surprising. There is a certain fittingness that it should be so. The women's stories have not only revealed the cycle of changes that link generations of womanhood, but have reached out beyond the telling and shaped the writing.

SUMMARY

Relationships-past-and-present is the third and final essential theme to reveal itself at this time. Themes are as van Manen (1990) suggests, a simplification, falling short of interpreting the whole experience, but they enable a capturing of the phenomenon one wishes to understand. The three essential themes, *living-with-a-changing-body*, *being-on-hormone-replacement-therapy*, *relationships-past-and-present* and their supporting components give structure to the women's experience, moving us closer to understanding the phenomenon of menopause, and how it and the taking hormone replacement therapy are experienced.

A discussion follows in Chapter Seven, the final chapter, which situates the findings of this study in relation to other qualitative studies. The findings will be presented as my interpretation of the data. Implications for nursing practice, education and research will be explored and recommendations made. The limitations of this study in answering the research question, *what is the experience of women taking hormone replacement therapy during the menopause*, will also be examined.

CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

The previous three chapters involved us in the deeply personal and unique manner in which the women experienced their bodies. An early expectation of mine was to focus on the experience of taking HRT but, as the study progressed, it became clear that the menopause and taking of HRT are inextricably linked in New Zealand society. Consequently, the study became a phenomenological interpretation of the women's experiences of the menopause and of taking hormone replacement therapy.

This chapter brings together the women's experiences and presents my interpretations of the research findings, touching on both the thematic and expressive dimensions of the phenomenological text. Comparisons with other relevant research are made. The study's strengths and limitations are explored, followed by an examination of the trustworthiness of the findings with reference to the points raised in Chapter Three. The role of the human science researcher is reflected on in light of my experience with this study. Aspects of the findings that have implications for nursing practice and education are analysed, and recommendations are made for further research.

Findings: Putting the Women's Experiences Together

The central theme of this thesis was drawn from the universality of the menopause and the women's individual responses to it. Therefore, *universal change - individual responses* became the title of this thesis. Inherent in the term universal change, when used to refer to the menopause, is an expectation that all midlife women will have a similar experience of menopause. This view, I believe, has created a blindness to the individuality of each woman's response. There are differences between the universal concept of the 'menopause' and each woman's experience of her own 'menopause'. These individual experiences and responses are a meld of similarities to, and differences from, every other human female. It is through phenomenological analysis and writing that these have been revealed.

In writing this phenomenological text, my aim was to offer a thematic and an expressive understanding (van Manen, 1997) of the women's experiences. The thematic dimension of this phenomenological inquiry consists of three essential themes: *living-with-a-changing-body*, *being-on-hormone-replacement-therapy* and *relationships-past-and-present*. My interpretations of the women's narratives attempt to capture the expressive dimensions, "in a manner that enriches our understanding of everyday life experience" (van Manen, 1997, p. 345).

This phenomenological text reveals that the universal female change of menopause was experienced within the context of each woman's life. Whether the menopause came as a natural event or through surgical intervention, the way it was experienced was a unique commingle of biopsychosocial and developmental elements for each woman. Apparent in the data relating to the first essential theme, *living-with-a-changing-body*, are the contradictions that are part of the menopause body change: a change that is experienced as universal yet individual, inevitable yet unexpected, normal yet an aberration.

Menopause, until it presented itself to the participants was something that other older women experienced. How the menopause would manifest itself in their bodies was something not to be thought about before it came. This not wanting to know about the menopause before it came was a continuation of the silence between generations of women that surrounds matters relating to female body changes and sex.

The women's deep connectedness to the monthly rhythms of their bodies alerted them, on a prediscursive and precognitive level, that something was changing. Each woman who experienced a natural menopause knew that they were menopausal, but so powerful is the medical discourse that most had to go to a doctor for confirmation of what they already knew. The body as a 'knower' was not fully acknowledged by the women nor considered relevant by the doctors. These ways of knowing are not highly prized in Western society, so our ability to know our own bodies is diminished by the dominance of the medical way of knowing about the body.

The experience of menopause involved moving from a situation of not wanting to talk about it to one of wanting to talk. "Really talking," which demands thick listening for it to occur also contains an element of checking out, "is what I'm experiencing normal?" A number of research participants and midlife female critical friends on reading the data, said "I'm not the only one to feel these things". This confirms that women do not generally talk openly or at a deep level about their experience of menopause.

Living-with-a-changing-body brought an inward-looking awareness of their bodies. Menopause experienced as a body disturbance or breakdown brought a sense of loss of the familiar self; that taken-for-granted knowing of their bodies had gone. In a sense, they were living in a place where the familiar signposts of their knowing about self had gone. This affected their ability to do, or want to do, the old familiar things from housework to having sex with their husbands. The body changes of menopause, as experienced by the women, impacted not only on their lives but on the lives of their families. Those who had lived with their mothers during their menopause now recalled the stories that had escaped the silence. The stories that they did not want to know about, as teenagers, relating to their mother's menopause had lain dormant until their own menopause. Where there were no stories to recall, they were sought through becoming a listener to the stories of others.

Most of the women, when reflecting on their menopause, compared their experience with those times when they were going through the body changes of puberty and pregnancy: times of change in their lives where they felt they were becoming something more, becoming a woman or becoming a mother. In comparison, they now felt that society saw them as becoming less. In Western society puberty is acknowledged as a biopsychosocial and developmental transition that takes place over a number of years and, as such, teenagers are usually afforded special attention that is understanding of their needs. Menopause is also a biopsychosocial and developmental transition, but the midlife woman is not given the same understanding or space to express herself.

The essence of menopause, which desires to express itself in more assertive ways, created unexpected feelings and emotions in some of the women. A number of women expressed this in different ways in relation to husbands and daughters: wanting to leave a husband, “break out” and do their own thing, and feelings of anger. The whirlpool of feelings and emotions affected every member of these families, so that some became “menopausal families” during this time. There was no socially acceptable way for these women to express their feelings of loss of control and self identity, and their anger; therefore, in most cases it was directed at those closest, husbands and daughters.

In the narrative of Mary, where she started to express herself independently of her family, we see a glimpse of the menopause as a transformative phenomenon. During this short time, prior to a complete oophorectomy and commencing HRT, Mary for the first time in her life became more assertive, more alive, putting her own needs before those of her family. For all the freedom and self management promised by HRT, we need to alert ourselves to the possibility that in some way HRT dampens down something that wishes to express itself, something that is not as yet acknowledged by modern Western culture.

The women in this study are the first generation of women who have had the experience of *being-on-hormone-replacement-therapy*. This opportunity to manage their lives by using HRT, for some of the participants, was accompanied by the personal dilemma of deciding whether or not to take HRT. In menopause, most participants could compare themselves to their mothers for a benchmark, but in the experience of taking HRT they had no benchmark. Some participants were more reflective, while other participants had done very little reflection about the use of HRT, so factors such as advertising, what the chemist said, the videotape they saw, and the pleasantness of the doctor influenced them quite unconsciously but no less powerfully.

Those women, whose lives became disrupted by the impact of how the menopause expressed itself in their bodies and lives, sought medical help to regain some control. However, it is in the experience of gaining some control over one’s body and life that

we begin to hear a whisper of dependency on HRT. While hormone replacement therapy helped some women to keep their bodies in control, there is a whisper of a fear of what might happen if they stopped taking it.

Most of the research participants worked with what was available and made decisions on very partial knowledge about a cluster of possibilities involving body control, social embarrassment, cancer risks, job management, and relational matters. In contrast, others were not aware of making a conscious decision to go on HRT but took what their doctor prescribed. The approach of some doctors of handing the decision over to the woman, while potentially a positive thing in itself, seemed to exacerbate the difficulty of coming to a decision, particularly in light of the fact that the doctors themselves were quite unsure about all the facts.

Some of the women felt that they could have coped without taking HRT but it was the public showing of menopause on their faces, in the form of hot flushes, that caused them to seek control through taking HRT. Being-in-control of one's body was a powerful concern that was behind the decision to take HRT for a number of the women. However, those who were also concerned about what they were putting in their bodies, and the possible risks of cancer, found themselves in a dilemma between gaining some body control and increasing their chances of developing cancer.

Once HRT was commenced, any problems a woman experienced were perceived by their doctor as being physiological, so a different brand of HRT was used, or the dose changed, or even a hysterectomy suggested. There was no attempt to consider what was happening in that woman's life at that time, and how that may have been impacting on her body. Narratives recalling conversations with doctors suggest that continuity of doctor, and the need to "really talk" as sought by the women were not understood. Also revealed was the silence that surrounds knowing when to stop taking hormone replacement therapy and how to do it, thus denoting the uncertainty of some doctors in relation to the long-term use of HRT.

The experience of the three women who had had a hysterectomy is both similar, yet different: similar in that these women were subject to the same stereotyping that

encompasses menopause, and had received little preparation for the body changes; different in that they did not have the problem of “breakthrough bleeds”. In many ways, their experience of HRT was more settled and smoother, until they tried to come off it. It was in this context that their experiences mirrored those women who still had an uterus. When Penny, due to financial costs, and Lynn, fearful over causing cancer, both stopped taking HRT, they experienced a return of living with a body out of control.

According to the participants, the experience of menopause and of taking HRT cannot be considered separate from the context of their lives. The hormonal changes of menopause, and those artificially induced by HRT, are firmly grounded within the total social reality of each woman’s life. Empirical research, when focused on the biochemical changes of menopause, becomes blind to the reality of lived experience. Again and again, the women showed that the issues of self concept, of knowledge, of compliance, of self management, and of dealing with relationships meant that their biochemical responses to the menopause and HRT were just one of the ingredients. The placing of a woman’s response to menopause and HRT in a biopsychosocial and developmental framework is not to dismiss the very important aspects of hormonal changes within a woman’s body, but is to ground it in a more adequate context.

These women, while coping with the changes effected by menopause and the taking of HRT, were at the same time going through challenges with partners, families, and careers. The complex society in which they live is reflected in their stories of *relationships-past-and-present*. These are not women on their “last legs”; these are mainstream women contradicting “young is beautiful, old is useless”. They are women living through a universal, yet intensely personal life change in the midst of conflicting information and uncertainty, as they work at controlling their bodies and their lives - “pretty busy lives”.

Support From Similar Research

From the literature two important points emerged. First, the way that the menopause has historically and culturally been viewed influences the way it is attended to. Secondly, the philosophical underpinnings of medicine have dominated the questions asked and the methodologies used to answer these questions. These studies have gathered the kind of data that informs about the physiological changes and symptomatology of menopause, and the pharmacodynamics of HRT, but not data which tell us about how a woman lives this experience

During the 90s a small number of qualitative studies have been carried out exploring the lived experience of midlife and the menopause, for example the phenomenological studies of Brown (1994) and Dickson (1994). Brown (1994) emphasises power as an essential part of a woman's perceptions about menopause; power which comes from how much control the woman has over her body and her life. Although a desire for power was not apparent in the present study, seeking to control their bodies and their lives was an issue for the research participants. Other similar themes identified by Brown are "living in an unpredictable body", "a body out of control", and "searching for the self that was". The similarities with the subthemes and components supporting the essential theme *living-with-a-changing-body* in the present study are clear. However, none of Brown's participants sought to regain control of their bodies through taking HRT

In relation to the decision whether or not to take HRT, Choi's (1993) grounded theory study suggests that the decision is a definitive one by the time a woman is postmenopausal. In contrast, the findings of the present study suggest that the decision is an ongoing dilemma. On the other hand, Dickson's (1994) phenomenological study of menopause suggests that the women were not interested in hormone therapy until they perceived that they had a problem which hormones might help.

Strengths and Limitations of the Study

The hermeneutic phenomenological approach of the study resulted in the gathering of rich, meaningful data and the writing of a text which invites us to “see” the experience of menopause and the taking of HRT as lived by the research participants. The women’s reasons for commencing HRT, their future expectations, and their reasons for adhering or not to HRT regimes, when viewed within the context of the phenomenological view of the person, offer us new ways of understanding their actions.

The intensely personal material presented here must be regarded with respect and caution exercised in the way the wider implications are stated. The vulnerability of some women to certain words, denoting that in some way their bodies are deficient, increased their susceptibility to promises portrayed in the advertising of HRT by the Pharmaceutical Companies. Thus the insights revealed, through phenomenological analysis and writing, have the potential to not only inform clinical practice, but to be used to enhance the selling of HRT.

The limitations which I imposed and those which were outside of my control are identified here. As the study is critiqued by others and a dialogue develops, other limitations that I am unable to see at this time may become apparent.

The processes of data analysis, interpretation, and writing were not conducted in a smooth and continuous manner. These happened around a full-time working life, which both impeded and assisted my understanding. My understanding was impeded in that writing was not continuous, and my moving between the part and the whole interpretation of the data was done in bursts. However, my understanding was also assisted because I am a midlife women engaged in a busy working life, which in many ways mirrored the lives of the participants. I could not leap outside of my everyday reality to understand either myself or the participants (Chesla, 1995). I acknowledge that there may be undetected personal biases and assumptions which may influence my interpretations. These are the processes which my supervisors have guided me through.

The ways in which the women in the present study clearly differed from one another was in their ability to tell and reflect upon their stories. I am aware that my beginning skills as a phenomenological researcher may not have brought out narratives and interpretations in the way that a more skilled researcher could have.

The method of data collection through the use of taped interviews, keeping of a journal, and fieldnotes did not fully capture the body language of the women, although I included in the transcripts where a participant laughed, or cried, or sounded surprised at what they had said. Also the total volume of the data collected was rich and long, so I was faced with the predicament of wanting to include it all in the phenomenological text. However, I found that the constant asking of the data, “what makes the experience of taking HRT during the menopause what it is and without which it would not be what it is?” guided the process of knowing what was to be included and what was to be left out. I acknowledge that my reflective abilities are not conclusive.

This study focuses on the women’s reflections of their experience of menopause and of taking HRT, and only touches on family members and friends. Through writing this final chapter, I have become aware that the impact on families is greater than first revealed, in that they could be referred to as “menopausal families” during the time of the women’s transition. This further interpretation of the data illustrates the ongoing process of phenomenological writing. However, because of timeframe restrictions, I have come to the stage where I must submit this phenomenological text to the scrutiny of others.

Trustworthiness

The trustworthiness of the study is examined in relation to some of the aspects referred to in Chapter Three. Lincoln and Guba (1985) emphasize the importance of understanding the naturalistic inquiry paradigm. Throughout the study, I have aimed to make visible the philosophical underpinnings, from the presentation in Part One of a case for hermeneutic phenomenology through to the data analysis and writing

processes. The ethic of remaining “loyal or true to the phenomena under study” (Denzin & Lincoln, 1994, p. 488) is apparent in how the data has directed the research process. It is also apparent in how my views concerning the menopause and HRT have been challenged and turned around.

Sandelowski (1986) offers a number of strategies for evaluating the trustworthiness of a study, three of which were outlined in Chapter Three. First, the research participants confirmed my interpretations of their narratives as accurate, and those who read the completed phenomenological text perceived it as capturing their experience, through the process of member checking. Secondly, the applicability or fittingness of the findings were confirmed when midlife women, who were not research participants, read the text and commented, “I’m not the only one to experience this”. Also supporting the study’s fittingness are the similarities to the findings of Brown (1994) and Dickson (1994).

Thirdly, the audit trail set out in Chapter Three and the three data chapters which followed ensure that the reader can follow my thinking. The inclusion of sufficient data in the form of the women’s narratives enables the reader to participate in the “consensual validation of the data” (Leonard, 1989, p. 53).

Finally, I have extensively reflected upon, and made open to the reader, my pre-understandings, beliefs, biases, and assumptions in relation to the research focus. I have also attempted to explicate the meaning of the phenomenological view of the person, exploring the implications for myself as researcher.

The Qualitative Researcher and What I Learned

Drew (1989, p. 431), states that, in phenomenological studies, the experience of the interviewer in relation to the research focus can be “considered data and examined within the context of the study for the part it has played in the study’s results”. I entered the project as a partial insider (in ethnographic terms) in that I was a midlife woman who had experienced menopause but not the taking of HRT. I was also a

nurse educator and as such was familiar with medical language that dominates menopause discourse. The degree to which my cognitive knowledge initially limited my understanding became apparent only after I learned to really listen and to trust that which van Manen (1997, p. 346) refers to as “noncognitive sensibilities”. Again my supervisor assisted me to learn how to “dwell in the data,” by developing a conversation with it and listening to it, seeking to “see” not only that which is often hidden by our taken-for-granted understanding of our bodies, but also those things that fill the silence that surrounds topics relating to the female body.

Most of the interviews took place in the homes of the participants. Consequently, the social norms concerning politeness would have impacted on interactions between us. I was a guest in their homes, and there are certain social norms relating to that of hospitality and politeness. The need of the research participants to check out my age and menopausal status, before revealing their stories, has implications not only for research but also for the care of midlife women. In order to be invited to share in meaningful narratives, the human science researcher must have credibility in the eyes of the research participants. Van Manen (1997, p. 368), referring to the writing of thoughtful phenomenological texts, states that “the researcher is an author who writes from the midst of life experience”. This statement also has implications for the gathering of the data, because when the research participants can place the researcher appropriately in the midst of the life experience being studied, they open themselves up to talking deeply.

This thesis has been a very personal journey. As the inquiry has unfolded, the short but deep involvement in the participants’ lives and the experience of writing a phenomenological text has had a profound effect on me. I have, to date, largely inhabited a world that has rewarded my cognitive abilities and required me to keep my intuitive knowing hidden or to be shared only with others of a like mind. The experience of being a researcher in this phenomenological study has given me new insights into my own experiences and a confidence in expressing both my cognitive and intuitive sensibilities.

Implications for Practice, Education and Research

The findings of the study and my reflections on the research experience raise a number of issues applicable to the practice of nurses and other health professionals working with midlife women. Implications for nurses are emphasized.

Practice

It is important that the potential of menopause as a developmental transition be recognized, and that the midlife woman be assisted to find meaning in her experience of menopause, in a place where she can talk to someone she perceives as understanding the menopause. This would include acknowledgment that some women have unexpected feelings and emotions of anger that they do not understand and do not know how to express. It also needs to be considered that, during midlife, unfinished business may arise, and that some women may require professional assistance. The decisions which a woman makes at this time are going to deeply affect the remaining third of her life. Consequently, attention to her individual responses must be integrated into her care. The following strategies are suggested.

Provide evidence-based health care which utilizes not only research findings but woman-oriented evidence that matters. The latter would involve the completion of an in-depth holistic assessment which documents the woman's knowledge and understanding of menopause, the source of that knowledge and the meaning she gives to this experience. Included also would be an assessment of her concerns about her body and how she would like to manage 'her menopause' as opposed to 'the menopause'.

Teach the woman about her body in terms that acknowledge and enhance her body as a "knower". Support her through the experience of living with a changing body. Offer signposts of what is part of normal menopause and what is not, so that the woman knows when to seek medical advice. It is here that the nurse must ensure that the information which is given is individualized to meet the woman's needs and not couched in the terms of medical discourse. Information must be given in a way that

empowers the woman to make decisions as to how she wants to manage her menopause. The nurse may also need to support the woman during the decision making process. It is important to remember that the decision to take or not to take HRT does not need to be made immediately, that it is not a definitive decision, and that the way the woman chooses to manage her menopause can involve ongoing change, depending upon how she responds.

Explore with the woman, when required, ways in which her husband and children can be informed about her menopause and ways to cope with relationships and “hormonal upheavals”. In situations where relationship difficulties do arise, counseling services may be required.

Encourage continuity of health professionals, particularly for the midlife woman who wishes to discuss matters relating to her menopause.

Play an active part in changing society’s attitudes toward ageing, especially to women. Such work would involve first examining one’s own attitudes to ageing, menopause and midlife women, and then interacting in ways that fully acknowledge the midlife woman’s worth. In health care today, we can no longer afford to work with midlife women in ways that do not recognize both their individual and collective value to society.

Education

In most undergraduate curricula (nursing and medical) little time is allocated for the study of the menopause. However, opportunities can be made by educators whilst working with students in the clinical setting, who are caring for midlife women.

Other opportunities exist at the postgraduate level. When we consider the number of women in our society who are experiencing or who will experience the menopause (natural or surgical), and the individual responses of these women, there is a need for educative programmes that will inform nurses at a more advanced level. As previously referred to, nurses have undertaken research in the area of menopause, but the

findings of these studies have not impacted greatly on the education of nurses and other health professionals. The development of a postgraduate programme, informed both by research and clinical experience, would enhance the health care of midlife women. Such programmes should also include a component that will assist nurses to disseminate knowledge through both the professional and lay press.

Research

A number of areas that warrant research have been alluded to. However, in order to clarify these, the following recommendations are presented as fruitful areas for further research.

First, there is little understanding of the commingle of physiology, female hormones, and the psychosociocultural and environmental factors involved. Qualitative and quantitative multidisciplinary research, exploring the complex interactions of these factors in women of different cultures is required. Secondly, the mix of unexpected feelings and emotions, particularly anger, as experienced by some midlife women, warrants further investigation. Included in such a study could be an exploration of the husband's and daughter's experience during the menopause of their wife or mother. Thirdly, the present study suggests that the phenomenon of menopause is something that desires to express itself in ways that Western culture does not acknowledge or value. Also suggested is that the taking of HRT dampens down this expression in some way. The application of qualitative methodology, comparing the experiences of women who take HRT with those who do not, may enlarge upon this finding.

Finally, research is needed to identify ways of preparing women for their menopause. Such an inquiry would aim to identify what women need to know and, how they need the information to be presented. The reluctance of many women to want to learn about the menopause before it is experienced would be a challenge for such a study.

Concluding Statement

The dilemma experienced by a number of women in the present study, of trying to weigh up the various outcomes of taking or not taking HRT, challenges the statement made in the report by the National Advisory Committee on Core Health and Disability Support Services (1993) This report stated that “it is unlikely that women will necessarily weigh the various outcomes affected by HRT equally” (1993, p. 18)

This thesis reinforces the view that the phenomenon of menopause, the way women experience it, and the decisions they make in order to cope with it, do not occur within a physiological vacuum, but are grounded in the reality of each woman’s life. If society and health professionals continue to focus on the physiological and ignore the psychosociocultural and developmental dimensions, they will seriously impede the full development of the midlife woman in Western society. When we seek to understand how the menopause and the taking of HRT are experienced from the phenomenological view of the person as a self-interpreting being, new insights and exciting possibilities emerge.

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APPENDIX A

MENOPAUSAL HORMONE REPLACEMENT THERAPY: THE EXPERIENCE

Consent Form

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

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree/do not agree to the interview being taped.

I have the right to request that the audio tape be turned off at any time.

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

Signed: _____

Name: _____

Date: _____

APPENDIX B

Advertisement

INVITATION TO WOMEN TAKING HORMONE REPLACEMENT THERAPY DURING MENOPAUSE TO REGISTER THEIR INTEREST IN A RESEARCH STUDY

I am seeking voluntary participants for a research study as part of a M.Phil Thesis through Massey University. If you are experiencing menopause and have just commenced taking hormone replacement therapy, or have been taking it for up to two years, and would like to register your interest in being a research participant in this study, please contact: Maxine Anderson (06) 844 4875 (evenings).

APPENDIX C

MENOPAUSAL HORMONE REPLACEMENT THERAPY:

THE EXPERIENCE

Information Sheet

My name is MAXINE ANDERSON. I am a graduate student of the Department of Nursing & Midwifery at Massey University. I am currently enrolled in my Masters Thesis. Information gathered during this study is for this purpose only. I am a Registered General & Obstetric Nurse. I have spent the twenty-one years of my professional life working in hospitals both as a nurse and a supervisor, and the last five years as a nursing tutor.

My Thesis Supervisor is DR Valerie Fleming, Department of Nursing & Midwifery, Massey University, Palmerston North.

This study has grown out of an interest in women's health issues, and a concern about how little has been published which focuses on the experience of women taking hormone replacement therapy (HRT) during menopause. Given this gap in the literature, I would like to do an in-depth study on the meaning women give to this experience, their rationale for commencing and future expectations of HRT.

The criteria for acceptance into this study are women who:

- are taking HRT during menopause and are in their first or second year of treatment.
- have experienced a surgical menopause within the past year and are taking HRT.
- have no medical history of chronic disease.
- are not known to the researcher personally.
- are prepared to commit themselves to two to four one hour interviews over an eight month period and to keep a written log over a two month period.

As a participant, you are asked to consent to:

- a. Being interviewed approximately two to four times, over a period of eight months. The interviews will be audio-taped and will take approximately sixty minutes. The purpose of the interviews is to gain further insight and understanding into your experiences. The respective dates, times and venue for each interview will be mutually arranged.

The data obtained at each interview will firstly be validated with you, analyzed, then taken back to you for further validation. During subsequent interviews, you may be asked to comment on the analysis of any preceding interviews.

- b. Keeping a diary/log for a two month period, recording all insights and reflections concerning your experience of taking HRT during menopause.

If you take part in the study, you have the right to:

- refuse to answer any particular question, and to withdraw from the study at any time
- ask any further questions about the study that occur to you during your participation
- provide information on the understanding that it is completely confidential to the researcher, my supervisor and transcribing typist. All information transcribed from the tapes will only include pseudonyms of any names of people or institutions, and it will not be possible to identify you in any reports prepared from the study.
- be given access to a summary of the findings from the study when it is concluded.
- agree/not agree to the interview being taped.
- request that the audio tape be turned off at any time.

Please register your interest by phoning (06) 844 8710 Ext. 5405

APPENDIX D

83a Avondale Road
Taradale

Dear Mr/Doctor

This is to inform you that I am undertaking a research project on the experiences of women taking hormone replacement therapy during menopause, as fulfilment of requirements for a M.Phil Thesis at Massey University.

You will be aware that a Consensus Development Conference Report (1993) to the N.Z. National Advisory Committee on Core Health and Disability Support Services on HRT, acknowledges the need for qualitative data.

The proposed research will be a qualitative study which will focus on the women's experiences and their interpretation of what it is like to be a woman living through the experience of taking HRT during menopause.

Although each research participant is a volunteer obtained from the community, it is because they have been prescribed HRT that in part makes them eligible. However, I wish to emphasise that the focus is the women's experiences and not medical treatment.

Should you wish to follow up an interest in this study please do not hesitate to contact me.

Yours sincerely

Maxine M Anderson
M.Phil Thesis Student

APPENDIX E

MENOPAUSAL HORMONE REPLACEMENT THERAPY: THE EXPERIENCE

Non disclosure of information

I will not disclose any information I access through transcribing interview tapes or any word processing relating to the above Thesis research.

I will take all reasonable steps to ensure the confidentiality of the material while it is in my hands.

Signed: _____

Name: _____

Date: _____