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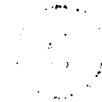
THE UNIVERSITY OF ALBERTA

WOMEN'S VIEW OF MENOPAUSE

BY

JANET A. MORAN



A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SCIENCE

IN

FAMILY LIFE EDUCATION

DEPARTMENT OF FAMILY STUDIES

EDMONTON, ALBERTA

SPRING, 1990

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled, WOMEN'S VIEW OF MENOPAUSE submitted by Janet A. Moran in partial fulfillment of the requirements for the degree of Master of Science.

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Supervisor

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Date: ....December 20...... 1989

ABSTRACT

To enhance our understanding of midlife we need to consider female as well as male experiences during the middle years. Previous research models of development have been derived from male life paths and career changes. A unique midlife female event is menopause.

The purpose of this study was to understand the process of menopause. Most of the research on menopause has been deductive with theoretical models based on the assumptions that menopause is an important event because it ends women's reproductive capabilities and is linked to their role in society. Menopause has been described as a hormonal deficiency disease, a loss of roles, or as a social construct.

Unstructured, open-ended face to face interviews were conducted with 11 women, who had become peri or postmenopausal through natural causes, and ranged in ages from 45 to 58. Grounded theory methodology facilitated the development of a model of menopause.

The common element present in women's experience of menopause was feeling different because of various physical or emotional changes. The recurring theme was making sense out of feeling different and this was basically seen as a mental process. It had five main stages: recognizing the beginning of menopause, experiencing changes, making connections, seeking equilibrium and closing the cycle. The cessation of menstruation was not perceived as a crises because the women did not connect their identities, roles, or value, with their menstrual periods.

Further investigation is needed to verify the propositions that have been developed in this research, and to clarify those changes that are directly related to menopause and those that are related to other life stages, in order to develop a more complete model of the middle years.

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Above all my love and gratitude goes to my husband, Jerry, and our three boys, Philip, Tim, and Mark. Without their willingness to expand their understanding of what it means to be a family, I never would have had the courage to begin or complete this journey to search for more knowledge.

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CHAPTER ONE
INTRODUCTION

The 20th century has brought many developments to make human life easier and more enjoyable. Among these benefits is increased longevity (Deveraux, 1987). As a result of this change, in the past two decades, a large body of literature on the elderly has developed. The diversity of patterns of old age that emerged from the research encouraged scholars to ask about the antecedents of old age and to focus on the individual and family aspects of the process of aging (Neugarten, 1968). Consequently this has lead to an interest in midlife as a researchable phenomenon (Gould, 1972).

Justification of the Problem and Statement of the Question

Individual and family models of development are concerned with changes and growth. Recent models of individual development which include those of the middle years (Erikson, 1959; Havighurst, 1952; Levinson, 1978), view life as progressing and changing sequentially along a continuum of stages with one stage built on another. These models are based on career paths or changes in understandings about mastery over one's environment. The issues that emerge at each stage are derived from biological, social and psychological sources.

The validity of the application of these models to women's lives has been challenged. Some researchers (Neugarten, 1979; Notham, 1979) question these models of development as being inappropriate for women because they are based on information gained from male patterns of development. They do not accept the assumption that men and women go through the same life experiences in the same sequence nor that the male life path is the model for women's experiences. Women,

they claim, may experience different role and career patterns compared with men because of changing combinations of children, work and marriage.

In addition, the lack of consideration of female experiences in models of development contributes to the negative image of women in midlife. Roberts & Newton (1987) state that women's life structures appear to be less stable than those of their male counterparts because women have diversity of concerns such as marriage, motherhood and career while men emphasize occupational concerns. Gilligan's (1982) research findings demonstrate that women's moral development is not slower than men's as Kolberg's model indicates, but rather, women's primary orientation is toward caring, interpersonal relationships while men favor the ideal of autonomy. The media and popular literature reflect some of these views of women in the middle years by portraying them as emotionally unstable and in need of medication and cosmetics to return them to their more pleasing younger selves (Gelein & Heiple, 1981).

There is a need, then, to include female experiences in the creation of models of development. The general focus, therefore, of this research is to examine how women construct and understand experiences that happen to them during midlife.

One of the obvious differences between midlife experiences of men and women is that women go through menopause. It is an event that all women who live into their fifth decade will experience. Early developmental models held that menopause is an important event in the lives of women because it ends women's reproductive capabilities and is linked to their role in society.

Based on these assumptions the research on menopause generally considers menopause as a negative phenomenon. Medical research defines it as a deficiency disease of estrogen (Ettinger, 1987), while the psychoanalytical explanation is that menopause is a loss of femininity and childbearing capacities (Dudley & Chapman,

1968). The psychological description of menopause is that it is a period of adjustment or maladjustment to this loss (Durst & Maoz, 1979). On the other hand, some research views the importance of menopause as dependent primarily on cultural values (Perlmutter & Bart, 1982). Very few of these studies on menopause, consider women's reflections upon the place of menopause in their lives (Koeske, 1982).

Events of the last thirty years have had an effect on women's reproductive abilities and their role and function in the family. With the advent of reliable fertility control, women can have children later, can have fewer children or choose not to have children. One consequence of this is that the time of child-bearing corresponds less to the span of fertility and more to women's choice. Another development that has occurred in the last two decades is the increase of women employed outside the home. This has placed women in the position of having roles other than those of wife and mother (Gower, 1988). As a result of these developments the assumption that there is a link between the role of women, reproduction and menopause is weakened.

Given the fact that previous research has paid little attention to the midlife developmental events of women and that the one midlife phenomenon, menopause, which has received some research attention, is based on the assumption that its importance lies in its connection to the end of childbearing capacities, the specific question that this research addresses is: How do women in midlife view the process of menopause?

CHAPTER TWO

LITERATURE REVIEW

Research into the phenomenon of menopause has been undertaken in different fields each utilizing different theoretical orientations. These fields include physiology, medicine, psychology, psychiatry, sociology, and anthropology. The following literature review will look at the research on menopause conducted in these various disciplines.

The first section will consider menopause from the biomedical perspective in which menopause is thought to be a disease. Included in this part will be a consideration of menopause as an experience of loss, as portrayed in the psychiatric and psychological literature. The first section will conclude with an examination of the symptoms associated with menopause and a brief look at the risks and benefits of estrogen replacement therapy. The second part of the literature review will focus on research that views menopause as a sociocultural event. It will present the results of some cross-cultural studies as well as research on women's attitudes toward menopause in our society. The literature review will conclude by indicating the major flaws and gaps in using either the biomedical or the sociocultural model as a framework in which to understand menopause in the lives of women.

The Biomedical Model

Menopause as Disease

Menopause is the cessation of menses. From a physiological perspective, it is commonly said to have occurred after a woman has had no menstrual periods for one year. Hormonal changes preceding and following menopause occur over a number of

years, during which time ovarian follicles no longer produce estrogen and progesterone in the rhythmic patterns associated with the menstrual cycle (Woods 1982).

From an historical medical perspective, menopause has been understood in various ways. Especially in North American culture, menopause was first considered a medical non-event, then discovered to be disease-causing and finally transformed into a disease itself.

Menopause became a health issue when women's longevity increased. Until the 18th century, women did not live long enough after menopause for anyone to be concerned about the effects of menopause on their lives. In the 19th century women were living longer and doctors were more involved in their treatment (Barker-Benfield, 1975). Smith-Rosenberg and Rosenberg (1973) claim that it was 19th century physicians who played a primary role in discovering menopause. The medical profession at that time saw women as prisoners of their reproductive systems. They believed women's uteri and ovaries controlled their bodies and behavior from puberty through menopause. Many diseases and symptoms were also attributed to menopause by physicians. These included hot flashes, paralysis, cancer, diabetes, irritability, depression and even insanity. Smith-Rosenberg and Rosenberg conclude that in the 19th century the medical profession viewed menopause as a physiological crisis which could lead to either tranquility or disease, depending on a woman's behavior and her predisposition to malignancy.

The completion of the medicalization of menopause began in the 1930's with the increased understanding of the role of hormones in sex differentiation, reproduction and sexuality. It was the lack of hormones that was seen as responsible for the physical and the concomitant emotional manifestations experienced by menopausal

women. Midlife women of that era were seen to have acquired a hormonal deficiency disease called menopause (MacPherson, 1981; McCrea, 1983).

The final stages of the medicalization of menopause was accomplished when a cure for the "hormonal deficiency" was found. The development of synthetic estrogen in 1983 brought a solution to the lack of estrogen in aging women. Kaufert and Gilbert (1986) state that once therapeutic means are available to correct a condition defined as disease, physicians are obliged to treat the disease. Reciprocally, people with a disease are under obligation to seek treatment. This means that physicians are obliged to provide, and women to seek, estrogen therapy.

Bell (1987) explored the medical literature of the 1930's and 1940's which described menopause as a disease caused by hormonal deficiencies. She concludes that the medicalization of menopause had a paradoxical effect. Although this approach distinguished biological changes from psychological and environmental changes, it had the effect of reducing medical treatment of menopause to measuring hormones and treating hormonal deficiencies alone. It excluded the social, psychological and environmental factors in individual women's experiences of menopause. The medical profession, Bell states, wanted to assure women that menopause was normal, not pathological, yet the new view of women as being hormonal deficient re-enforced the traditional image of women as being helpless and at the mercy of their hormones.

Modern medicine continues to promote a view of menopause as being pathological and abnormal. Wilson (1966), a medical doctor, Reuben (1969), a psychiatrist and Masters (1977), a sex therapist, all paint a grim picture of women's destiny as one of spending their life in a sort of living decay without the treatment of estrogen,which they claim will restore women to the fountain of their youth and beauty. The view of menopause as pathological is present in the report from the Fourth International

Menopause Congress in 1984 in which menopause was defined as a sex-linked, estrogen deficiency disease (Voda & George, 1986).

Menopause as Loss

Psychoanalysis adds the notion of loss to the "disease" concept of menopause. Freud saw reproduction and motherhood as the prime goal and function of the mentally healthy woman. Menopause with its resulting infertility was therefore seen as a psychic loss which could account for women's neurotic behavior at this time. The early school of psychoanalysis also saw menopause as a time of disappointment and mortification because of the perceived loss of, and decline in, sexual attractiveness as well as reproductive capacity (Dennerstein, 1987). One of Freud's female disciples, Helen Deutsch (1984) describes menopause not only as an organic decline, but as a dreaded time of life when a woman feels she has lost her major function and her femininity.

Freud's conceptualization of "anatomy is destiny" especially reinforces the North American cultural belief that women are defined by their reproductive systems (Singer, 1976). The Freudian legitimation of psychological reactions to biologically defined roles, lead researchers to examine the effects of menopause as the expression of women's unresolved role conflicts. The resultant stresses were seen to manifest themselves in emotional disturbances. For example, the repression of ideas and internal frustrations experienced by women were exhibited as hysteria; the inability to effectively resolve internal role conflicts was attributed to women's weaker superegos (Fine, 1979). The conclusion was that if women accepted their feminine role and had children, they would have fewer problems at menopause.

The psychological perspective of menopause accepts the idea that menopause is a developmental stage or crisis. However, its interest lies in how well women adjust to the basic loss (Steiner, 1983). It holds the view that in the normal emotional life of women, reproductive ability is intimately related to femininity, the loss of which represents a blow to feminine self-esteem (Steiner, 1983). How well women adjust to this loss will have an effect on the emotional problems they experience at menopause (Brown & Brown, 1976; Kruskemper, 1975).

The Menopausal Syndrome

The concept of menopause as a disease and as a psychiatric and psychological loss lead to the association of menopause with a pattern of symptoms known as the menopausal syndrome. It included symptoms of mental ill health as well as other bodily symptoms (Woods, 1982).

The catalogue of symptoms is impressive. Davis (1983) indicates that there are 50 complaints attributed to peri and postmenopause. The symptoms are usually clustered into three categories, although the actual categories and their components may vary. Autonomic or hypothalamus symptoms include hot flushes and flashes, night sweats, tingling, numbness in the extremities and gastrointestinal complaints. Somatic and metabolic symptoms include vaginitis, skin atrophy, musculoskeletal (including osteoporosis) and menstrual dysfunction. The third category consists of psychosomatic or psychogenic symptoms such as emotional changes, change in libido, depression, apprehension, panic attacks, fear of insanity, insomnia, headaches and latent neurosis.

The number of women estimated to experience any of the menopausal symptoms is not consistent. In a national health survey conducted in the United States, MacMahon

and Worcester (1966) found that 10% of women between the ages of 56-64 expressed some menopausal complaints. In contrast, Greenblatt (1974) states that no more than 15% of women experience menopause free of symptoms. Hammond (1977) found 25% of women at middle age consult a physician, while Haspels and van Keep (1979) claim 40% consult physicians about problems related to menopause.

There is considerable disagreement among researchers as to what constitutes menopausal symptoms. The method of data collection seems to be one reason for the ambiguity of menopausal symptoms. McKinlay and Jeffreys (1974) indicate it is difficult to determine whether reported symptoms are related to menopause or to other conditions because the reporting of symptoms is part of the customary medical procedure or recording of case histories. On the other hand, Davis (1983) suggests that the data generally come from highly impressionistic reports from clinical observations and clinical trials often aimed at evaluating the effectiveness of proposed treatments for menopausal complaints. The etiology of hot flashes, which is the most common reported symptom is unclear. Even estimates of its occurrence among women vary from 28% to 92% (Levine, 1986; Feldman, Voda & Gronseth, 1985). Others (Lennon, 1987; Schindler, 1987; Fink, 1980; Hunter, Battersby & Whitehead, 1986) have found no evidence for the existence of a specific constellation of psychiatric symptoms that might characterize menopause.

Some of the difficulty in describing the menopause syndrome comes from methodological inconsistencies. The point in attributing certain symptoms to menopause is not whether women are experiencing these symptoms but whether they can be defined as menopausal. In a study on menopausal symptoms, Kaufert and Syrotiuk (1981) state that the main problems in medical research include: confusion in the use of terms when defining climacteric and postmenopausal women, use of

unstandardized questionnaires with unknown psychometric properties, reliance on clinical populations and failure to control for the effects of age and cohort differences. In addition, Goodman (1982) believes that case-control methodology does not lend itself to the study of menopausal symptoms because menopausal or postmenopausal women are generally older than pre-menopausal controls, and therefore the confounding effect of age presents a source of bias.

Many theories have been offered to explain the development of the symptoms attributed to the process of menopause. The theory most prevalent is that they are brought on by the disappearance or decrease of estrogen hormones (Utian, 1977). Some researchers do not concur. Campbell (1977) and Gordon (1977) indicate that no correlation has been established between the amount of estrogen present in the blood and either the existence or severity of symptoms. The only laboratory finding that is characteristic of menopause is the elevation of the blood and urinary gonadotrophins caused by the failure of feedback control in the absence of significant quantities of ovarian hormones. Therefore, of all the symptom associated with menopause, the only one that is universally reported is the cessation of menses.

A review of the literature does not give a consistent picture of the symptoms associated with menopause. Nevertheless, there is a body of research that concurs that even if the cause and description of menopausal symptoms is not known, the solution is known, and that is estrogen replacement therapy (ERT).

Estrogen Replacement Therapy

Estrogen replacement therapy is based on the assumption that menopause is a physiological problem caused by the lack of estrogen. It therefore requires medical intervention for treatment. Gambrell (1982) expresses this viewpoint when he states,

"This author considers the menopause to be a hormonal deficiency state, and like all endocrinopathies, should be managed as vigorously as need be and without a necessary limitation of time" (p. 457).

There is prolific research on menopause which focuses on estrogen replacement therapy and on the risks and benefits of such treatment for menopausal and post menopausal women. The findings, however, from this research are inconclusive and contradictory. Almost from the beginning of the use of manufactured estrogen, its link to cancer was established (Gusberg, 1947). After Wilson (1966) advocated estrogen replacement as a means for women to remain forever young, further research confirmed that there was a connection between ERT and endometrial cancer (Ziel & Finkle, 1975; Smith, Prentice, Thompson & Hermann, 1975). The controversy resulted in progestogen being added to the estrogen and the recommended dosage lowered, with the hope that this would reduce the risk of cancer (Weiss, 1978). Some researchers claim that this combination of hormones actually prevents cancer from occurring (Gambrell, Massey, Castaneda, 1980; Nachtigall & Heilman, 1979; Thom, White & Williams, 1979). On the other hand, Rauramo (1986), and Huppert (1987) argue that there are many unknowns in the use of this type of therapy. These include the long term effects, the optimal duration of use, dosages required and even type of hormonal agents to be used. In addition, there is an indication that ERT is also linked to gall bladder disease, hypertension and the thromboembolic diseases (Rowe, 1986).

Some researchers hold that ERT can relieve physical and psychological complaints associated with menopause. These include the reduction of vasomotor symptoms (Townsend, Whitehead, McQueen, Minardi & Campbell, 1980; Jensen & Christiansen, 1983); urigenital atrophy (Lauritzen, 1976); heart disease (Whitehead & Fraser, 1987) osteoporosis (Nachtigall & Heilman, 1979; Ettinger, 1987) and emotional behavior

(Ballinger, 1975). Other researchers question the advisability of using ERT indiscriminately to reduce menopausal symptoms (Notelovitz, 1986; von Schouotz, 1986).

Conclusion

The biomedical model of menopause helps to create a negative expectation of what women can expect as they approach midlife. Each woman, according to this model knows that she will succumb to a deficiency disease which has the possibility of interfering with various physical or emotional aspects of her life. Menopause then, is not a normal process but a health hazard. It can be classified with such long term deficiency diseases as diabetes or anemia. As a disease, menopause is exclusively within the medical domain. Such a view supports the notion that women should not rely on their own experience nor that of other women, but ask their physician for information and advice.

The psychiatric and psychological aspects of the model define women solely in terms of their biological function in society. It reinforces the traditional concept of being a woman. Motherhood and womanhood are equated. A standard of aging which implies that women must remain attractive, youthful looking, and full of "joie de vive," despite the fact that they are getting older, is also part of this model.

The biomedical model misses the other dimensions in women's lives. It does not take into account that although menopause is a physical reality, it occurs within the entire context of women's lives, their relationships, goals and future plans. It does not consider the fact, if women experience difficulties at menopause it could be because of the expectations, stereotypes and status of women in a given society.

Sociocultural Model of Menopause

Menopause is a physiological event that happens to women who live in a certain culture, time and place. The sociocultural model of menopause holds that a given culture defines how the event is perceived, experienced and expressed by women; what symptoms will be exhibited, and how the women are treated (Flint, 1982; George, 1988). It ascribes to the idea that a given culture provides labels for bodily experiences, provides sources of information, exposure to models for social comparison, and socialization into a system of meanings.

The social implications of becoming menopausal are products of the status of women in a given society, the value placed on aging, beauty and women's reproductive capacities. These societal and cultural factors are known to modify the psychological experience of menopause and midlife. For example, Kaufert (1982) develops a theoretical framework of menopause using these assumptions. She relates the stereotype of menopause in a given society to the self-esteem of women as they enter perimenopause.

In order to differentiate the sociocultural from the physiological, one way to examine menopause according to this model, is to look at cross-cultural studies from non-Western, non-industralized societies. The studies of menopausal women in non-Western countries indicates that they do not experience the symptoms of which Western women commonly complain in connection with menopause. Among Mayan Indian (Beyene, 1984), North African residents in Israel (Walfish, Antonovsky & Maoz, 1984), the Rajput of India (Flint, 1979),and Japanese (Lock, 1986) the occurrence of somatic symptoms is either low or absent. These differences are often attributed to the fact that menopause precipitates a positive role change for women in many non-Western cultures (Flint, 1975; Griffin, 1982).

Other anthropological researchers imply that it is not the particular culture that influences women's experience of menopause, but certain personal and social variables. Wright (1982) in a study of Navajo women who lived on a reservation found that health and economic status are the best predictors of menopausal symptom experience. In a Belgium study, Severne (1982) demonstrates that women who have greater material and educational facilities are less prone to difficulties of the climacteric. Both researchers point out that employment has a positive effect on experiences of the upper socio-economic women. Housewives, especially in the lower socio-economic groups, experience more menopausal symptoms. Similar results are recorded in a study undertaken by Abe and Moritsuka (1986) with a group of Japanese women. Low educational background, dissatisfaction with present life and the feeling of being in poor health; having few intimate friends, low self-esteem and being anxious about the future, are related to menopausal symptoms and complaints.

There is evidence of ethnic and religious differences in women's experience of menopause. Flint and Garcia (1979) indicated that Cuban women have more negative attitudes and are more apt to feel sickly Goodman (1980) found Caucasian and Japanese women living in Hawaii to be asymptomatic, while Bart (1979) found Jewish women more likely to be depressed at menopause than Christian women.

These findings are not accepted by all anthropological researchers. The assumption that role stability or status gain of postmenopausal women in different cultures have an effect on their menopausal experiences has been challenged by Davis (1983) who claims that cross-cultural studies reflect a narrowness of scope with the emphasis on discovering which group has the most negative attitude and which reports the most symptoms. Davis argues that the day-to-day interaction of a variety of sociocultural factors is ignored in favor of easily quantifiable data that tends to characterize

menopause as a medical issue. In addition, Beyene (1984) contends that we know virtually nothing about the relationship of genetics, environment and diet to circulated estrogen levels, nor about the interrelationship of psychosocial variables and estrogen levels. Lock (1986) in a study conducted with Japanese women, concludes that indiscriminate use of symptom reporting lists and psychological scales can lead to erroneous results if the items have not been tested for cultural validity. Furthermore, Lock, Kaufert, and Gilbert, (1988), point out it is essential to use small-sample, intensive interviews to gain an understanding of how the subjective experience of menopause is a product of particular cultures and sub-cultures, of individual biology and of a personal history.

Feminist Understanding of Menopause

The social-cultural model of menopause is accepted by feminist investigators of menopause. The implicit argument behind the feminist construct of menopause is that there is no consistent relationship between biochemical or physiological changes and behaviors (Weideger, 1976; Gornick & Morgan, 1972). Symptoms are a response to factors that repress women, this model proposes, leaving them powerless. Some of these factors are sex-role conditioning, decreased status at this stage of life, and loss of role. Because of the importance attached to the role of mother for women the loss of this role when the nest empties is seen as an important factor in menopausal depression (Boston Women's Health Book Collective, 1976). In the feminist view women do not equate menopause with a physical process but rather a social process which especially in the industrialized world, leaves them devalued in society.

Women's Attitude Towards Menopause

The medical and health care systems, sociocultural studies and feminist thinking each give a specific meaning to menopause. These views in turn affect how menopause is perceived, experienced and expressed by women themselves.

Women's attitudes towards menopause has been the subject of several studies. Neugarten (1967) conducted a study regarding attitudes which women hold concerning menopause. The women in the study saw other menopausal women in a more negative light than themselves. Half the women identified negative feelings and events related to menopause, such as losing physical attractiveness or a dreaded event. However, 75% felt that after menopause a woman would be calmer and happier than before, as well as being freer to do things for herself. Muhlenkamp, Waller, and Bourne's (1983) findings were similar in that women rated other women, whether they were menopausal or not, in a less favorable manner than themselves. They did not link negative attitudes to women in menopause anymore than to women in general. In a study of Belgian women, Boulet, Lehert, and Riphagen (1988) demonstrate that women did not consider menopause to be a traumatic event in relationship to other life events of midlife. The findings do indicate that post menopausal women, women from conservative groups and in lower socio-economic situations attach more importance to menopause than women in other categories.

There is some evidence that women regard menopause as a condition requiring little medical intervention. Kaufert (1986) found that women do not hold the view that menopause is an event to be medically managed. In a study of 2500 Canadian women, approximately one third of the women who had experienced menopause had never asked a physician, nor been told whether or not they were menopausal. Less than half said that they had reported any type of menopausal symptom to a physician. On the

other hand, Leiblum and Swartzman (1986) found in a group of 244 women of varying menopausal status that although the majority of respondents felt that menopause should be viewed as a medical condition and treated as such, they did not subscribe to the notion that it was a particularly malevolent one. The women also preferred natural treatment over hormones, were apt to attribute psychological difficulties that occurred around the menopause to distressing life changes than to hormonal fluctuation and strongly rejected the notion that sexuality is seriously compromised subsequent to menopause. Less educated and older women were more likely to subscribe to a medical view of menopause than younger and more educated women.

In terms of actual knowledge of menopause, LaRocco and Polit (1980) found that myths and old wives tales still abound regarding menopause. On the average, women ages 40-60 in the study responded correctly to 59% of the questions regarding menopause. Younger women, those who were employed and women with higher levels of education performed better than older, unemployed and less educated women. Women showed the least knowledge on questions which were associated with negative expectations about menopause and would indicate that these are still held by women.

Some researchers suggest that women's concept of themselves does not change at menopause. Rosenhand (1984) found that self-concept and feelings of femininity were unaffected by menopause. Very few women expressed regret about the end of menstruation and the majority indicated that their marriage was better than ever. Wiskel (1985) also found that women's sense of well-being was not affected during menopause.

Conclusion

The sociocultural view of menopause expands the view of menopause, but it restricts the view of women. It expands the concept of menopause by taking it beyond

a bodily disorder from which women need to recover. However, it reduces women to a set of roles and functions or a composite of reactions to the society or environment. In this model menopausal changes and variations are interpreted either as social or as cultural symbolic events without however, a theoretical basis for understanding how social and cultural factors can lead to the physical and psychological symptoms that women experience.

The sociocultural view tends to minimize the biological side of menopause. This is especially seen in the feminist literature. The result of this is that some women who are experiencing physiological complaints might be deprived of adequate health care. This understanding of menopause could also have the effect of creating guilt in women because any discomfort they feel, must be in their heads, since the biological side of menopause is not significant .

Summary

From the literature review it can be seen that many meanings or interpretations are given to menopause. The past research has provided descriptions of the menopausal experience which focuses on dysfunctional aspects of menopause and links these to defects originating at more basic levels, such as hormone deficiencies, psychosocial conflicts, family or environmental stresses or societal prejudices and sanctions. In addition, past research ignored the context of the menopausal event. It tended to make a distinction between mind and body, cognitive and emotional factors, normal and abnormal phenomena, biological and sociocultural variables.

Menopause happens to women who live within a certain temporal order. They live in a certain culture, in a particular period of history, and have a given set of personality traits. Developmental issues, concerns arising from the life situations, psychodynamics

of the individual, expectations from cultural stereotypes may all contribute to women's experience of menopause. All these factors are integrated into women's lives. It is necessary, then, to look at ways in which women understand and interpret these experiences. The real meaning of menopause, then, must be grounded in the experience of women themselves. In this way models can be found which go beyond seeing women as only bodies, a set of roles, or victims of their hormones, psyches and societal stereotypes.

CHAPTER 3
METHODOLOGY

The purpose of this research is to gain an understanding of menopause by considering how women view the experience. The literature review indicates that although there is a great deal of information available on menopause, it is based on assumptions which are not adequately verified or are based on a limited perspective of menopause. What is needed is an approach to the study of menopause that will not use former assumptions as the theoretical framework, but will consider the various perspectives of menopause as they are integrated into women's experiences. The most appropriate method of research to be used in this situation is grounded theory.

Grounded Theory Methodology

The purpose and structure of grounded theory make it the most reasonable choice in an area of inquiry where a new focus is needed. The grounded theory method of research is a systematic way to collect, organize, and analyze data. The aim is to gain an understanding of how a group of people define their realities via social interaction. Its function according to Stern and Pyles, (1985) is to discover and generate explanations for phenomena by identifying the dimensions, characteristics, and the conditions under which these realities occur and vary (p.8). It is for these reasons that the grounded theory method offers a new approach to an old problem. In addition, Stern (1980) believes that the grounded theory method can offer a fresh perspective in a familiar situation because the researcher looks at interactions before static conditions.

Grounded theory is especially suited to a study of women's view of menopause because the resulting theory emerges or is grounded in the experience of the women.

This is achieved by using a process of comparative analysis which compares every piece of data with every other piece. By doing this the researcher attempts to discover the core variable or category which is the essential requirement for grounded theory research. The core category will account for most of the variation in women's view of their experience of menopause. The other categories and their properties that emerge from the analysis will be related to the core category and be the basis for the generation of a theory on menopause.

The grounded theory method of research is also suitable for this research because it is based on the assumptions of symbolic interaction. One of the assumptions of symbolic interaction is that it assumes that the meaning of an event must be understood from the perspective of the participants. The other significant assumption for this study is that meanings are derived through social interaction which includes the participants' self-definitions and shared meanings. These assumptions contribute to grounded theory as an approach to the study of women's view on menopause because they are based on the contexts and forces that impinge on human conduct. Grounded theory, then, is an approach that can examine menopause as a multi-dimensional experience instead of as a one-dimensional reality. Benoliel (1983) states that grounded theory method is "one means of conceptualizing the interacting influences of personal characteristics, social processes, and cultural circumstances as they bear on the adaptation of individuals and groups to crises and change "(p.184).

Data Collection Methods

The Sample

For the purpose of this research menopause was defined as the cessation of menses for a minimum of 12 months, not obviously attributable to other causes (Treloar,

1982). For this reason, women who had experienced surgical menopause or menopause caused by reasons other than natural causes were not included in this study. However, because one of the assumptions of grounded theory is that the sampling be done across the phenomenon, women who were perimenopausal, that is, who had experienced some changes in menstrual flow or irregularity, as well as women who were postmenopausal, that is, had not experienced a period in 12 months, were included in the sample.

One of the limiting factors of previous research had been the extensive use of clinical populations of women. For this reason two further criteria delineated the sample. One was that the women possess good physical and mental health. The other criterion was that the mean age for menopause of 51 (Friederich, 1982) be used as a guide. Since Friederich also states that ovarian decline begins about five years prior to menopause, the age of 45 was used as the lower limit of age for the sample.

Sample size was not predetermined. This is not possible in grounded theory according to Field and Morse (1985) because appropriateness and adequacy of data received from the informants are more useful in evaluating qualitative samples than probability and sample size (p. 92). The sampling continued until no new information was collected, concepts had been confirmed and the researcher had gained an understanding of the situation. In order to achieve these goals of grounded theory, eleven women were interviewed.

Informants came from two sources: informal contacts and one family physician who had agreed to invite participation of women patients. Special care was taken in discussing the sample criteria with the physician. These women received a letter explaining the project (see Appendix A). The doctor enclosed a covering letter confirming his approval of the study. The investigator followed through with a phone

call to informants, whose names were supplied by the physician's office and by informal contacts, to seek the women's assistance in this project and to answer any questions or concerns. No pressure was placed on the women to participate. If the women agreed to become involved, an initial interview was arranged.

Of the eleven participants, six were perimenopausal and five were postmenopausal. Of the six perimenopausal women, two were having regular periods, but noted other unusual menstrual modifications such as change in flow or number of days of flow. The four other women experienced their periods intermittently with two to four months time lapse in between periods, as well as changes to the flow and number of days. These menstrual alterations had been occurring from six months to three years. At the time of the interview the four women had experienced a period within two months. The women who were postmenopausal had not experienced a period in 12 months to two years.

All of the women considered themselves in good health except one woman who felt her health was affected by "going through menopause." None of the women had undergone a hysterectomy; three had had a D&C because of excessive bleeding. Although eight of the women were referred through a physician's office, they had not started to see him because of any menopausal difficulties, but had been using him as a family doctor for a number of years. Three women were on a hormonal medication.

The ages of the women ranged from 45 to 58 years. Nine of the women were married, one woman was a widow, and one was single. Eight of the married women had children, ranging from two to five in number. Of the eight women, three no longer had any children living at home. One woman was unable to have children. The education level varied from women who had completed high school to women who had post graduate education.

Data Collection and Recording

The main method of data collection consisted of unstructured interviews. This method of data collection was chosen because it allowed the interviewer to explore previously unexamined directions. The informants could also teach the interviewer about the phenomenon. An interview schedule of general questions was used as a guide (see Appendix B). All interviews were audio-taped and transcribed verbatim for data analysis. Second and third interviews were scheduled when there was a need for additional data, clarification, or confirmation of existing data analysis.

A secondary and supplemental method of data collection was participant observation (by the interviewer) and field notes. The observations consisted of a record of perceptions made by the researcher to compare and contrast what was said with what was seen and experienced. These observations were compared with what was said by the participants. Field notes connected ideas or gave possible directions for the next interview. Both the observations and the field notes were written immediately on leaving the interview site.

Interviews were conducted in face-to-face sessions over a four month period in settings of the participant's choice. The eleven first interviews were forty-five to ninety minutes in length. One was a joint interview with two women who had agreed to participate in the study. Five participants were interviewed a second time for periods of one hour to one hour and a half. Four interviews were held at the researcher's house, three at the participant's work place, one in a church office, and eight in the informant's house.

Most of the first interviews were sixty minutes long. The first part of the interview consisted of becoming acquainted with the participant, explaining the general purpose

and format of the research, assuring confidentiality, completing the consent forms and offering a summary of results after completion of the research. Participants had few questions to ask, but seemed more concerned about the value of their experience in relation to the research.

The second part of the interview was an unstructured questioning process. The first statement made was, "Tell me something about what has happened to you since you have had your last menstrual period, or since your periods have been changing". This allowed the women to share any event of their present lives that they thought was significant, to describe their menopausal history of recent years or to define where they were with regards to menopausal status.

The second interview lasted forty-five to ninety minutes. It was held approximately two months after the first interview. Questions for the second interview were developed prior to the interview. These arose in part from a careful scrutiny of the first transcript to clarify areas that appeared confusing or contradictory to the researcher, as well as questions that came from other participants' responses. Some concerns and issues that came from the field notes taken immediately after the first interview were also incorporated. In order to help the interviewer arrive at the core category, the informants in the second interview were asked to draw an illustration of where menopause fit into their lives or to discuss one that the researcher had drawn prior to the interview.

All interviews were audio-taped and transcribed verbatim immediately following the interview. This method of data collection records or aims to record, everything that was said and the manner in which it was said. In this way, meaningful information such as participants' reactions to questions, inflections, points of emphasis and other communication methods were preserved. Names of participants and references to

family members were altered during the transcriptions to preserve the anonymity of participants.

Data Analysis

The major task of the researcher was to code the data into categories and then to define, develop and integrate them. This required that the researcher simultaneously collect, code and analyze the data from the first day in the field.

The first step in concept formation was to code the data. This was accomplished by reading the verbatim transcribed interviews so that the beliefs, attitudes, and perceptions of how women viewed the process of menopause could be identified. In the preliminary analysis, a system of open coding was used whereby the data were examined line by line or incident by incident and the key words or codes that symbolized the event or process were underscored and written in the margin of the transcript. These key words and the context in which they were embedded in the interviews became the coding units or incidents for further analysis. Clusters or categories were formed according to obvious fit. The following example illustrates the initial coding of data:

> I just want to have lots of energy and I mean I don't expect to be as young as I was, I think that's naive, but I just want to be able to do everything that I want.

The underlined words was originally coded as "wanting to get back to being me". After further analysis of the interview there arose a cluster of codes that centered around the idea of "returning to normal."

The data from each interview were constantly compared across interviews with the same person, as well as with interviews provided by different informants. As a result of this fundamental method of data analysis in grounded theory, known as

"comparative analysis" the researcher looked for patterns which described women's experience of menopause. By comparing similar incidents, certain differences were noted, boundaries were established and relationships among categories were gradually clarified. For example, as a result of comparative analysis it was found that the cluster of ideas around returning to normal was part of a larger category called "wanting to take charge."

Once initial categories were formed, the researcher continued to search for additional categories. It was necessary to reduce certain categories by making them more specific or more general in nature. This process was aided by the discovery of the negative case that contradicted the criteria that had been identified for some of the categories. When the negative case was identified it became clear that there were two parts to a category that had been developed called "losing control." The negative case felt that she was in control over her life, however she attributed this to factors that were out of her control, that is, to heredity and to the way "things were meant to be." Thus to the concept, losing control, was added the concept of "beyond control" to include those factors of menopause that a woman could not control.

An important part of generating theory about women's experiences of menopause was memoing. According to Glaser (1978) "memos are the theorizing write-up of ideas about codes and their relationship as they strike the analyst while coding" (p.83). In the beginning of the study, the principal source of memos were the codes themselves. These memos appeared in the right hand margin of the transcript. As concepts emerged, the memos were written about relating concept to concept, drawing out the properties of the concept. Memos also reflected the thinking process of the researcher as connections were developed among concepts. Eventually categories and their related properties were delineated which allowed definitions to be formulated. The

definitions then acted as a guide for further data gathering. For example, it was found through the process of comparative analysis and memoing, that the concepts of beyond control and losing control were part of the higher ordered category of "seeking equilibrium."

As the researcher brought the higher order categories together, the conceptual framework began to take shape. Categories were linked and tentative hypotheses regarding women's perception of menopause were formulated and then further tested against the data. For example, it was hypothesized that a woman's experiences of menstrual periods would reflect her experience at menopause. In order to test this hypothesis another method of grounded theory was used called selective sampling. From the list of informants one woman was interviewed that did not fit the hypothesis, that is, her history of menstrual periods was uneventful but her menopause experiences were very uncomfortable.

Selective sampling was also used to saturate categories and dimensionalize them. Previous informants had indicated that they did not want to go on medication, while one woman anticipated that hormonal medication would be a solution to her present problems. Information was needed that would add to the concept of medicine as a coping strategy. Another category that needed further saturation was "loss of role of reproduction." A woman who was single with no children was interviewed to develop this category.

Incidents, while descriptive of women's view of menopause, did not make the theory. They served to illustrate the theory. If an incident contributed to a new property of a category, or signified a new category, it was retained and integrated. Incidents which did not contribute to the emerging framework were discarded.

At the same time that analyzing of data was taking place the researcher was consciously looking for a core variable. Glaser (1978) describes a core variable as "the main concern or problem for the people in the setting, for what sums up in a pattern of behavior the substance of the what is going on in the data, for what is the essence of relevance reflected in the data" (p.94). Several times throughout the research it seemed as if the core variable was emerging. However through verification by second interviews and also a joint interview with two new informants, these categories were not confirmed as core. One more informant was added to the sample after the joint interview to assist in discovering the core category. Through further comparative analysis of the data, the core category emerged which adequately described how women viewed the experience of menopause across the sample.

The final conceptual categories were re-grouped until five categories emerged that were dense with concepts and saturated to the point that a range of variation was present. The researcher examined all of the categories, their relationships to each other and to the core category. The resulting relationships were laid out in the form of a diagram (see Figure l). In this way the researcher was able to visually examine the emerging theory for poorly developed categories, missed or incorrect relationships. The five categories are discussed in Chapter Four.

Validity and Reliability

Scientific research is concerned with rigor which is demonstrated by the validity and reliability of the findings. Generally validity refers to internal and external validity, and reliability refers to the accuracy of the measuring instrument and the replicability of the study (Kerlinger, 1979).

Internal validity refers to the approximate truth of the study. In qualitative research internal validity refers to the extent to which the research findings represent the reality of the participants. One major concern of internal validity in this kind of study is whether the theory generated from the data was objective and validly represented the experience of the participants or was it the subjective interpretation of the researcher. This was dealt with in this grounded theory research by the researcher going back to the informants with the analysis to confirm that the emerging categories, definitions and their relationships represented or were grounded in their experiences. Peers, knowledgeable in the area of study were consulted to help validate the researcher's organization of the content.

External validity refers to the generalizability of the observations to other populations. This is usually achieved through random sampling of a population to assure the distribution of a property. In this grounded theory method of research, the purpose was to describe women's view of menopause and in doing so to discover the diversity of experience. In grounded theory, generalizability rested on internal variety (Chenitz & Swanson, 1986, p.13). The range and variation that was achieved through theoretical sampling in this study increased the generalizability so that the results represented a range of women 's view of menopause. The discovery of the "negative" case was addressed and incorporated into the categories.

Reliability in a qualitative study is best judged by consistency rather than by replicability (Lincoln & Guba, 1985, p. 292). In quantitative research reliability depends on the ability of one researcher to duplicate the results of a previous researcher. In a grounded theory approach no two researchers would have structured the data collections, interacted with the participants or analyzed the data in the same way, so no two theories could be exactly alike. The analysis of the data was the result

of a creative, interactive process between the researcher and the data. However it is hoped that the results were presented in such a way that it provided for the potential of auditability whereby another researcher can test the findings by tracing the line of reasoning and come to the same conclusions.

Since the investigator is the measuring instrument, her accuracy, focus and biases were critical in this data collection method of unstructured interviews. In addition, the status position of the researcher is important as it can prevent informants from revealing certain information. The fact that the researcher was in the same age cohort as the informants contributed to the "naturalness " of the conversation.

Another test for reliability is through the use of the theory and its applicability to similar settings. In qualitative research it is up to the audience to determine what application the research outcome has to other contexts or settings. The presentation of a theoretical model of women's menopausal experiences which is based on credible findings will provide other researchers with the opportunity for further testing.

Ethical Considerations

Before the first interview began, a written informed consent was signed by the informant and the researcher (see Appendix C). The form briefly outlined the intent of the research, the format of the interviews and the participant's right to control their own contributions, to not answer questions and to withdraw from the research if they chose.

The confidentiality of the information was maintained in the analysis and presentation of the results The participants were renamed during transcription. Personal details were altered in the research report to ensure that participants would not be identifiable in any of the excerpts used to illustrate the concepts. In addition, the written consents, interview tapes and transcribed interviews were stored in the

researcher's home in a locked security box. The true identity of the informants was not present on the tapes nor on the transcribed interviews. The transcribed interviews and written consent forms will be kept for a period of five years by the researcher.

The unstructured interview as a method of data collection can present some difficulties that require special consideration. The method required the informant to centre on an aspect of her life and the interpretation of it. While some researchers identify this method as a potential benefit for the informant, the method also presents risks (Cassell, 1978). The process of reflecting on the experiences associated with menopause with the guidance of a skilled interviewer may change the woman's view of some aspect of her life and cause her some distress. To provide for the possibility of this event, if an informant appeared distraught or requested more help a list of agencies that provide workshops and seminars on menopause and other aspects of concern for women in midlife was provided.

A short report of the research findings will be forwarded to each informant upon completion of the study. They will also be invited to an informal evening to discuss the study and their reactions to it. The purpose of this gathering will be to inform and educate the participants about women's experiences of menopause and to check for any confusion or negative feelings that may exist (Tesch, 1977).

CHAPTER 4

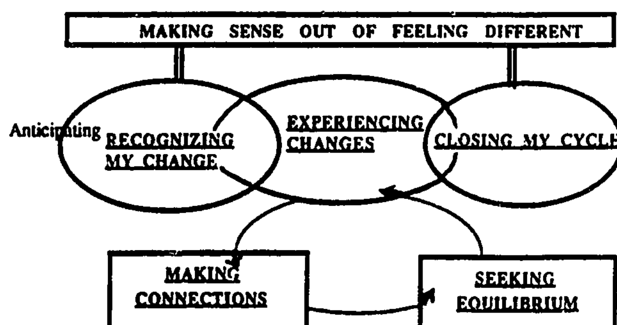
RESULTS

The purpose of the research was to describe how women view the experience of menopause. In order to accomplish this, the first goal of the research was to discover and name the conceptual elements which would account for how women see themselves becoming menopausal. The concepts which emerged from the data indicated five stages. These are: recognizing my change, experiencing changes, connecting the changes, seeking equilibrium, and closing my cycle.

The second goal of the data analysis was to locate and name a core category that describes how women view the process of menopause. The core category, "making sense out of feeling different", was identified through comparative analysis of the data obtained from the interviews. Several categories emerged as possible core categories during the initial analysis, but were not confirmed by further data collection. Only "making sense out of feeling different" linked the various data together and explained much of the variation. The core category was also identified as a basic social psychological process because it included two or more clear emergent stages with individual properties and conditions which unfolded over time and involved changes (Glaser, 1978, p. 97-101). The following diagram illustrates the basic social psychological process, "making sense out of feeling different," and the stages that are are part of it.

Figure 1

A MODEL OF MENOPAUSE



In this chapter an overview of the core category will first be given. This will be followed by the results of the analysis. Each of the five stages of achieving menopause will be defined and evidence for each stage will be provided from the transcripts. The variety of experiences as well as the pervasiveness of patterns across the sample will be demonstrated by references to the data. The last part of this chapter will define the basic social psychological process, making sense out of feeling different, and relate each stage of the process to the core category.

Overview of "making sense out of feeling different"

The common theme present in women's experiences of menopause was that the women were feeling different or feeling that something different was happening to them, as a result of various physical or emotional sensations. These differences varied. Consequently women journey through the five stages proceeding at different rates. For each woman a stage could last longer or be experienced more intensely. The process was very simple and straightforward for some women, while for others it was more complicated and arduous.

Despite individual differences the women went through the same process. The first stage of making sense out of feeling different was recognizing that the changes to their menstrual cycle were indicative of the beginning of menopause. In the second stage women continued to experience changes, which were either physical, emotional or both and these caused various disturbances to their lives from slight inconveniences to major interferences with their normal activities. For some women changes that were generally considered part of the second stage were part of the first stage for them, as they needed

further changes such as hot flashes to help them identify that they were peri-menopausal.

All the women attempted to find an explanation for the pattern of changes they were experiencing. This led to the next two stages, making connections and seeking equilibrium. Making connections involved seeking explanations for the pattern of changes by referring to past experiences, while seeking equilibrium referred to the desire women had to offset the changes so that they could be in charge of their own lives. For some women making connections and seeking equilibrium were processes that took place several times as they continued to experience different physical or emotional changes. The last stage of making sense out of feeling different was the closing of the cycle. This was an ambiguous stage for many of the women as they did not know when they had completed menopause and therefore, from their perspective, they were still experiencing changes.

Making sense out of feeling different, was the common underlying theme at each of the stages. The women wanted to understand what was happening to them and they wanted to feel normal. One woman summed it up in this manner:

> Menopause didn't come, I was expecting it and it didn't come. But when it did I thought it was great. I mean I'm fifty-four years old. I was eleven years old when I started to menstruate, so it was an awfully long time. And I thought it was great. I thought as long as I don't feel different and I feel I can do anything I want, it'll be great. They (periods) are gone. There comes an end to everything.

Anticipating "the change"

Before the women in the study began the process of menopause they had a general awareness that one day their menstrual periods would stop. On the whole it was not a subject they gave much thought to before the age of forty. After that age, several women encountered specific incidents which heightened their awareness of menopause. This included participation in a teaching seminar on menopause, or a breast biopsy

which became the reason to begin reading on cancer as well as menopause. Other women as they became older were made more aware of menopause, especially if their friends had become menopausal.

> Well like I say, it's something that you know sooner or later because you are a woman, that it's going to come and that you're going to have to deal with it. I think once you reach 45, then you start thinking more about the fact that your period is going to come to an end.

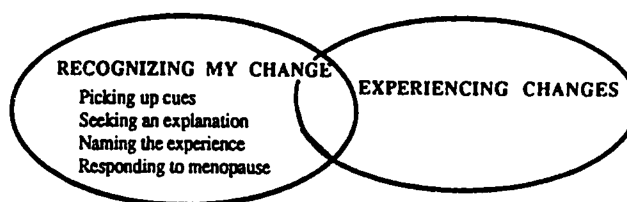
> Most of the people, most of my friends who are about my age, they've all finished three, four, five years ago. It's (my periods) still hanging on.

Recognizing My Change

Definition

The first stage of making sense out of feeling different is "recognizing my change." It is defined as the time when a woman realizes that her periods are changing and personalizes this as her experience of menopause. It includes picking up cues that the menstrual cycle is different, seeking an explanation for this difference, naming the change and responding to this acknowledgement.

Figure 2



Picking up cues

For all the women in the study, noticing a difference in the pattern of menstrual cycle was the key to recognizing that their bodies were undergoing a change that would lead to menopause. The menstrual changes occurred in a variety of ways. For some women, the length of the cycle was shortened or lengthened or they had intermittent

periods. The number of days of flow decreased or increased for other women, or the flow became heavier or lighter. For most women, these differences either happened gradually or were noticed gradually. Several women experienced a very sudden change in their menstrual cycle, in that their periods either stopped abruptly, or became very light. The following excerpts illustrate the diversity of cues that women noticed about how their periods were changing.

> Well, I think that the shortness of the length of my periods, from a normal five or six day cycle, they just gradually tapered right off to a day. And that was my first indication that my body's changing.

> I just figured I had lost track of the calendar. I just don't worry about it. And because I was not getting the hot flashes and I was not experiencing what all my friends were experiencing, I was convinced that I would never have menopause. And when finally after a couple of times when I was missing my periods for a longer stretch of time I realized that it was happening. But I didn't wake up one morning and say, hey, this is it. I was into it before I realized it.

> It wasn't like just all of a sudden you notice it. It's like almost a gradual change, until all of a sudden you realize that you aren't feeling the same and that it is going on longer, at least in my case, it's going on longer, and heavier and it was almost like waking up and saying, gosh, is this normal? Am I going to hemorrhage?

> And I never had any problems before, I mean up to fifty-four, it was regular, every month, the same day, just about, and then all of a sudden it stopped.

At the time that their periods were changing, women also noticed other physical sensations taking place. Physical distress associated with monthly periods such as bloating, sore breasts, headaches and premenstrual tension were considerably reduced for several women. On the other hand, three women experienced more bloating, headaches and cramps than normal for them at this time. Extreme or uncustomary fatigue was also a cue for some women that something different was happening.

Seeking an explanation

Women attempted to find an explanation for these physical changes they were experiencing. They used diverse sources to find answers. Some women knew the

meaning of the changes because of previous knowledge derived from medical or non-medical reading. Other women talked to women relatives or friends. Some women confirmed their conclusions with the doctor at their annual check-up.

> Actually menopause never even entered my head at that stage. I just thought there's something wrong here and I better find out what it is.
>
> Oh, all my life, I've read articles, if I happen to pick up a magazine, that happened to have something in it, like I wouldn't get an actual magazine or article just on menopause.
>
> Well just from talking to some of my friends that have gone through actual menopause and are no longer going through it, I would say that I've just started.
>
> And therefore naturally I thought, it must be something that's affecting this and what have you. But I didn't bother about it until I went for the yearly physical.
>
> When these things (heavy flow and bloating) happen you don't necessarily run up there (doctor's office) right away. You just think, oh well, what happened? Like, it'll go away, right?

Those women who found the changes to their cycle to be very unusual or who were suffering some health problems around the time of their periods consulted the medical profession for an explanation. One woman went to the doctor to determine if she was pregnant when her periods stopped abruptly. Sometimes the explanations that were given erased women's fears and concerns, while other times it caused frustration.

> My reaction was that possibly I had a medical problem. I think most women immediately start thinking about cancer because everybody says if you get a drastic change in your period and especially if it's a heavy flow there could be a growth on your uterus. Well I think I went for about two, three months before I actually went to see my doctor and then when I went to see him and told him his first reaction was that, "well, maybe you've started your change" .
>
> When these things were starting and I was beginning to question what was happening, I got the response from my doctor, "It's your age". It's not something that makes you feel any better though. Am I starting menopause? Well he can't say. I mean this is the answer that I got. So eventually I could see women thinking with that kind of response, well it's just something I have to go through.

Naming the experience

After women had an adequate explanation for the change in their cycle or at least the best that they could receive, the next step was naming the experience. To do this the women used a variety of expressions: starting menopause, in menopause, beginning menopause, starting my change or premenopause. All of these terms meant that the end of their menstrual periods was approaching.

> I realized that's all it was, just the beginning of the menopause.

> Oh, I thought I was just too hot. But I kind of thought it was different and by then I was missing the odd period so I just assumed it might be menopause.

> I think what I've maybe recognized medically just recently is that I am definitely in premenopause. I mean I'm certainly not moving into the active part of menopause as yet. I've got a lot of symptoms medically, but I think that it's what's ahead might never happen or might happen.

Responding to menopause

Naming the experience brought an immediate response. The women expressed relief and even joy that their periods would be over. This was especially true for those women who had experienced difficulties during their monthly periods. One woman said she was "on top of the world" that her suffering would now be over. Another woman said she was excited at the possibility of not having to endure her usual difficulties each month. Other women were simply pleased that soon they would no longer have the inconvenience of menstrual periods.

Along with the note of optimism, the women expressed some concerns about starting menopause. They were worried about emotional difficulties they might experience as well as apprehensive about the length of time it would take to finish the menopausal process. The women expressed these fears in the following manner:

> Well I was a little bit leery because I'd heard of how some women go through menopause. They have problems. But the other reaction was oh boy, I hope it's quick so I can quit having my periods altogether.

> I really hope it doesn't go on and on and on and that I don't run into some problems. Like I know the tendency for depression has always been there.
>
> I suppose this was the first physical sign that I'm heading in that direction, so I suppose from there on I probably became quite apprehensive about what's coming next. Now I'm going to have all these other marvellous things happening that I've concerns about. I was very pleased to see the first sign. I think the inconvenience of periods is something we all would like to be rid of.

Summary

Women ended the first stage of menopause when they recognized and named the break in the pattern of their menstrual periods as the beginning of their menopause. The change in pattern did not happen in the same manner to all women. In addition, the women looked forward to the end of their menstrual periods with ambivalent feelings as there was a concern that the process might involve some unpleasant experiences.

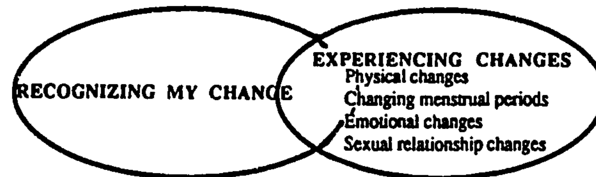
Some women needed other physical sensations, such as hot flashes, to confirm that they were beginning menopause. Other women had various physical and emotional changes occurring at the same time that they noticed their periods were changing. For some women, the end of stage one came when they recognized all these changes as starting menopause.

Experiencing Changes

Definition

The second stage of making sense out of feeling different was the occurrence of physical and emotional changes that women experienced after they defined themselves as being in menopause or premenopause and up to two years after their periods stopped. It also includes changes to the menstrual cycle. It excludes role changes or other sociocultural changes that women may also be experiencing at this time.

Figure 3



Physical Changes

The physical changes that the women experienced varied in kind and in intensity. One woman scarcely felt anything physically different was happening to her, while another woman felt that her body was "falling apart" to such an extent that she did not even feel like herself. The period of time in which these physical changes took place in the different women ranged from six months to three years.

All women in this research did encounter physical differences that had not occurred before their periods began to change. These included bloating, cramps, insomnia, facial hair, thinning of vaginal walls, less vaginal lubrication, shortness of breath, tingling of extremities, hot flashes, night sweats, excessive perspiration and enlargement of thyroid. These physical sensations caused various degrees of discomfort.

Hot flashes

The most common physical sensation of women experiencing a change in their periods, or even if menses had stopped, was hot flashes. Ten out of the eleven women interviewed experienced some kind of hot flash. The experience varied from a feeling of clamminess to unbearable feelings of being hot. Some women gave very vivid descriptions of hot flashes. The following excerpts are some of the women's descriptions and reactions to hot flashes.

> Just sometimes feeling sticky and hot. But for a length of time feeling as you would on a hot day when it's a bit muggy outside, that clammy feeling. But it isn't hot and it's not muggy outside. It's just you.
>
> I would just be sitting at my desk at work and all of a sudden you get one of these and you would feel totally wet and you're totally exhausted from it. It's like you've been doing something very exerting. And then all of a sudden it's gone. It lasts for maybe five to ten minutes sometimes.
>
> I can remember though when I started the hot flashes. I just couldn't get over them. They just astonished me so much. I mean, they would even take my breath away. I can feel the heat coming out of the top of my head. I feel like I'm burning up inside and yet I'm cold on the inside.
>
> Oh and you'd just see me from the bust up. I would just turn red. I would just flush. My nephew was sitting here one day and I went to the door and I went like this (Pulls T-shirt out at the neck) and he says, "Auntie, I see steam."

Hot flashes were also seen as an inconvenience by some women. For one woman they were a source of embarrassment and two women felt that other people might be wondering if there was something wrong with them.

> But as I was dashing about, serving food and so on, I just had more hot flashes and I was absolutely dripping wet, just beet red. When everyone left I asked a friend afterward, "Did I look like I was beet red?" and she said, "Not at all." And so that's really uncomfortable. You'd rather that it didn't happen. That's a fact.
>
> And it's an uncomfortable feeling because you can feel your face and your neck and your arms, you can feel that there's perspiration on them. You think that everybody's looking at you and saying that there's something wrong with this lady.

Cramps and bloating

Feelings of discomfort were also associated with other physical sensations. Several women experienced severe cramps. One woman compared them to labor pains. Another woman used the comparison to pregnancy to speak of the extreme bloating that she experienced at times. For another woman the retention of fluids was inconvenient and was a constant reminder that something was happening to her. The women expressed feelings of irritation and frustration.

> One of my worst experiences was early in the spring, when I think I went about three and half months without a period, and I was so bloated that I really truthfully felt pregnant. It was heavy and just uncomfortable. It was horrible.

But when you retain your fluids and your ankles are puffed up and you can't get your rings on and off. That's a tremendous inconvenience and so you're reminded all the time, hey, darn it, there's something going on here.

Fatigue

Fatigue was a concern that five women mentioned. They did not all associate this feeling of being tired to menopause. Some women simply thought that as they became older they expected to have less energy. Others linked fatigue to factors such as sleep disturbance due to the night sweats. or to blood loss due to the excessive flow from their periods. One woman found her lack of energy to be the most annoying factor of her experience of menopause.

Just fatigue (is the biggest change) and that I find extremely annoying.

Then I would wake up and I'd even have to get up and change my nightgown. I was just wet. And then I would walk the floor and then I would lay down and then I would kick the blankets off and it was just a miserable time.

I'm a little more tired, but I put that down to being older. Like I haven't suddenly gotten more tired, it's just that I'm just not as energetic as twenty years ago.

Weight gain

Weight increase was another physical difference that some women experienced at this time. The women felt very uncomfortable with the weight gain and did not feel very attractive as a result. However sometimes the women were not entirely sure that the weight gain was connected to menopause.

I just don't feel good in my clothes and I am gaining weight. When I look in the mirror, I don't feel good about what I see, a sort of rolly-pollyness, I'd rather be without.

My weight is another problem. That bothers me. I fight with it. I always have fought with it.

Changing Menstrual Periods

During this stage of menopause, the women continued to experience changes in their periods until they stopped completely. Erratic lengths of menstrual cycles were common to a number of women. Some women found that their periods were easier to cope with now than in the past, while others found that they were encountering more misery. The excerpts below illustrate the range of experiences.

> They quit gradually. Like I'd miss one and then have one....but when I did get them back, they were right on time and they were as usual. And then I didn't get one for six months. And then again I did and then it was about ten or eleven months I hadn't had any and then I got one. And now it's been a year since the last one.

> They were very heavy and I often had headaches with them. I really don't have headaches anymore. I find that I'm flowing a lot less at the moment and a little bit shorter because I used to be the full seven days and very very heavy. And I'm down to probably five days and not quite as heavy. And that makes a big difference. It's really quite relaxing actually.

> I would say probably six months after the D & C I was regular again, like without the profuse bleeding and that sort of thing. And then it went back to the heavy bleeding and the heavy flow. And you felt like your innards were literally coming down. I mean it's a strange feeling. And then I went without a period for two months and had hot flashes but nothing of any degree. And that went on for probably three years, no periods for two or three months in a row and then on again. And then I'd have this period for ten days and then not have it for a couple of days and then have it for another ten days. I never knew when I was going to have a period. And a lot more discomfort than I'd ever had before.

Emotional Changes

Emotional changes were common among the women during this stage. Seven of the women experienced some type of emotional change that had not been part of their lives previously, or were present now to a greater degree. The intensity of these changes also varied from woman to woman. The emotional changes included irritability, shortness of temper, insomnia, crying, mood swings and depression. The following illustrate the gamut of these emotional changes.

I'd be vacuuming and I would start to cry. If you'd come in and said, can you put your finger on any one thing, I couldn't. There wasn't anything in my life that was making me cry.

It's more drastic, like all of a sudden you're just very very upset about something that ordinarily you wouldn't be and that seems to happen more often than before.

I can say yes to something and get really excited about it and five minutes later, I can think of all the negative things as to why I shouldn't do it, or vice versa, think of all the negative things as to why I shouldn't do it and then, within five minutes I'm ready for it. I'm really emotionally unbalanced.

I don't notice it in myself. But my kids sometimes said, "Well Mom, you're kind of short sometimes." But I don't notice it.

Sexual Relationship Changes

Some women also experienced a change in sexual relations with their husbands. Two women in particular attributed this to feelings of physical discomfort or fatigue which did not make sexual love making very appealing. Vaginal lubrication was less than normal for two women, but it did not interfere with their normal sexual relationship patterns. Another woman expressed concern because she felt that she was losing her desire for sexual relations and that this was very different from previous years.

I can certainly relate to having no lubricant. Definitely. And at times, maybe not as bad as other.

I think that somehow you never feel totally relaxed, and I think that does affect your sexual life. So I would attribute it (change of sexual pattern) to that. I don't feel a definite lack of interest all of a sudden.

Because if you're not feeling terribly well, you think, "Oh, don't bother me." And you know that you're being unfair and you don't give a damn.

I feel sometimes that I'm losing my sexual desire. This really surprises me because I've always enjoyed sex previously.

Summary

The women all experienced changes. For some women the biggest change was in the pattern of their periods. Other women experienced physical or emotional changes

that were very noticeable and which caused them discomfort. In addition, some women were not clear as to whether the changes they were experiencing were related to "going through menopause" or other factors in their lives.

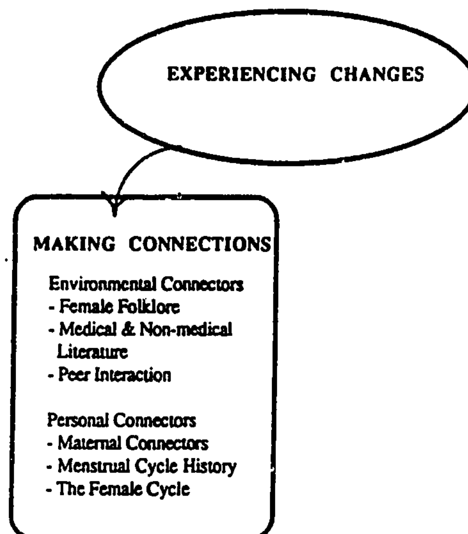
Women wanted to understand why these changes were happening to them. Whatever the type or intensity of change, women expressed the desire to know if their experiences were normal. They also expressed the need to be able to cope with these changes and to have their lives settle into a pattern so that they could meet their personal goals The results of analyzing the data lead to two processes that were an integral part of experiencing changes, making connections and seeking equilibrium.

Making Connections

Definition

Making connections refers to the establishing of links between the changes that women associate with the process of menopause and experiences in their lives. These connectors are factors that women use to gain an understanding of their changes or provide them with a norm by which to measure their experience. The connectors that emerged from the analysis came from two main sources, factors in the environment and personal sources.

Figure 4



Environmental Connectors

The women in the research connected the experience of changes to their expectations of menopause. These expectations were derived largely from society's image of the menopausal women which were found in female folklore, that is, stories passed from woman to woman, or from knowledge obtained from medical or non-medical literature.

Female Folklore

Many women in the research were aware of stories about other women who had gone through menopause. The overwhelming image that they had of menopause was that it was a negative experience for many women, although they had heard of women who "simply breezed through menopause." The negative images were attributed to experiences of hot flashes, but even more so to stories of women having emotional disturbances at this time. They had heard of incidents in which women "go over the deep end," "become mentally imbalanced," or "are never the same," after menopause.

These stories brought about various reactions in women. Those who were not experiencing any difficulties, used the folklore to judge their experiences up to this point as "easy," "not a difficult time," or "they were fortunate" or "lucky." For women who were experiencing some emotional changes, the stories of women struggling with emotional stability added to their anxiety. One woman thought that these stories were exaggerated until she experienced some difficulties herself.

> And I think that (menopause) maybe comes with a stigma attached that I've heard as I grew up anyway, well, she went over the brink in the change of life. In fact I was told that not so long ago about an acquaintance that I have, and someone said, "Oh yes, she's been through some really difficult times. She was never married. She's never had children. She went right over the brink through the change. And I suppose, right now, I recognize this person as being a little bit unstable and insecure. I never knew her before.and that could have always been the case. But I'm saying "Oh,wow, WOW." I suppose that would be my worst fear that this would happen to me..

> It's amazing. When you become the participant, things do change. No, I think it's just basically because you hear and used to hear stories about women in the past having mental problems with their menopause. And I think personally that I thought that a lot of that was exaggerated and it wasn't real or couldn't have been due to something like a change of life. But when you start to enter into it--now I'm only in the early stages myself, but dealing with the hot flashes, it wears you out. You feel totally exhausted after you've had a number of those hot flashes.

Medical and Non-Medical Literature

All the women in the research had done some casual reading on menopause over the years. Three of the women had also done some medical reading on menopause because of their educational background. Several other women indicated that their reading on the subject had increased since they had been experiencing physical or emotional changes. For three woman in particular, reading was the basic source of their information as they were the first in their group of friends to experience menopause and also because they indicated that menopause was not a topic discussed frequently among their peers.

The women used reading material as a means of seeking explanations for things happening to them. They mentioned reading about topics such as lack of vaginal lubrication, tingling of the extremities, hot flashes or other physical occurrences that were happening to them at this time. Some women made a point of indicating that this was casual reading, and that they did not deliberately seek out this material. The following are examples of how women made the connections between what was happening to them and what they had read.

> I was having hot flashes as well. So I sort of put two and two together myself. I figured that it probably was something like what I had just been reading about menopause. They tell you that oftentimes the fluids dry up, your natural fluids, and so I assumed that this was part of it.

> And it is only after the panic attack that I began to do any reading. I guess I simply thought, oh, is this what can be happening to me? It's not as simple as I thought it was.

> Well I haven't picked it (negative ideas about menopause) from an individual, or somebody that I know, but articles in women's magazines. You read about some who actually have to take medication. Others it affects them in various different ways, attitude towards people; and things. So I'd read all of this, not purposively read it, but it would be an article in a magazine that I bought. I haven't gone out to read an article on it.

The material that the women read also contributed to their expectations that menopause might be a terrible experience emotionally. Many women mentioned reading material about women who were depressed over not being able to have children or feeling old as a result of menopause. The women who read these articles commented that these later conditions did not apply to them. The following quotation is typical of this type of connection:

> I have read articles, I don't know how accurate they are, where women do get depressed because with their menopause then that means they can't bear children anymore, whereas especially in my case, I didn't want any more children anyway, so I wasn't worried about that affecting me. Whereas I have read where some people do, and also some people feel that suddenly they're old then, because you've had your menopause, but I've always looked at that like I'm only a day older than I was yesterday anyway. So I don't feel old.

Several women found assurance in more technical reading. This type of information gave them objective explanations for what was happening to them. The conclusions they reached from this reading was that the changes they were experiencing were not in their heads nor were they hypochondriacs. One woman expressed this connection in the following manner:

> Oh I think it's definitely a hormonal change. I mean your hormones are definitely, to my understanding, quite out of whack and your whole body is functioning in a different manner and I think that it's very strong in some people.

Peer Interaction

Other women's experiences were a source of helping some women make sense out of their own changes. The sharing of information gave them the opportunity to compare behaviors. Interaction with other women also provided women with a norm from which they could judge their own experiences. The following quotation indicates how women connected their experiences with other women's experiences:

> Some are grumpy, short, snappy. Like you say something and then they look at you as if you are stupid or what. I know these two girlfriends for years. So I can see the difference from what they were when they were younger. I saw that they were sometimes so short with their answers that I thought, boy, not only to me, but to their husbands, and I thought, "Am I like that"?

> The bloating and the stiffness or the heavy, heavy whatever you want to call it, that I was shocked at because no one had ever commented about that.

> I'm annoyed that other people have simply sailed through it, and I'm annoyed that they have finished with this and I'm annoyed that I'm still having to bother with it.

Personal Connectors

The second category of factors in the process of making connections is personal connectors. Woman in the research used some personal connectors to understand the changes that were happening to them. These connectors were their mother's experience

of menopause, their own menstrual history, or the female reproductive cycle itself. Not all women used the three connectors but they each connected with at least one.

Maternal Connectors

Five women in the research linked their experience of menopause with their mother's experience. The link was made in different ways and for different reasons. One woman began to reflect back on her mother's experience of menopause when she knew that she was beginning menopause because she had a fear of depression. Another woman was struggling with a feeling of emptiness because her children were leaving home during her premenopause. She was especially anxious and apprehensive about what the future might hold for her because of her mother's experience. These fears are depicted in the following excerpts:

> Once you come to this realization this is probably what's happening, you start looking more through the family. Like what was it like, what was the age of my grandmother? What did she experience? I know I had one grandmother that was very, what I would consider young and I thought, O God, I hope, that I take after her. That is your reaction. With my mom, she ended up with a hysterectomy. She was something like fifty two. But the depressions were terrible prior to that and a lot of that was because of the particular problems that she had with menopause.

> I watched my mother go through a really rough time. And that happened for her when we all left as well. But she went through a really difficult time emotionally, and she did let it get to her. And she got very down and went through some difficult times and I guess subconsciously, I think I'm worrying about that, is that going to happen to me? Am I going to be troublesome or unreasonable?

The timing of menopause was another reason for women to connect their experiences to their mothers'. Two women, one who experienced menopause at 43 and the other at 54 considered this to be a little early or late for menopause respectively. However it was not a concern for them because their mothers had experienced menopause at this age. One of these women felt that the older she became the more she

was like her mother in many things, including menopause. The other woman expressed her connection with her mother in the following way:

> . . . because my mother was also fifty-four years old when she stopped. So I was just thinking, well, my mother was that old, maybe you know, sometimes it doesn't work that way. But I was counting on fifty-four. I thought if I quit sooner, I'll be lucky. But it didn't. So I was just fifty-four.

Another woman felt that she owed her sane "take it or leave it attitude" towards menopause to her mother's matter of fact approach not only to menopause, but to the inconveniences of menstruation. On the other hand, another woman's mother had left her with a negative expectation about menopause. She told her "it was nothing to look forward to."

For some women there was no connection between their mother's experience and their own. They had very little knowledge of their mother's attitude or experience. This was because either they were too young when their mother reached menopause or lived too far away, or there was very little discussion about the topic.

Menstrual Cycle History

Some women saw a connection between what was happening to them now and what had happened to them during menstruation. Several women experienced little physical or emotional problems with menstruation and did not see why they should have a problem now. "It would end as simply as it began". Others recognized the same problems now as during their monthly periods, except they were more extreme. Two women were not sure if they were experiencing more discomfort, or if they simply had the time to notice it now, where before they were too busy raising a family. Another woman made a strong connection with the premenstrual emotional disturbances she experienced for many years with the possibility that these emotional difficulties would continue and perhaps become worse after menopause.

The Female Cycle

For five women the experience of menopause, whatever it was, made sense because it was part of the female cycle. It was not seen as an unnatural event although it may not always have been comfortable. There was an acceptance that this is part of what is meant to be born female. The following quotations exemplify this connection:

> I knew that's how life goes. You start with it. You get pregnant and it stops, and then at a certain age, it's over and done with. You don't know what that age will be but eventually everybody's going to get there.

> I think you question why do you have to go through this. You go through a period for the better part of your life and then why when this period ends do you have to go through all this nonsense again? . . . it just fits in as part of life. I mean that's my feeling that it's another stage of our life that we have to deal with.

> The whole thing is just part of the process of life. It was just a continuation of being born female and carrying on.

Summary

Making sense out of the physical or emotional changes the women were experiencing was accomplished in a variety of ways. Overall the women had negative expectations of what happens to women at menopause although they did not necessarily apply those expectations to themselves. Whether their expectations were met or not, they tried to find reasons for their particular changes. Making connections is just one process that women used to make sense out of experiencing the changes. The next process they used involves wanting to take charge of the changes that are happening.

Seeking Equilibrium

Definition

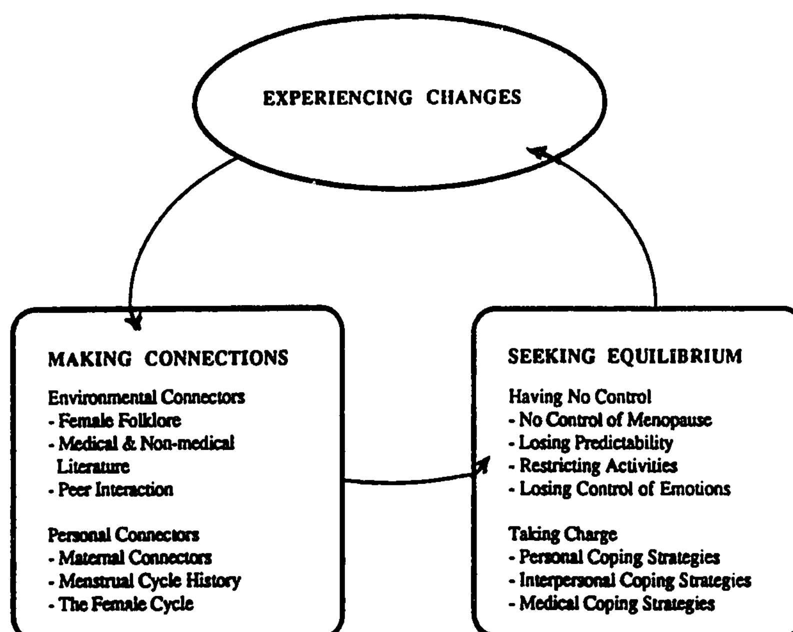
Seeking equilibrium is the fourth stage of making sense out of feeling different. It refers to the desire women had to continue what they considered their usual standard of

activities and to feel like their normal selves. Analysis of the data yielded two corresponding parts within this process. One part, "having no control," refers to the feeling women have of not being able to control specific physiological or emotional changes. The second part, "taking charge," refers to the strategies that women develop in order to feel that they are in charge of their lives so that everything can remain or return to normal. The need to seek equilibrium.is not constant for all women. It depends upon the intensity of the changes and how they interfere with what the women want to do. The more the changes affect their lives, the more the women want to counteract the imbalance. The following two passages illustrate the two extremes of needing to seek equilibrium from being a slight inconvenience, to a situation that is intolerable.

> Well they (periods) stopped just over two years ago and as regards anything from discomfort or any kind of negative effect because of it, there's none whatsoever. There was a feeling of being hot, but that never bothered me.

> I expect things to be better that's all. And
> I just want them to be better, so I get frustrated. And I don't have much patience about it.

Figure 5



Having No Control

Having no control refers to the lack of ability the women feel they have to control the direction and pattern of menopause. For some women "having no control" also includes losing the ability to predict menstrual cycle, needing to restrict activities, and losing control over emotions.

No Control of Menopause

Women expressed the opinion that they had no control over how menopause would happen to them. Factors such as when menopause occurred, the length of time that it took to reach menopause and the changes experienced were seen as beyond their control. This element of no control was attributed to individuality, genetic make up, fate, or the "luck of the draw." This attitude of menopause being beyond a woman's control was expressed in these ways:

> I just think it's the way, can't say meant to be, that's a silly cliche, but that's unto me, the individual that I am. And as I say, the older I get, the more I think that a lot of things are meant to be. Be it the ups, be it the downs, what have you.

> I think there was one friend that said, "Well, my mother had a pretty rough time so I might too". But they didn't seem too worried about it. I think part of it with anybody I know, is it's something that you can't do anything about anyway. If you have a problem with it, then maybe you can help that. But it's not like, somebody can say, "My mother had a rough time having children and I might, so I'm not having children." But you can't stop menopause.

> I imagine (it will take) another couple of years. I've never given it much thought. I can't do anything about it one way or the other.

Losing Predictability

Losing the ability to predict the occurrence of losing their menstrual cycle gave women the impression that they were also losing control of their lives. Nine of the eleven women experienced very irregular lengths of cycles. This irregularity

represented a lack of control for the women because it meant they had lost their ability to predict when their periods would occur and to plan for it.

With the predictability of cycles gone, the women had the impression that they were more vulnerable. Previously, some women used the knowledge of the timing of their cycle to prepare themselves for the irritability or depression that normally accompanied their menstrual period. They would plan activities around this time, avoiding stressful situations as they believed these mood changes could affect their work or their relationships. One woman said that when she knew that her period was coming she would put up a "safeguard" and watch what she said especially at work and also plan to do more demanding activities at another time.

For other women, the unpredictability of periods caused minor annoyances such as having to carry pads at all times or cancel doctor's appointments for pap tests several times. One woman who had a difficult time each month found it disconcerting because planned holidays were often marred by unplanned periods.

For some women the unpredictability of their periods was disconcerting because of unusually excessive flow. This situation, on occasion, was a source of embarrassment while engaging in social activities or business meetings. Stained clothes, the fear of not having enough pads, worrying about staining bed sheets at home, or when visiting, were also concerns. For one woman the unpredictability of her period bothered her the most, because she "never was sure of what was going to happen, how heavy the flow would be or when it would occur."

Restricting Activities

Some of the physical changes that the women experienced curtailed certain activities. Hot flashes, fatigue and excessive menstrual flow were a cause of in-conveniences for some women and interfered with their activities. In order to avoid

very uncomfortable hot flashes women changed the pace or type of activities that they engaged in. For example, two women said that they had to gear themselves not to rush around when doing housework Another woman found that she could not sit and work outside, when it was warm, as the heat, which she normally enjoyed, became unbearable. Fatigue also curtailed activities that the women normally engaged in or it slowed them down considerably.

<u>Losing Control of Emotions</u>

Another area where women [illegible] that they could loose control was over their emotions. Six women indic[illegible]his was happening to them more than usual. The women considered losing con[illegible] over their emotions worse than any other physical difficulties connected with menopause. This upset them especially if it interfered with their work or relationships with their families.

> I think the fact that I'm a Dr. Jekyll and Mr. Hyde is really, really, really a big thing, and that can happen without you noticing it. And to me that's worse than hot and cold flashes. So what if you're cold. So what if you're hot. At least you're keeping your balance. But this one minute you're a real sweetie pie and the next minute you're a real witch is pretty difficult for other people to take.

> I have trouble with the emotional side of it. That's my biggest problem. I mean the physical side of the heavy flow and the cramping, I figure I can get real good help for it...You can do something about it. The emotional side, I'm having a horrible problem dealing with. I find you start to lose control with your emotions. If you are a person that has lived all your life keeping your emotions inside and always been in very firm control, to find yourself all of a sudden for no reason crying in front of people is the most devastating thing that can ever happen to you.

Another woman was experiencing several major changes in her life, the last child was leaving home and her husband was planning an early retirement. She felt these changes were enough to handle without the emotional upheaval she was experiencing at this time and anticipated would even increase. This situation filled her with a sense of being overwhelmed about what menopause itself would do to her.

> I have a lot of fears of what it's going to do to me, both physically and emotionally And I suppose emotionally more so. My concern is can I handle it? I don't want to fall into the trap of letting it beat me, of letting it control my life. I don't want to have to face the consequences of an emotional upheaval, a disruption in my marriage or my role as a mother of adults, or I don't want the family to have to worry or I don't want to be overreacting to things, like finding that I'm needing to cry often. I don't want to lose control of my emotions.

Taking Charge

The women wanted to take charge of what was happening to them. Up to this point in their lives, they had learned to live with inconveniences and sometimes even pain of their menstrual cycle. The new things that were happening to them as a result of becoming perimenopausal or menopausal needed to fit into their concept of how they saw themselves in the past. Three women did not experience this as a difficult task because their physical or emotional changes were not affecting them very noticeably For the women who were experiencing changes that they found were controlling or disrupting their lives, regaining control was seen as a problem that needed to be solved. Two women expressed it thus:

> I just want to have lots of energy and I mean I don't expect to be as young as as I was, I think that's naive, but I just want to be able to do everything that I want. If I want to go home in the evening I really would like to have the energy to do some baking, or some sewing, or do some gardening or whatever, instead of simply flaking out with a book.

> As long as on a daily basis I can certainly keep myself in shape or keep myself at a tempo where I don't jump up and down, I'm O.K.

In order to gain control over their lives women used a variety of coping strategies: personal, interpersonal and medical.

Personal Coping Strategies

The women in the research had several personal ways of dealing with their situation which came from their personalities and approach to life. They considered their menopausal pattern to be part of their unique selves. One woman said, "Well that was

just me the individual, wasn't it? We're all so different." Other women were of the opinion that the mind could control the body. It was for this reason that they found keeping busy, and finding meaningful activities, helpful in adjusting to their changing bodies.

> I think it's often a case of mind over matter and if your mind is occupied with something besides yourself, you really are a healthier person. If I were at home, I probably would turn into a real hypochondriac.

> I think through life you can bring on a lot of things, if you're a very idle person and don't keep yourself wound up for the world.

> I'm determined that I am going to do something else with my life and I think that your mental state plays a very important part in this whole thing.

Another woman picked up a helpful phrase from her doctor which helped her place her mood swings in perspective. It gave her permission to feel the way she did.

> He says, O.K. just stop in the middle of your sentence and say, oh those dang hormones. I've never done it, but I've stopped and thought of that comment and sat there and laughed at myself. I just don't know what it was. But it was such a stupid little comment. And such a small sentence. And it said it all. For me it seems to be one of the best, what would you call it, a tranquilizer.

Interpersonal Coping Strategies

Another source of coping strategies were the relationships that women had. These relationships included marital, family and peers.

Marital support.

The women found that their husbands helped them cope with the changes. The husbands did this by offering moral support, assisting with household jobs, encouraging the women to seek medical assistance when necessary and trying to understand the changes their wives were experiencing. The assurances that the women received from their husbands helped them face some of their own uncertainties.

> I think he's become almost protective in the sense. If I come home from work and I start crying trying to tell him about something going on and this poor guy sitting

> there, I think, they think that somebody has done something so terrible to you. So they're going to go in there right now tomorrow and they're going to take them in and say don't do that to you.

Several women in particular wanted their husbands to understand what they were going through and to be patient with them especially during times of emotional upheavals. One woman expressed this need quite poignantly.

> It may or may not happen, but; if it happens, please understand why I'm totally bizarre, or jumpy, or if there's mood swings. I think that's the big thing. Please try and understand that this is what I am going through and please be patient.

Two women whose lives were not greatly affected by menopause did not discuss menopause with their husbands to any great extent. One woman said that she did not bother to talk it over with her husband because it was so inconsequential. The one woman described her husband's response:

> I had mentioned that I was missing the odd period and he wasn't too concerned. If ever I had a hot flash or something like that he's just sort of said, "Going through menopause?"

Familial support.

Women did express a fear that their emotional mood swings might affect their relationship with their families. They wanted support and understanding from their families regarding the emotional changes or physical discomfort that they might be experiencing. For the most part, because the children were older the women sensed that this support was there. Some sons and daughters would share knowledge about menopause that they had picked up at school. Humor or teasing was used to overcome the tensions that might occur at home. Several of the daughters encouraged their mothers to try new adventures to help them overcome some of the changes that they were struggling with, such as weight gain.

Extended families, especially female relatives formed a support network for some women. One women in particular found comfort and encouragement from all her female relatives.

> We're a very large family and I guess we do a lot of talking about these certain problems. No one really worries about them. They're a thing that we know we have to go through and we do it, and that's life.

Peer networking.

On the whole, the women in the study did not use other women to help them gain control over their changes. Women did not discuss menopause with each other a great deal except under one condition, and that was through laughter or humor. All women mentioned occasions in which jokes were made, particularly about hot flashes. However, through humorous stories, women learned some techniques to handle hot flashes. They also found that it was good to be able to laugh about it. In addition, several women mentioned that humorous incidents were an easy way to bring the subject of menopause into a conversation. making it possible to discuss other aspects of menopause. Laughter and humor, they indicated, were a non-threatening way of doing this.

Two different reasons were offered as to why women did not speak more to each other about menopause and share ways of coping with the changes. One woman expressed the opinion that maybe women did not want to talk about menopause because they wanted to hide their age and they would feel saying anything about menopause might reveal this. On the other hand, another woman felt that menopause was something that today's women did not worry about and so it was not considered a noteworthy topic.

Those women who did discuss it with their friends found it reassuring to know that other women have the same problems as they do. Women who were "ahead" of their

friends or co-workers would share their experiences and act as a type of mentor in the situation.

> It's better if you can openly discuss things like that. It makes it easier for you because you find out things that maybe they're going through or have been through, that you're just starting and it eases it. And I think that you give each other advise. Like, well try this, I've tried it and it didn't work for me, but maybe it will for you.

> She put them on (hormonal patches) and then she started to read the material that the doctor gave her. It has a number of side effects, this particular type of hormone. So she tore them off and brought the material for me to read for my opinion. And I said well I'd be inclined to agree with you. I said I don't think that I'd be too anxious to try it. . . . And so she's brought two or three articles with her and we do discuss it quite openly.

Medical Coping Strategies

Another coping strategy that women used to take charge of the changes in their lives and acquire equilibrium was medication. It was not a strategy that women considered initially. In fact, women expressed a great desire to handle any discomfort or emotional difficulties by themselves, by which they meant, without medication. They expressed the view that to take medication was a sign of weakness or a lack of will power. In addition, the women were aware, in a general sense, that there were some undesirable side effects to hormonal medication, such as an increased risk of cancer and a return of regular periods.

Women who chose medication as a means of coping with the changes did so as a last resort. The reasons for seeking medication were unbearable hot flashes, uncontrollable emotions, or extreme fatigue. When these changes became such that women felt that they were interfering with sleep, work, or the family, they then made the decision to take some medication. The waiting period before seeking medication, after experiencing these changes, was from five months to a year. The following selections illustrate the women's attitude toward using medication as a coping strategy.

I thought I was going to be really smart and strong and wouldn't need anything. I really did.

Well, because I couldn't stand it anymore. It was getting so bad, it was uncomfortable. So I thought I have to do something. So I thought I'm going to talk to the doctor. I knew there were pills for this.

I'm not a person who gives into things easily, but I just found out, that when we had those thirty degree days, I just couldn't handle it. I wasn't on medication then. In fact it's only been three weeks since I started the medication. . . . but if it will keep the hot flashes down, then I'm willing to stay on it for a period of time anyway. I'm not anxious to be on a hormone because you hear so many stories about hormones and what estrogen can do to you.

One woman was looking forward to going on hormonal treatment. She was experiencing a deterioration of her health and a loss of energy. Although she was aware of the side effects of hormonal medication, she was willing to try it because she had the expectation that it would restore her back to her "normal self".

The hormonal medication did help curb the hot flashes and for one woman controlled her crying spells. One woman took herself off of the hormone pills after one year, but found that the hot flashes came back. The women were willing to continue this medication even though they were not convinced that there were no side effects but it made them feel much better. The medication made the women feel like their normal themselves again.

For several women, non-hormonal medication was used. Two women were prescribed vitamin B-6 by their doctors. Another woman stopped taking hormonal medication because extreme cramps occurred. Instead she found that oil of primrose, a medication suggested by other women helped her deal with the physical changes she was experiencing. Women made comments similar to the following, concerning the effects of the medication.

I think in the back of your mind you think, can one little pill do this much for you. But as I say, in probably two weeks I was a completely different person. Oh I was getting my energy back I wasn't sluggish. I wasn't tired.

> But whether or not it's for real or whether it's imaginary but I think I can handle myself better. I don't know why.

The women were relieved that the medication has successfully controlled their discomfort. When these women were feeling like themselves again they considered that the experiences of menopause were "not that bad," or that they were fortunate because they had found something that allowed them to continue with their lives in a normal fashion.

Summary

While women were experiencing various emotional and physical changes, they were constantly trying to make sense out of these changes. This continued even after their periods had stopped, but the other changes were still occurring. They made sense of this experience by connecting these changes to some factors that made them feel like this was a normal condition. At the same time they attempted to take hold of these changes so that they could continue to do all those things that they wanted or needed to do at this time of their lives. The cycle of experiencing physical changes, finding connectors and seeking equilibrium continued until the women were no longer experiencing any new changes.

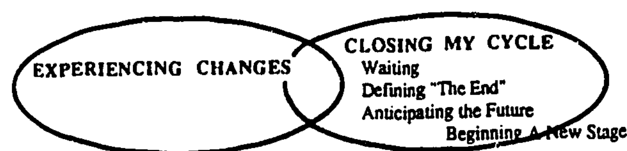
Closing my cycle

Definition

The fifth stage of menopause, closing my cycle, is defined as the time when a woman identifies that she has "finished menopause." From the analysis of the data it became clear that there was an element of ambiguity as to when this occurs. Women form their own definition of when menopause is over for them. Part of closing the

cycle is waiting for confirmation that their menstrual periods will not reoccur and anticipating the next stage of their lives.

Figure 6



Waiting

Women who were experiencing periods regularly or intermittently, were not certain when their periods would end. Even the women who had not had a period in two years were not totally certain that this was the conclusion of their menstrual periods. However, one woman did think it was inappropriate to think that her periods would come back after she had not had a period in two years. Other women expressed annoyance, apprehension and a feeling of helplessness over the uncertainty of the end.

> It can't go on forever. I know it can't go on forever. I'll have paid my dues and I'll feel great again.

> I'm going slowly. I'm going very slowly. So I imagine it's going to take a long time if I'm having my periods that often. I can't see myself waking up one morning and that's it. Finished. Cut off. Period.

> But it's the first ill health that I had ever had before and I just feel for the last three years I've been falling apart and when is this going to be over, is what I would like to know.

There was no known way to ascertain if the experiences would get worse or better. There was also an element of waiting for " this big storm that's coming". Will it come? When will it come? How bad will it be? were questions that some women could not answer .They could only wait to see if their fears would be confirmed. One women expressed her apprehension very explicitly.

> Like I'm predicting that I'll have more frequent hot flashes. I'll have more frequent retention of fluids. I'll have more frequent mood changes and hopefully I'm all wrong, but I guess that's how I'm envisioning it. I'm just getting ready for this big storm that's coming.

Defining "the end"

Women had two elements that formed their concept of the end of menopause: the cessation of periods and the discontinuation of the other physical and emotional changes that they were experiencing. When both of these conditions were met, they then considered themselves "finished menopause." They had completed the female cycle.

Although the women were clear about the definition of when menopause was over, they had a difficult time determining when it was over for them. Part of the reason for this lack of precision was due to the fact that the women had heard stories of women having a "period" in their sixties, many years after their menopause. In addition five of the women experienced what they perceived to be a period after not having one for one or two years. The lack of clarity in defining when menopause was over is depicted in the following selections.

> It was more of a shock because there it (period) was and I didn't count on that. You think that when it is gone, it's gone, you come to a certain age and you think, well this is it.

> I don't expect another period. But I am still in it because I am still having hot flashes. It's over when the symptoms are finished.

> Are there any tests that they can run on you that says yes or no, that you're out of menopause. Or do you take these (pills) for the rest of your life?

> Because I don't think there is any special year or month or anything to menopause? I don't think there is, is there? I think people can come in and out of it. Some can drag on it for years.

Anticipating The Future

As women waited to be through menopause they anticipated that they will either feel no different after menopause than they had before, or they will even feel better. For the women in the research who did not have any disturbing physical or emotional changes, they anticipated that after menopause they would feel as normal as before. For the women who were experiencing some difficulties, they anticipated that they would feel better after this experience was over and that they would return to their normal selves. One woman who has not had a period in approximately two years, indicated that she "feels great." Another woman who had extreme difficulties with her menstrual periods, and has not had a period in two years revealed that she feels "terrific." The women did not express any regret over not having their monthly periods. These attitudes are exemplified in the following passages.

> It's like I've been sidetracked for awhile. Now I feel that I am back on the right line again.

> I'm not going to feel any different. If anything I'm going to feel better and as I said this can only be good. . . .I will be delighted when this is finished and I think that from what I have discussed with friends, that's exactly how they feel.

> And I think I should be quite back to my normal self.

> It's a time when you can look forward to not having a period and for some, not having to worry about having any more problems.

> I see it just as a kind of hump to get over before you can get on with your life.

On the whole the women anticipated good health. They attributed this to family history or to the fact that people were living longer in our society. Specific health concerns as a result of menopause, such as a deficiency of calcium, were mentioned by two women and one woman expressed concern about breast cancer because of family

history. With today's high standard of health care, the women indicated that there was no need to worry about aging at this stage of their lives.

Beginning A New Stage

The women associated "the end of menopause" as the beginning of a new stage of their lives. There was a feeling expressed by all women in the research that there were many challenges and new roles waiting for them. They recognized that menopause meant the end of their reproductive years, but this did not bring any regret or disappointment with it. Several women were struggling with the situation of children leaving home. Nevertheless the women saw the time after menopause as one of freedom, relaxation, and a time when they could be more themselves. The following passages reflect some of the positions the women held finishing one stage of their lives and beginning another one.

> My husband will take an early retirement. He'll be home and that will give me freedom And I think we have an understanding that's the way it'll be. It'll be a chance for me to go and do my own thing.
>
> I thought for a long time as I was thirty, thirty-two, thirty-three that the day I reached menopause I would know that I couldn't have a child for sure and maybe it would really bother me. But it didn't. I think you resort yourself in your thirties.
>
> It's not a nice feeling (children leaving home). In some ways it's a relief because you're ready for it. I'm ready for it. I mean I've had enough. I'm tired. I would just be horrified if I had any younger children, but at the same time you're also suddenly, you're not needed.. . .It's a good feeling being needed.
>
> You reach the point where you can be your own person again. For a number of years you have been a number of persons.
>
> And like I say the fact that we have our children. They're healthy and well and we are too. I just find that it's a part of life, that I think in the back of my mind I think that perhaps it's a more relaxing part of your life. You're looking forward perhaps to retiring and an easier lifestyle.

Part of anticipating the future was the recognition by the women that they were getting older. The women made a distinction between getting older and aging. They

used a number of expressions to indicate this difference: "aging was a frame of mind", "you are only as old as you feel", and "growing old gracefully." The women held the opinion that their yearly birthdays were a marker or sign of becoming older just as much as menopause. Only one woman believed that menopause itself would make her look older. Generally the women stated that becoming older would not bother them as long as they could continue to participate in those activities that interested them. These attitudes towards aging are expressed in the following excerpts.

> I don't have any apprehensions about aging. I certainly when I see people that are in their late eighties and getting into their nineties and really very tired of living, I do have apprehensions about aging to that degree, but as for the aging process of say, between fifty and eighty to me, must be very good years. I see them as golden years. Basically I see it as a really nice time in my life.

> As long as we can both keep healthy and do all the things that we like to do, age doesn't matter.

> Well you get older so things slow down a little bit. I mean when I do my housework I get tired and when I was twenty five I didn't know what tired was. I mean that's the things that change, but if my period would be still there or not, I don't think it (aging) has anything to do with your menopause. Not in my case anyway. I still do all the things. I love to swim and I do that still. And we like to camp and we like to walk, so that hasn't changed.

> Age has never been a problem with me. I've always felt young. I guess you might think that's crazy to say but I don't feel my age. I really don't and I don't worry about it.

> I don't think that I'd feel younger if I kept my periods.

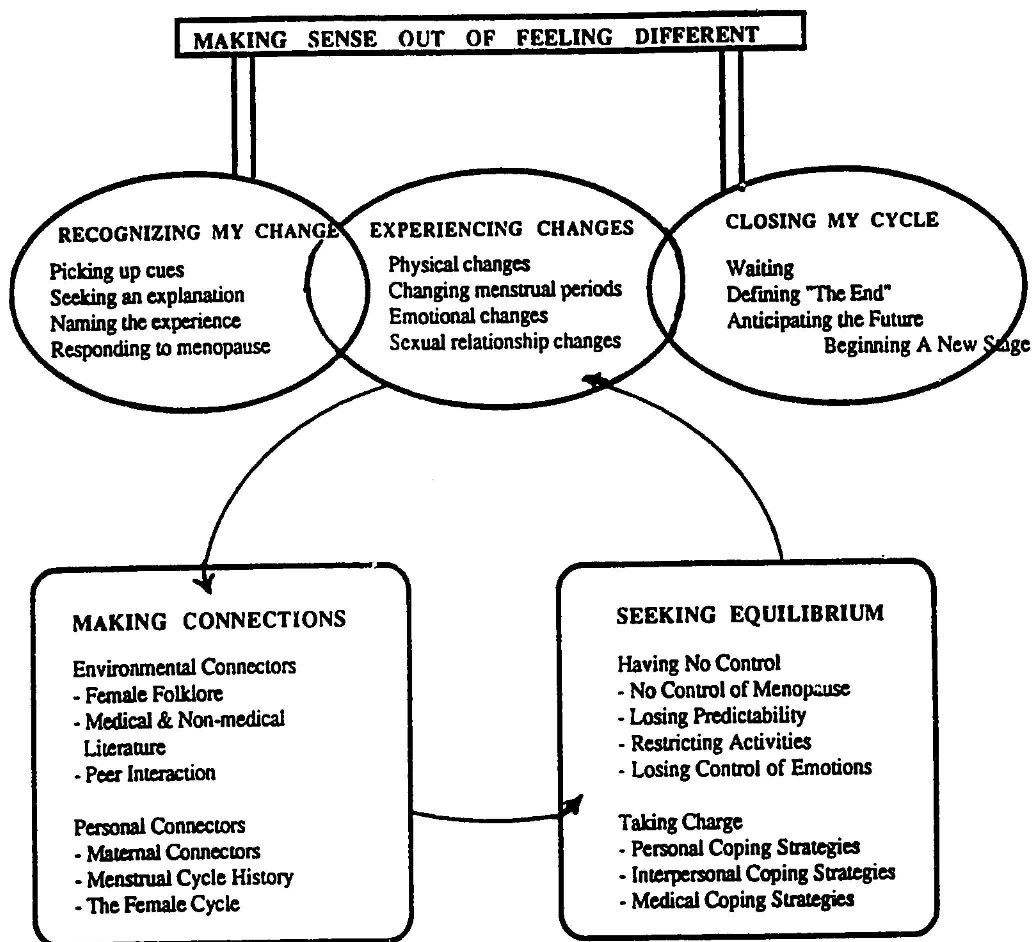
> I mean menstruation is a marker when you are growing up, so menopause is a marker I'm starting to slow down.

Core Category: Making Sense Out of Feeling Different

Women's view of their experiences of menopause had many variations and individual differences. The five parts described above represent the common elements that characterized their experiences of menopause. Unifying these five parts of

women's description of menopause was the basic social psychological process of "making sense out of feeling different."

Figure 7



Making sense out of feeling different is an activity that women are involved in from the time they notice that the pattern of their periods is changing, to defining when menopause is over. It involves a pursuit of knowledge and explanations of the changes that are taking place during this period of time. It is not a search for a technical medical knowledge. The women search for answers that will reaffirm that what they are going

through is normal. They look for feedback that will assure them that there is nothing physiologically or psychologically wrong with them.

Feeling different covers a wide spectrum of experiences. It involves the most basic change of menopause, that is, a break in the menstrual cycle and eventually its cessation. Other differences encompass mild discomfort to more radical changes such as extensive hot flashes or unusual mood swings. The feelings that are evoked as a result of these changes represent a range of emotions. These include puzzlement, acceptance, resentment, apprehension, annoyance, concern and anticipation.

Making sense out of feeling different was the way the women tried to achieve continuity with their concept of themselves. "As long as I don't feel different" is the state that all the women tried to maintain or to achieve throughout the experience of menopause.

CHAPTER 5
DISCUSSION

The findings in this study represent the understanding this researcher gained about how women view their experiences of menopause. The data obtained indicate that the women in the study perceived menopause to be predominantly a physiological experience. The common theme that emerged was the need women had to make sense out of feeling different which was associated with physical and psychological changes. Five stages were part of this process: recognizing my change, experiencing changes, making connections, seeking equilibrium and closing the cycle. The following section will include a comparison of the concepts that form these stages and the current understandings of menopause as presented in the literature review in Chapter 2. Secondly, how the findings of this research are related to other developmental theories on midlife will be considered next. The discussion will conclude with some possible directions for further research on menopause and midlife events.

A View Of Menopause: Making Sense Out of Feeling Different

Menopause is a physiological process that involves hormonal level changes in women and which ultimately leads to the cessation of menstrual periods. Making sense out of feeling different is a basic social psychological process that describes how woman in this study view the process of menopause. What is going on here? is the underlying question that was asked as the women proceeded through the five stages of the model (see Figure 1). At each stage women asked themselves questions in order to understand what was happening to them.

The women in the study experienced menstrual periods for approximately 35-45 years. Their idiosyncratic pattern of experiencing periods was familiar to them. When there was a change in this pattern, which is the usual the signal of perimenopause, women were prompted to ask the question: What is happening here? Why are these changes occurring? Is this normal? Making sense out of this situation was achieved when the women looking for explanations of these changes, could recognize and name the experience for themselves as the beginning of their menopause.

Making sense out of feeling different continued into the second stage where more changes were experienced. These changes raised further questions in the minds of the women: Why are these changes taking place in me? Why now? Is this the normal way menopause is to occur? Is this menopause or is it something else? When the knowledge that these changes were simply part of menopause was not adequate, the women made further sense out of of feeling different by connecting it to other known situations or seeking new information. How do I connect what is happening to me now with what has happened to me in the past? To the knowledge I have about menopause? To how I see myself? The women moved out of this stage when they found answers that fit their experience. They made sense out of the next stage of seeking equilibrium by recognizing that part of menopause experience was beyond their control. They then found ways to that made them feel in charge and in control of their lives.

These three stages, experiencing changes, making connections and seeking equilibrium, formed a loop as is seen in Figure 5. It could be experienced many times as different changes occurred over time, or it could be experienced as simultaneous processes as when several changes took place at the same time. Women continued to

go through these three stages until no new changes occurred or until they found a coping strategy that made them feel like their normal selves.

At the last stage of the process of menopause, closing the cycle, women continued to make sense out of feeling different. For the women the most perplexing part was to know when the changes that they were experiencing would be over. They looked forward to the time when they could finish this part of the female cycle.

The model that has emerged from this research presents menopause as an experience of making sense out of physiological experience which is perceived as a natural part of being a woman. The following section will take each part of the model and demonstrate how it is compares to the previous models of menopause as outlined in the literature review in Chapter 2.

Comparing Models Of Menopause

Recognizing My Change

Women in the study were aware that someday their menstrual periods, which had started during puberty, would be over. When changes to their menstrual cycle did occur, women's first reaction was to seek an explanation. They looked for a medical answer only if the change to their cycle seemed extreme. For example, excessive flow which might be an indication of cancer, or an abrupt stopping of periods which might mean pregnancy.

The women's initial reaction to recognizing that they were in menopause was generally one of relief to know that they would not have to bother with the inconveniences of monthly periods. The women did not consider menopause to mean that their body was functioning in an unnatural or unhealthy manner. This attitude is similar to findings in a study conducted by McKinlay, McKinlay and Brambilla (1987).

They found that there was no correlation between menopausal status and visits to the doctor and self-assessed health status. This attitude seems to contradict the biomedical model of menopause outlined in the literature review in Chapter 2, which considers menopause to be a deficiency disease that needs to be medically managed.

There was no initial regret expressed about the loss of ability to have children and therefore a loss of role, as the psychoanalytical literature would suggest. However part of women's reaction to knowing that they were in menopause was that of apprehension. They perceived that the cultural expectation of menopause was that it could be a time of emotional upheaval. There was a fear, or at least an awareness of the possibility of this happening to them.

Experiencing Changes

The women in the study experienced various physical and psychological changes. Some of these changes were unusual for them, others were simply an increase in symptoms associated with menstrual periods. The biomedical model calls these changes, symptoms, since they are an indication of a hormonal deficiency disease. The psychoanalytic literature also classifies these changes as symptoms which result from the struggle with the role loss that women experience at this time.

The women did not consider their changes as symptoms of a disease. To them the changes were indications that their body was going through a natural physiological process. Of itself it was not an unhealthy state to be in, although there was a recognition that some of the changes could make them feel unhealthy temporarily.

One physical change that women did express a concern about was weight gain. Those women who had a weight problem felt that they should be doing more about it. This is in agreement with the study conducted by Berkun (1986) in which it was found

that weight gain was the most frequent complaint of women over forty. Berkun indicates that women either struggle to control their bodies and to mold them into shape or feel guilty and immoral for not doing so. This view is congruent with the feminist model of menopause [illegible] in Chapter 2 which states that it is society's standard of what is an acceptable [illegible] shape that makes most women feel dissatisfied with their bodies at this time in their lives.

In the model that emerged from the data, women did not list any role or status change as part of menopause. If women were experiencing changes of roles they did not link them to menopause. Adult children leaving home or moving away, challenging jobs, or dead-end jobs, sick husbands, changing roles because of retirement, were all stresses that could be part of women's lives at this time but independent of menopause. These stresses could be the source of some of the changes the women were experiencing. Several studies (Coulam, 1981; Greene & Cooke, 1982; Ballinger, 1985) have reported that there is a relationship between people with life stresses and the occurrence of psychological symptoms such as depression or anxiety.

The women did identify some sexual relationship changes. These seemed to be related to various factors, such as vaginal discomfort, stresses in life, or even loss of sexual desire. There was no indication that the women felt less of a sexual being as as result of menopause. Recent studies on menopause and sexuality have contradictory findings. Whether changes in sexual functioning are related to the changes of menopause or to other factors cannot be concluded at this time (Channon & Ballinger, 1986; Cutler, Garcia & McCoy, 1987). The women in the study attributed vaginal discomfort to menopause because that is the information they had received from their doctors or from reading material.

There was uncertainty expressed by the women as to underlying cause of the changes they were experiencing. Doubts were raised as to which changes were the direct result of menopause and which were related to other conditions. This lack of understanding about menopause was found in a study conducted by Berkun (1986) in which 80% of the women felt that they had insufficient information about menopause. Berkun concluded that women were looking for more than simple reassurances or biological facts. They wanted information that would enable them to sort out the controllable from the uncontrollable physical and psychological sensations even if these were not causing excessive discomfort.

Making Connections

In going through the next stage of the process, making connections, the women became more acutely aware of the cultural expectations associated with menopause. They were cognizant of the emotional difficulties they could experience because of losses associated with reproductive capabilities, role of mother, femininity and womanliness. However the women did not link these changes to their own menopausal experience.

The issue of the l[illegible] of the ability to reproduce as a stressful change was not part of the model. The women in the study who had children had decided the size of their families many years previous to menopause. Therefore the loss of the ability to bear children was not a concern. The woman who could not have children, as well as the single woman, indicated that they had "sorted" out the question of having children at an earlier age. Today's control of fertility via birth control has given women the ability to make these reproductive decisions.

One of the most frequent connections that women made to help them understand the changes that they were going through was linking it to the female cycle. This component of the model indicates that the women held the view that menopause happens to them precisely because they are women. It is part of the normal female cycle along with menstruation and childbirth. They considered this cycle to be a distinguishing female feature. This would appear to contradict the psychoanalytic literature that has as one of its assumptions that women experience difficulties at menopause because they are struggling with their identity as a woman.

It is interesting to note that the women do not equate the ending of the menstrual cycle with the ending of womanhood. This might be expected since the education and literature about menstruation uses expressions which link the beginning of womanhood with the beginning of menstruation. This connection can be seen in the educational materials on menstruation which are designed by commercial sanitary product companies and which often have formed the basis of teachings about menstruation. Dashiff (1986), Whisnant, Brett, & Zegans (1975), in analyzing the most widely used commercial company programs found that one of the attitudes implied is that menstruation will bring about the transformation from girl to woman. The underlying assumption of this attitude is that there would be an association of the end of womanhood with the end of menstruation.

Seeking Equilibrium

The desire to be in control of their lives was a frequent theme expressed by the women. When the women had sorted out the controllable changes from the uncontrolable ones, they searched for coping strategies that would help them gain control so that they could continue their normal standard of activities. This attitude

differs from the psychoanalytic literature presented by the literature review which found women are at the mercy of their hormones and psyches, with no power to change this.

The women found several levels of coping strategies. One possible source, peer networking was not used frequently. There was not a free exchange of information among the women about ways to cope with menopause. Part of the explanation for this was that menopause was considered a private matter. This could be due to the manner in which education about menstruation was obtained. Menstruation was often considered secret , personal, and private, and not often discussed in an open atmosphere in educational settings or at home. (Bloch, 1978; Koff, Rierdan, & Sheingold, 1982; Kieren & Morse, 1989).

The fact that women did not consider menopause to be a pathological process was also demonstrated in the using of medication as a coping strategy. The women did not go to the doctor immediately, even if they were experiencing disturbing changes. The attitude was one of "Surely the doctor has better things to do", and "I'm not really sick. I can handle this by myself". Part of women's reluctance to use medication as a coping strategy could also be attributed to the feminist view of menopause according to Posner (1979). In a review of the feminist research on menopause Posner found that in this view, because menopause is a natural process, women should not experience any difficulties. If a woman is experiencing difficulties, then there must be something wrong with her. It therefore creates a sense of guilt in women, Posner concludes, and can stop women from seeking treatment when it is needed.

Despite the fact that some women decided to take medication to counteract the effects of hot flashes or to stabilize their emotional mood swings, they considered themselves healthy. This somewhat seeming contradiction could be accounted for in a conclusion that Zaurta and Hempel (1984) reached after a literature review on subjective

well-being and physical health. They concluded that a sense of well being colors people's perception of their lives. It would follow from this that if these women were feeling good about themselves, then the physical discomforts they experienced would not be classified as ill health.

The other factor that might account for women considering themselves healthy is that when the medication eliminated their discomforts they then made the judgment that the experience of menopause was "easy and was not causing any problems". This demonstrates again that the women did not consider menopause itself to be a pathological condition. If the changes that women experienced could be controlled so that they could continue with their activities, then menopause was not seen as a health problem.

Closing of the cycle

Women had difficulty in defining when menopause was finished. The fact that the women had this difficulty is understandable since the terms associated with menopause are not widely understood or uniformly used (Voda & George, 1986).

This lack of clarity about when a woman has reached menopausal status can contribute to "the menopausal syndrome" discussed in the literature review because women, physicians, and society as a whole, can attribute any change that is happening during midlife as part of menopause. Many midlife changes may very well be part of aging, or related to other life events, or even some other type of illness. "The menopause " becomes a convenient nomenclature to be used by professionals and lay audiences for a the variety of physical or emotional changes that can occur around this period of time.

The last part of the process of menopause includes the concept of anticipating the future. This concept is not in agreement with the psychoanalytic literature as well as the feminist approach since both hold the view that menopause is difficult for women because it indicates that they are getting older and their usefulness to society is over or is not appreciated. However the women in the study were optimistic and had a positive view of the future. They saw the next period of their lives as a time to be more relaxed, to be free, to continue to pursue interests., or to take up new ones. These attitudes are similar to the findings by Baruch, Barnett and Rivers (1984) in which women repeatedly reported feeling much better about themselves and their lives now, in their forties, than in their twenties. The study also found that overall women had a positive [illegible] idlife and their views about aging were different from those ascribed to them [illegible] n those reported by men.

Conclusion

The components of the model present menopause as a developing mental process. It is grounded in a physiological experience which the women consider to be normal. The physical and emotional changes they experience are viewed as temporary. The main focus of this experience for them is to make sense out of these different changes so that they can distinguish between the controllable and the uncontrollable factors. The women did not connect their identity, their roles, or their value, with their periods. There was no regret expressed over losing this rhythmic pattern to their lives.

Reconceptualizing Menopause Model as Part Of Reconceptualizing Midlife Theory

The findings of this research which focused on women's view of menopause have yielded an emerging theory that is developmental. There are transition points, but there

is a growth theme with reconciling attempts made to come to grips with the changes that take place physiologically and which have some impact on other aspects of social living. Menopause was perceived in this study as predominantly a normative physiological process that is expected and experienced by all women during midlife. Several concepts from the emerging theory are related to aspects of some existing developmental theories. On the other hand the findings of this research add to some developmental concepts by further dimensionalizing them. The following concepts will be discussed in relation to developmental theories: normative physiological change as a non- crisis transition, the influence of the cultural and historical context on the enactment of social roles, and an expanded view of family life stages which is less linked to age or timing of events.

Concept of Change As Non-Crises Transition

One of the concerns among adult development researchers is the question of whether change is characterized by continuity or discontinuity (Rodgers, 1973, p.48). In traditional developmental theory, change has been associated with developmental tasks (Levinson 1978; Erikson, 1959). The amount of discontinuity is related to the expectations about the degree to which developmental changes will be experienced as a crisis. Developmentalists perceive change as crisis if the developmental task represents a major negotiation of self and identity. It is stressful, in this view, to give up the mainstays of identity and negotiate a new relationship between the self and the world (George, 1982, p.26).

Menopause marks a change in a woman's capability to reproduce. In this research, this change was viewed as a normative physiological change. Women expected it to happen to them and they considered this change part of being a women. In this view of

the process of menopause there was no major negotiating between self and the world. Neither was there a break in how the women viewed themselves as a result of being menopausal. Menopause, then, according to developmental theory is not a crises.

Another way that an event or series of events can be considered stressful is if the individuals can no longer function as fully as before (Silverman, 1982). The basic social psychological process of menopause was that women experienced menopause as "feeling different." The differences were physical or psychological changes that they associated with going through menopause. These changes had the potential of having a disequilibrating effect in that they could interfere with established patterns of behavior. These changes did not cause a crises because the women recognized these changes as temporary. They did not see menopause as a "change of life" that would affect their pattern of behavior in a permanent manner.

Theories of individual development consider midlife changes a crises from another perspective. Sheehey (1977) connects midlife crisis with the factors of imminent mortality and feelings of having achieved too little. Levinson (1978) and Vaillant (1977), suggest that developmental changes are characterized by general reappraisal and modification of life structure. The process of going through menopause did not seem to be the occasion for women to reassess their lives, work, or their life span. Menopause marked the time that the women looked forward to the future rather than assessing the past.

Menopause did represent one of the factors involved in women realizing that they were becoming older. However there did not seem to be a redefining of themselves as an older women in terms of menopause. There were many other social signs of becoming older such as age, wrinkles, gray hair, and weight gain that could be the

source of relating to society as an older woman. Menopause was seen as private and therefore the social self did not have to be redefined in relationship to the world.

Menopause as viewed in this research illustrates a change, but one that is not considered a crisis. It represents the end of a process that has started for women many years previously when they entered menarchy and continued as they made decisions about the ability or potentiality of bearing children. Menopause also represents moving to a new stage of life where women perceive greater freedom, less responsibilities and greater possibilities. The emerging theory of menopause from this research is an example of a non-crisis transition model.

Context of Change

The concept of time is important to several developmental theories, in particular to family development theory and to the age-stratification theory. Rodgers (1973), states that concept of time is the unique contribution of the family development theory. It consists of both historical time and behavioral history of individuals (p. 12-14). The age stratification theory, (Marshall, 1978; Strauss, 1978), on the other hand, holds that social, political, economic and cultural processes help shape developmental processes. It follows from this then that members of any birth cohort, that is, persons who are born at a particular time, are exposed to the same sequence of social and historical change, and experience the developmental process differently from every other birth cohort. Karp and Yoels (1982), in an analysis of the different theories of aging, claim that cohort of persons have a unique set of historical experiences. They state, "Each cohort, therefore, brings distinctive values, ideas and consciousness to these life periods" (p.29).

One finding of this research was that the way women constructed their experience of menopause did not match up with the cultural expectations as being a time of stress as expressed in popular literature and by society as a whole. The concepts of time from family development theory, and birth cohort from age stratification theory, can help account for this difference.

A good portion of research that has been undertaken in the past on midlife or menopause and from which current popular images are drawn, use cohorts of women who grew up around the time of the Great Depression. The present research involved women who grew up after World War II. The women in this research have experienced a higher standard of living than their parents, have benefited from universal education, increased health care, reliable fertility control, and availability of job opportunities. These changes mean that women are living longer, are better educated, have smaller families, and are in a better position to pursue careers than the previous cohort of women. Consequently menopause no longer comes at the end of women lives, nor does it signal the end of their usefulness to society as they can continue present jobs or start new careers. The economic and social changes connected with this cohort of women help to account for the reasons why women in this research might view their menopausal experience differently than the previous cohort.

Concept of Family Life Stages

Another important dimension of historical time for family development is social process time, which is considered the periods comprised in the life space of a group or individual with a given process. This concept of time is directly related to the idea of family life cycle stages (Rodgers, 1973, p.13).

The age span of this research extended from 45-58 years of age. It represented women who were very actively involved in parenting young children and women

whose children had left home a number of years ago. There were women who were grandmothers and women who had no children. Some women stayed at home as full time mothers and wives, or others had been working at their professions outside the home for a number of years, and other women were just starting a new career. These conditions reflect what Germain (1987) describes as age cross-over. This means that it is no longer possible to have a fixed age-connected time or age-appropriate stage for learning, marrying or remarrying, first-time parenting, changing careers, retiring or moving into other statuses and roles. Such transitions are becoming age-independent.

The previous concept of menopause occurring at the same time of the family life cycle stage for all women and including specific events like the "empty nest syndrome" seems inappropriate. Cultural changes, with the concomitant age crossover, have given rise to a wider range of midlife role opportunities and constraints to such an extend that it is no longer possible to uniformly equate any other family life stage or any particular life event with menopause. Menopause cannot be identified with a distinctive role complex structure as there is no one distinctive role complex associated with menopause. This points to the necessity of expanding the concept of family life cycle so that it will be less linked to chronological age or predetermined stages.

Conclusion

Menopause is a normative experience for women. Menopause involves physiological changes. These changes are not a crises because women do not perceive that their role or identity has been changed as a result of menopause. The changes are a source of women feeling differently physically or psychologically. It is these changes that women have to be reconciled with and need to understand. Therefore, throughout the process of menopause, the recurring theme is making sense out of feeling different.

This theme has five main categories; recognizing my change, experiencing change, making connections, seeking equilibrium and closing the cycle.

According to Rossi (1980), the various family or individual developmental theories have not considered the biological variables that are part of physical changes in middle-aged adults because they are not as dramatic as changes in early childhood or old age. The emerging theory that has been developed in this study could be a contribution to understanding how physical changes during the aging process are related to the role expectations of society.

Future Research On Menopause And Midlife Events

Propositions Generated

Grounded theory identifies concepts and relationships among concepts which explain how a particular group resolves a basic social problem, in this case, how women view the experience of menopause. The relationships identified are stated in the form of hypotheses or propositions and indicate directions for future research.

The following propositions generated from this study could be used as the basis for confirmatory investigations of women's experiences of menopause. They may also be utilized by health professionals and family life educators as the basis for helping women in midlife understand the process that they are presently experiencing, or will experience in the near future. The propositions could also be used to educate younger women and adolescent girls so that they will be better prepared for this particular stage of their lives.

The propositions derived from this research are:

1. The number and type of physiological and psychological changes associated with menopause are positively associated with increased attempts to seek explanations.

2. The amount of information about menopause is positively related to increased recognition of personal signs of menopause.

3. The more menstrual periods are associated with discomfort in the past, the more menopause is positively anticipated.

4. The less physical or psychological changes during perimenopause, the less discomfort experienced.

5. The more connections made between physical and psychological changes associated with menopause to previous experiences, the more sense can be made of these changes.

6. The less the physical and psychological changes associated with menopause interfere with regular activities, the less menopause is perceived as a problem to be solved.

7. The less physical changes during perimenopause, the less perceived loss of control over the body.

8. The less emotional changes during perimenopause, the less anxiety experienced.

9. Cessation of physical and psychological changes associated with menopause is seen as the end of menopause.

Further Suggestions for Future Research

Several questions arose during the course of this investigation about midlife events that need to be investigated further. One area is the identification of those changes that are specific to menopause and those that are related to other stages of life. Another topic is the effects of physiological changes during the aging process.

In this research the women indicated that many changes that were occurring to them during perimenopause had begun many years before. This was especially true of

physical changes, such as weight gain, which some women noted had started to take place in their 30's. They also indicated that some important decisions about the directions of their lives, such as when their child-bearing function would stop were also made in their 30's. Longitudinal research into the changes that occur during the third and fourth decade of life would help to separate those changes that are connected to menopause and those that are connected to previous ages or to other factors.

Another topic that needs further research is women and aging. The women in the research had a positive attitude toward aging. Consequently an area which could be exploration is the conditions that are related to women viewing aging as a positive or negative experience. In addition to this is the question of when, or if there is, a specific period of time during midlife, that women are involved with the process of assessing their lives. From the present research it did not appear that the time of menopause was a occasion for women to re-evaluate their lives or change life paths.

The present study involved women and the process of menopause. Men as well as women go through various physiological changes at midlife and into old age. The process of making sense out of feeling different because of physiological changes could apply to a number of situations for both men and women. Further study is needed to understand the meaning of these changes and consequently of the process of aging.

Limitations Of The Study

The study represented a particular group of women living in a large metropolitan area. Although an attempt was made to include a variety of experiences, nevertheless some groups of women were not represented. These would include other ethnic groups, women with below high school education, lower socioeconomic status, and rural women.

The names of eight of the informants were chosen by the doctor's receptionist using the criteria given. Her desire to be of help to the investigator may have biased the selection of the names. In addition all the women who agreed to take part in the study were very willing to share their experiences. There was also the possibility that they wanted to please the researcher and therefore may have minimized some of negative feelings and experiences.

The last limitation of the study is related to the research method of grounded theory. The reliability of this method depends upon the talents of the researcher to be able to analyze the data and see the relationships between concepts. Therefore to the extent that this researcher's ability is limited, is the extent that this study is limited.

REFERENCES

Abe, T., & Moritsuka, T. (1986). A case-control study on climacteric symptoms and complaints of Japanese women by symptomatic type for psychosocial variables. Maturitas, 8, 255-265.

Ballinger, S. (1985) Psychosocial stress and symptoms of menopause: A comparative study of menopause clinic patients and non-patients. Maturitas, 7(4), 315-321.

Ballinger, S. (1975). Psychiatric morbidity and the menopause: Screening of general population sample. British Medical Journal, 3, 344-346.

Barker-Benfield, B. (1975). The menopause. International Journal of Psychoanalysis, 65(1), 55-62.

Barnett, R., Baruch, G., & Rivers, C. (1984). Life prints. New York: McGraw-Hill

Bart, P. (1979). Why women's status changes in middle age: The turn of the social Ferris wheel. Sociological Symposium, Fall

Bell, S. (1987). Changing ideas: The medicalization of menopause. Social Science Medicine, 24(6), 535-542.

Benoliel, J. (1983). Grounded theory and qualitative data: The socializing influences of life threatening disease on identity development. In P. S. Wooldrige, M. H. Scmitt, J. K. Skipper, (Eds.), Behavioral Science and Nursing Theory. St. Louis: C.V. Mosby Co.

Berkun, C. (1986). In behalf of women over 40: Understanding the importance of the menopause. Social Work, 31(5), 378-384.

Beyene, Y. (1984). Cultural significance and physiological manifestations of menopause: A biocultural analysis. Culture, Medicine & Psychiatry, 10(l), 47-71.

Block, D. (1978). Sex education practices of mothers. Journal of Sex Education and Therapy, 4 7-12.

Boston Women's Health Book Collective (1976). Our bodies: Ourselves. New York: Simon & Schuster.

Boulet, M., Lehert, P., & Riphagen, F. (1988). The menopause viewed in relation to other life events: A study performed in Belgium. Maturitas, 10, 333-342.

Brown, J., & Brown, M. (1976). Psychiatric disorders associated with the menopause. In R. Beard, (Ed.), The menopause. Baltimore: University Park Press.

Campbell, F. (1977). The management of the menopause and postmenopause years. Lancaster: MTP Press.

Cassell, J. (1978). Risk and benefit to subjects of fieldwork. American Sociologist, 13, 134-143.

Channon, L., & Ballinger, S. (1986). Some aspects of sexuality and vaginal symptoms during menopause and their relation to anxiety and depression. British Journal of Medical Psychology, 59, 173-180.

Chenitz, W. & Swanson,J. (1986). From practice to grounded theory. Menlo Park, CA: Addison-Wesley.

Coulam, C. (1981). Age, estrogen and the psyche. Clinics in Obstetrics and Gynecology, 1, 219-229.

Cutler, W. Garcia, C. & McCoy, N. (1987). Perimenopausal sexuality. Archives of Sexual Behavior, 16(3), 225-234.

Dashiff, C. (1986). Education for menarchy. Journal of School Health, 56(2), 56-60.

Davis, D.L. (1983). Blood and nerves. St. John's Nfld: Social and Economic Studies.

Dennerstein, L. (1987). Depression in the menopause. Obstetrics and Gynecology Clinics of North America, 4(l), 33-47.

Deutsch, H. (1984). The menopause. International Journal of Psychoanalysis, 65(1), 55-62.

Deveraux M. (1987). 1986 Census highlights: Aging of the Canadian population. Canadian Social Trends. Winter, 37-39.

Dudley, J., & Chapman, D. (1968). The Feminine mind and body. New York: Citadel Press.

Durst, N., & Maoz, B. (1979). Change in psychological well-being during postmenopause as a result of estrogen therapy. Maturitas, 1 301-305.

Erikson, E. (1959). Identity and life cycle. Psychological Issues, 1,50-100.

Ettinger, B. (1987). Overview of the efficacy of hormonal replacement therapy. American Journal of Obstetrics & Gynecology, 156(5),1298-1303.

Feldman, B., Voda, A., & Gronseth, E. (1985). The prevalence of hot flashes and associated variables among perimenopausal women. Research in Nursing and Health, 8, 261-268.

Field, P. & Morse, J. (1985). Nursing research: The application of qualitative approaches. Rockvill Md. : Aspen.

Fine, R. (1979). A history of psychoanalysis. New York: Columbia University Press.

Fink, P. (1980). Psychiatric myths of menopause. In B. S. Eskin (Ed.), The menopause: Comprehensive management (pp 111-118). New York: Masson Publishing.

Flint, M. (1975). The menopause: Reward or punishment. Psychosomatics, 16: 161-163.

Flint, M. (1979) Transcultural influences in perimenopause. In A. A. Haspels, & H. Musaph (Eds.), Psychosomatics in perimenopause (pp. 41-56). Baltimore: University of Park Press.

Flint, M. (1982). Male and female menopause: A cultural put-on. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on Menopause (pp. 187-199). Austin: University of Texas Press.

Flint, M., & Garcia, M. (1979). Culture and the Climacteric. Journal of Biosocial Science, 6,(Suppl.), 197-215.

Friederich, M. (1982). Aging, menopause and estrogens: The clinician's dilemma. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing Perspectives on Menopause (pp. 335-345). Austin: University of Texas Press.

Gambrell, D. (1982). The menopause: Benefits and risks of estrogen-progestogen replacement therapy. Fertility and Sterility, 37(4), 457-474.

Gambrell, R., Massey, F., & Castaneda, T. (1980). Use of the progesterone challenge test to reduce the risk of endometrial cancer. Obstetrics, and Gynecology, 55, 732-738.

Gelein, J., & Heiple, P. (1981). Aging. In C. Fogel & N. Woods (Eds), Health Care of Women. St. Louis: C.V. Mosby Co.

George, L. (1982). Models of transitions in middle and later life. The Annals of the American Academy of Political and Social Science, 464, 22-37.

George, T. (1988). Menopause: Some interpretations of the results of a study among a non-Western group. Maturitas, 10, 109-116.

Germain, C. (1987). Human development in contemporary environments. Social Service Review, Dec. 565-579.

Gilligan, C. (1982). Women in middle years. New York: Wiley.

Glaser, B. (1978). Theoretical sensitivity. Mill Valley CA: The Sociology Press.

Goodman, M. (1980). Towards a biology of menopause. Signs, 5(4), 539-553.

Goodman, M. (1982). A critique of menopause research. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on Menopause (pp. 187-199). Austin: University of Texas Press.

Gordon, H. (1977). The correlation of menopausal symptoms with cytohormonal status. In S. Campbell (Ed.), Management of the Menopause and Postmenopause Years (pp. 271-279). Baltimore: University Park Press.

Gornick, V., & Morgan, P. (1972). Women in sexist society. New York: Basic Books.

Gould, R. (1972). The phases of adult life: A study in developmental psychology. American Journal of Psychiatry, 129, 521-531.

Gower, D. (1988). Annual update on labour force trends. Canadian Social Trends. Winter, 17-20.

Greenblatt, R. (1974). Preface and reprise. In R. Greenblatt (Ed.), The Menopausal Syndrome. New York: Medcom Press.

Greene, J., & Cooke, D. (1982). Psychosocial factors in women during the climacterium: A community study. In C. J. Main (Ed.), Clinical psychology and medicine (pp. 131-152). New York: Plenum Press.

Griffin, J. (1982.). Cultural models for coping with menopause. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on Menopause (pp. 205-221). Austin: University of Texas Press.

Gusberg, S. (1947). Precursor of corpus carcinoma estrogens and adenomatous hyperplasia. American Journal of Obstetrics and Gynecology, 54, 905-926.

Hammond, C.B. (1977). Menopause: An American view. In S. Campbell (Ed.), The Management of the Menopause and Postmenopause Years (pp. 405-423). Baltimore: University of Maryland Press.

Haspels, A. A., & van Keep, P.A. (1979). Endocrinology and management of the perimenopause. In A. A. Haspels and H. Musaph (Eds.), Psychosomatics in Perimenopause (pp 317-371). Baltimore: University Park Press.

Havighurst, R. (1952). Developmental tasks and education. New York: David McKay.

Hunter, M., Battersby, R., & Whitehead, M. (1986). Relationship between psychological symptoms, somatic complaints and menopausal status. Maturitas, 8, 217-228.

Huppert, L. (1987). Hormonal replacement therapy: Benefits, risks, doses. Medical Clinics of North America, 71(1)

Jensen, J., & Christiansen, C. (1983). Dose-response and withdrawal effects on climacteric symptoms after hormonal replacement therapy: A placebo-controlled therapeutic trial. Maturitas, 5, 125 - 133.

Karp, D., & Yoels, W. (1982). Experiencing the life cycle: A social psychology of aging. Springfield: C.C. Thomas.

Kaufert, P. (1986). Menstruation & menstrual change: Women in midlife. Health Care for Women International, 7, 63-76.

Kaufert, P. (1986). Anthropology and the menopause: The development of a theoretical framework. Maturitas, 4, 181-184.

Kaufert, P., & Syrotiuk, J. (1981). Symptom reporting at the menopause. Social Science Medicine, 15, 173-184.

Kaufert, P., & Gilbert P. (1986). Women, menopause and medicalization. Culture, Medicine and Psychiatry, 10(1), 7-21.

Kerlinger, F. (1986). Foundations of behavioral research. New York: Holt, Rinhart and Winston.

Kieren, D., & Morse, J. (1989, November). Redesigning menstrual education programs using attitude toward menstruation. Paper presented at the Annual Meeting of the National Council on Family Relations. New Orleans, LA.

Koeske, R. (1982). Toward a biosocial paradigm for menopause research: Lessons and contributions from the behaviorial sciences. In A.Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on Menopause (pp. 3-23). Austin: University of Texas Press.

Koff, E., Rierdon, J. & Sheinsold, K. (1982). Memories of menarche: Age, preparation and prior knowledge as determinants of initial menstrual experiences. Journal of Youth and Adolescence, 11(1), 1-9

Kruskemper, G. (1975). Results of psychological testing in climacteric women. In P. Keep & C. Lauritzen (Eds.), Estrogens in the postmenopause: Frontiers of hormone research. Basel: S. Karger.

LaRocco, S., & Polit, D. (1980). Women's knowledge about menopause. Nursing Research, 29, 10-13.

Lauritzen, C. H. (1976). The female climacteric syndrome: Significance, problems and treatment. Acta Obstetrica Gynecologica Scandinavia, Supplement, 53, 47-61.

Leiblum, S., & Swartzman, L. (1986). Woman's attitudes toward the menopause: An update. Maturitas, 8, 47-56.

Lennon, M. (1987). Is menopause depressing? An investigation of three perspectives. Sex Roles, 17(1), 1-16.

Levine, S. (1986). Menopausal hot flash: Procrustean bed of research. Unpublished doctoral dissertation. University of Utah.

Levinson, D. (1978). The seasons of a man's life. New York: Alfred A. Knopf.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills: Sage Publication.

Lock, M. (1986). Ambiguities of Aging: Japanese experience and perceptions of menopause. Culture, Medicine and Psychiatry, 10(1), 39-45.

Lock, M., Kaufert, P., & Gilbert, P. (1988). Cultural construction of the menopausal syndrome: The Japanese case. Maturitas, 10, 317-332.

MacMahon, B., & Worcester, J. (1966). Age at menopause in the United States 1960-1962. Washington: U.S. Government Printing Office.

MacPherson, K. I. (1981). Menopause as disease: The social construction of a metaphor. Advances in Nursing Science, 3(2), 95-113.

Marshal, B. (1978). No exit. Aging and Human Development, 9, 345-357.

Masters, W.A. (1977). The risk of sex hormones as drugs. Women and Health, 2(1), 8-11.

McCrea, F. (1983). The politics of menopause: The discovery of a deficiency disease. Social Problems, 31(1), 111-123.

McKinlay, J., McKinlay, S., & Brambilla, D. (1987). Health status and utilization behavior associated with menopause. American Journal of Epidemiology, 125(1), 121-132.

McKinlay, S., & Jeffreys, M. (1974). The menopausal syndrome. British Journal of Preventive Social Medicine, 28, 108-115.

Muhlenkamp, A., Waller, M., & Bourne, A. (1983). Attitudes toward women in menopause. A vignette approach. Nursing Research, 32, 20-30.

Nachtigall, L,. & Heilman, J. (1979). The Lila Nachtigall Report. New York: Putnam's Sons.

Neugarten, B. (1967). A new look at menopause. Psychology Today, 1(7), 43-45, 67-69.

Neugarten, B. (1968). The awareness of middle-age. In B. Neugarten (Ed.), Middle age and aging. Chicago: University of Chicago Press.

Neugarten, B. (1979). Time, age and life-cycle. American Journal of Psychiatry. 136, 887-894.

Notelovitz, M. (1986). Post-menopausal osteoporosis. Acta Obstetrica Gynecologica Scandinavia. Supplement, 134, 67-80.

Notham, M. (1979). Midlife concerns of women: Implications of the menopause. American Journal of Psychiatry, 136 (10),1270-1274.

Perlmutter, E., & Bart, P. (1982). Changing views of the change: A critical review and suggestions for an attributional approach. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on menopause (pp. 187-199). Austin: University of Texas Press.

Posner, J. (1979). It's all in your head: Feminist and medical models of menopause (strange bedfellow). Sex Roles, 5(2), 179-191.

Rauramo, L. (1986). A review of study findings of the risks and benefits of oestrogen therapy in the female climacteric. Maturitas, 8, 177-187.

Reuben, D. (1969). Everything you always wanted to know about sex. New Your: Bantam Books.

Roberts, P., & Newton, P. (1987). Levinsonian studies of women's adult development. Psychology and Aging, 2(2), 154-163.

Rodgers, R. (1973). Family interaction and transition. Englewood Cliffs: Prentice-Hall.

Rosenhand, V. (1984). Menopause and its effect on femininity. Unpublished master's thesis. Florida Institute of Technology.

Rossi, A. (1980). Life-Span theories and women's lifes. Journal of Women in Culture and Society, 6(1), 4-31.

Schindler, B. (1987). The psychiatric disorders of midlife. Medical Clinics of North America, 71(1), 71-85.

Severne, L. (1982). Psychosocial aspects of the menopause. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on menopause (pp. 239-248). Austin: University of Texas Press.

Sheehy, G. (1977). Passages: Predictable crises of adult lite. New York: E.P. Dulton.

Silverman, P. (1982). Transitions and models of interaction. The Annals of the American Academy of Political and Social Science, 464, 174-189.

Singer, J. (1976). Androgyny: Toward a new theory of sexuality. New York: Anchor Books.

Smith, D. C., Prentice, R., Thompson, D.J., & Hermann, W.L. (1975). Association of exogenous estrogen and endometrial carcinoma. New England Journal of Medicine, 293, 1164-1167.

Smith-Rosenberg, C., & Rosenberg, C. (1973). The female animal: Medical and biological view of women in the 19th Century America. Journal of American History, 59, 331-356.

Steiner, M. (1983). Psychologic aspects of the menopausal syndrome. In H. Buchsbaum, (Ed.), The menopause (pp.160-170). New York: Springer-Verlag.

Stern, P. (1980). Grounded theory methodology: It's uses & processes. Images 12(1), 20-23.

Stern, P., & Pyles, S. (1985). Using grounded theory methodology to study women's culturally based decisions about health. Health Care for Women International, 6,(1-24).

Strauss, A. (1978). Negotiations. San Francisco: Jossey-Bass.

Tesch, F. (1977). Debriefing research participants: Though this be method there is madness to it. Journal of Personality and Social Psychology, 4, 217-224.

Thom, M., White, R., & Williams, R. (1979). Prevention and treatment of endometrial disease in climacteric women receiving estrogen therapy. Lancet, 2, 455-457.

Townsend, P., Whitehead, M., McQueen, J., Minardi, J., & Campbell, S. (1980). Double-bind studies on the effects of natural estrogens on post menopausal women: A follow-up report. In N. Pasetto, R. Paoletti, J. Ambrus, (Eds.), The menopause and postmenopause. (pp. 75-84), Lancaster: M.T.P.Press.

Treloar, A. E. (1982). Predicting the close of menstrual life. In A. Voda, M. Dinnerstein, & S. O'Donnell, (Eds.), Changing perspectives in menopause (pp. 289-304). Austin: University of Texas Press.

Utian, W. H. (1977). Current status of menopause and postmenopause estrogen therapy. Obstetrical and Gynecological Survey, 32, 193-201.

Vaillant, G. (1977). Adaptation of life. Boston: Little, Brown & Co.

Voda, A. M., & George, T. (1986). Menopause. In H. Werley, J. Fitzpatrick, & R. Tauton (Eds.), Annual Review of Nursing Research, (Vol. 4). New York: Springer Publishing Co.

von Schoultz, P. (1986). Climacteric complaints as influenced by progestogens. Maturitas, 8, 107-117.

Walfish, S., Antonovsky, A., & Maoz, B. (1984). Relationship between biological changes and symptoms and health behavior during the climacteric. Maturitas, 6, 9- 17.

Weideger, P. (1976). Menstruation and menopause. New York: Alfred A. Knopf.

Weiss, N. S. (1978). Menopausal estrogens and endometrial cancer. In S.G. Silverberg, & F.J. Major (Eds.), Estrogen and Cancer (pp. 27-35).

Whisnant, L., Brett, E. & Zegans, L. (1975). Implicit messages concerning menstruation in commercial educational materials prepared for young adolescent girls. American Journal of Psychiatry, 132(8), 815-820.

Whitehead, M. I., & Fraser, D. (1987). Controversies concerning the safety of estrogen replacement therapy. American Journal of Obstetrics & Gynecology, 156(5), 1313-1322.

Wilson, R. (1966). Feminine forever. New York: M. Evans & Co.

Wiskel, O. (1985). The effects of menopausal status and employment on psychological well-being in women at midlife. Unpublished master's thesis, University of Alberta, Edmonton.

Woods, N. (1982) Menopausal distress: A model for epidemiologic investigation. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on Menopause (pp. 187-199). Austin: University of Texas Press.

Wright, A. (1982). Variation in Navajo menopause: Toward an explanation. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on Menopause (pp. 187-199). Austin: University of Texas Press.

Zaurta, A., & Hempel, A. (1984). Subjective well-being and physical health: A narrative literature review with suggestions for future research. International Journal of Aging and Human Development. 19(2), 95-110.

Ziel, H., & Finkle, W. (1975). Increased risk of endometrial carcinoma among users of conjugated estrogen. New England Journal of Medicine, 293, 1167.

Appendix A

LETTER TO PARTICIPANTS

Dear Mrs. ....,

I have been asked to participate in a research project which will be undertaken by the Family Studies Department of the University of Alberta. My part is to find some women who will be willing to participate in this project. The purpose of the research is to look at the experience of menopause in the lives of healthy women. The criteria for participation is that the women:

1) are over 45.

2) are experiencing some changes with their menstrual cycle.

3) are in good physical and mental health.

In going through my files I have noted that you fulfill these qualifications. Would you be so kind as to allow me to give your name and phone number to the researcher, so that she may contact you and explain the project in greater detail? At that time you would be able to either give your consent to be part of the study or decide that it is of no interest to you.

The study consists of several interviews in which questions will be asked of you about your experiences of menopause. All information is confidential. Although I will be given a final report, as will all the participants, I have been assured that these results will not be able to be traced to any individual, nor will anyone be identifiable. In addition, the researcher does not have access to your medical files or any other information about you other than that you meet the required qualifications. There are no medical tests or examinations required.

I have known the researcher for many years. It is her interest in women's issues that prompts her to research the subject of menopause. Many of the medical and other

helping professions would like to know more about the effects of menopause in women's lives. This study would be an important contribution to our field of knowledge.

If you do not wish me to give your name to the researcher, please contact Hilda by June 15. Otherwise we will assume that you will at least allow the researcher to phone you to explain the project in greater detail and answer any of your questions. Please remember that you are not under any obligation to participate in this research and that you may withdraw from the project even once you have started.

I thank you for your consideration of this matter.

Sincerely,

APPENDIX B

QUESTIONS FOR INTERVIEWS

The following are possible questions or statements that could be used during the first interview

1. Tell me something about what has happened to you since you had your last menstrual period, or since your periods have been changing.

2 What did these changes mean to you?

3. What were your expectations of menopause?

4. What have you noticed happening to your body since your last period or since your periods have been changing? How does your body feel?

5. Have you noticed any other changes happening to you as a person?

6. Tell me something about what other women have said to you about their experiences when their periods stopped?

7. What did your mother tell you about menopause ?

8. Tell me something about how your periods started.

9. Tell me something about your husband's reactions to what has been happening to you recently? Have your sexual relations been affected by these changes?

10. Describe the different roles you enact in your life. Are some of these roles changing now? Describe how they are changing.

11. What does it mean to you to be feminine or to be a woman? Do you feel that this has changed?

12. Tell me the difference you see between a woman before menopause and a woman who has experienced menopause?

13. Tell me something about how you see your life in the next few years.

14. With what do you associate menopause?

15. When will menopause be over for you?

APPENDIX C

INFORMED CONSENT FORM

The purpose of this research project is to gain a better understanding of women's experience of menopause. Interviews will be conducted two or three times with each participant. Each interview will last approximately one hour. During these interviews questions will be asked regarding your views and feelings about menopause. The interviews will be taped and transcribed. These tapes will be stored in a locked security box in the researcher's home. The tapes and the transcribed notes will not contain the names of the interviewees. A final report will be available to all participants at the end of the study and an offer to attend an informal gathering to discuss the results will be made.

There may be no personal direct benefits to the participants of this study, but as a result of this research there will be more accurate information about menopause available to medical and other professional workers.

THIS IS TO CERTIFY THAT I,--------------------------------------
(print name)

HEREBY agree to participate as a volunteer in the above described research project.

I understand that there will be no physical health risks to me resulting from my participation in the research.

I hereby give permission to be interviewed and for these interviews to be tape-recorded and transcribed. I understand that at the completion of the research, the tapes will be erased. I also understand that the information may be published, but my name or anything that could identify me will not be used in the research.

I further understand that I may decline to answer any questions during the interview. I understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been given the opportunity to ask the researcher whatever questions I desire and all such questions have been answered to my satisfaction.

I also understand that this research is a project of the Family Studies Department of the University of Alberta and that Dr. Norah Keating (492-4191) may be contacted to answer any concerns about the research.

____________________ ____________________ ____________________

Participant Researcher Date