Menopause: An Exploration of Career Women's Experience

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LOYOLA UNIVERSITY CHICAGO

MENOPAUSE: AN EXPLORATION OF CAREER WOMEN'S EXPERIENCE

A DISSERTATION SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL IN CANDIDACY FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

SCHOOL OF NURSING

BY

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DEDICATION

This dissertation is dedicated to my husband, for his incredible patience and encouragement under all circumstances, my parents for their constant support, including my mother's editorial assistance, and my two great-aunts who have been there for me throughout all my educational endeavors.
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TABLE OF CONTENTS

ACKNOWLEDGMENTS ................................................................. iii

LIST OF TABLES ........................................................................... v

Chapter

I. CONCEPTUAL FRAMEWORK AND MODEL DEVELOPMENT ... 1

II. LITERATURE REVIEW.............................................................. 22

III. RESEARCH METHODOLOGY............................................... 39

IV. POPULATION AND SAMPLE ................................................. 48

V. DATA COLLECTION AND ANALYSIS ....................................... 58

VI. CONCLUSIONS ...................................................................... 119

Appendix

A. CONSENT FORM ..................................................................... 127

B. DEMOGRAPHICS QUESTIONNAIRE................................. 128

REFERENCES .............................................................................. 129

VITA ............................................................................................ 139
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DEMOGRAPHICS INFORMATION</td>
<td>59</td>
</tr>
</tbody>
</table>


CHAPTER I

CONCEPTUAL FRAMEWORK AND MODEL DEVELOPMENT

Introduction

The overall purpose of this study was to explore career women's experience of menopause. Women in developed countries often live 30 or more years beyond menopause, yet little is known about the experience of menopause and the needs of women experiencing this transition. The study of women's experience of menopause will enable health care professionals to identify and meet these women's needs, needs which are presently unmet for the growing numbers of mid-life women.

The specific aims of the study are to explore the menopause experiences of career women, a growing population whose experiences and needs have not been studied, and to use thematic analysis as a means of organizing data to depict the experience both generally and individually.

Menopause is a normal developmental process for women that encompasses the period of time preceding and following the last ovulatory cycle. Today women have a longer lifespan than in previous generations...
and the menopause occurs not at the end of women's lives, but in their middle years. In most developed countries, women live 30 or more years after menopause. This section will examine the concept of menopause, develop a theoretical framework to be used for further study of the concept, and examine the literature on menopause research. Menopause can occur naturally or be iatrogenically induced either surgically or chemically. This study focused on naturally occurring menopause.

Menopause is an important concept for nurses because it is a universal experience for women. The NAACOG standards for women's health care (1991) address the special needs of women during and after menopause (p. 21). All nurses, not just those in women's health, interact with women experiencing menopause, either on 1) a professional level with clients or friends and relatives of clients, 2) a social level with family and friends, or 3) the level of personal experience of menopause. Menopause affects not only those women experiencing it but those who care for them on whatever level.

Some may argue that menopause itself is a medical concept. However, interdisciplinary conferences and anthologies that include nurses use the term "menopause" (MacPherson, 1990; Formanek, 1990), as well as the women who are nursing's clientele. As Rodgers (1991) said about the
uniqueness of nursing,

Many nurse authors have argued that it is the perspective that helps to differentiate nursing from other disciplines and that enables theories developed in other fields to be used in nursing, provided they are adjusted to fit the nursing perspective. (p. 179)

There is no universally accepted framework used to describe menopause that would help with the understanding of the concept and provide a theoretical basis for research. This may be due to the fact that little scientific data exist on changes women experience due to menopause and changes attributable to aging in general (Whelan, Sandler, McConnaughey, & Weinberg, 1990; Formanek, 1990; Engel, 1987; Jackson, Taylor, & Pyngolil, 1991). An analysis of the concept of menopause based on Rodgers' (1987) approach serves to illustrate what is known about menopause, what needs to be known, and what directions future research can take.

The Use of Rodgers' Method of Concept Analysis

The menopause is a complex phenomenon involving many interacting variables. Rodgers' unrevised method (1987) of concept analysis fits particularly well with the concept of menopause because it has a
dispositional approach. The concept of menopause has historically been in a state of evolution and development much as societal factors (e.g., culture, politics, and control of women's bodies and women's status) have evolved and developed over time. Because menopause is an abstract, complex phenomenon that has physiological and psychosocial correlates that interact and thus cannot be viewed completely in a reductionistic framework, it cannot be regarded as a fixed point in time with specific boundaries. This is very much in keeping with Rodgers' (1987) view of concept analysis. In fact, her description of the attributes of a concept, which "...appear more as a cluster which serves as a means of evaluating future encounters in reference to their resemblance to the defined concept" (p. 117) is applicable to the attributes found in the literature on menopause. In addition to its complex nature, menopause lacks specific boundaries because knowledge about this concept is continuously developing. Also, there is such a close relationship between changes associated with menopause and those associated with normal aging that it may not be possible to delineate clear boundaries between the two concepts.

The steps in Rodgers' approach (1987) are:

-choice of concept,
-identify all the ways in which the concept is used,

-identify and select an appropriate realm/sample for data collection

-identify the attributes of the concept,

-identify references, antecedents, and consequences,

-identify related concepts,

-and identify a model case.

Due to the dispositional nature of concepts, these steps may progress in any order, but for the purpose of this paper, they will follow as listed above.

Accessing The Literature

The concept chosen is menopause. A consultation with a librarian at the American College of Obstetricians and Gynecologists Resource Center yielded the findings that most of the literature on menopause is divided into two categories. One category is based on a biomedical view of menopause, which considers it a deficiency disease; this literature deals mainly with hormone replacement therapy. The other category contains literature which focused on adaptation to and psychosocial views of menopause. (Interestingly, a request for a literature search on nonhormonal approaches to the treatment of menopausal symptoms yielded the response that that topic did not exist in the literature at present.)
Both these viewpoints can be considered reductionistic in that they view menopause as either purely biological or purely psychosocial or cultural, thereby ignoring the complex nature of both women and menopause and also the multiple levels of interaction between the mind and the body (Koeske, 1982). Kaufert (1982) examined both these models and found them to be myths. She describes myths as a social product that serves as a specific window used to look at a concept that may have no relationship to the reality of that concept. She does not examine the accuracy of these myths, but uses them "...as a means through which to understand the world view of the myth-owners" (p. 141).

There is no simple way to review the literature on the complex phenomenon of menopause. The literature appears in a variety of disciplines and contexts. This phenomenon also changes historically with sociocultural changes. Therefore it is important to seek out all the different uses of the concept in order to get the most complete definition possible. This literature review consisted of systematic sampling from the information in the ACOG search, interdisciplinary conferences and anthologies and journals, as well as follow-up on citations from all of these. In addition, research generated from the Tremin Trust, a longitudinal study of women's menstrual lives that now
covers three generations, was used as a source of both information and further citations.

Ways Menopause is Used

The large amount of data yielded by these searches necessitated some type of organizational system. Thematic analysis fits well with the data on menopause because there are many underlying, common themes in the literature. The clusters seemed to fall easily into two groups, individual and societal. The number of articles describing menopause as a complex phenomenon that has certain benefits and risks associated with it fall under the heading of attributes.

Under individual factors falls women's experience, either women's experience of menopause itself or, more commonly, the need for inclusion of women's experience of menopause in the study of menopause. The attitudes toward menopause and perceptions of menopause of women of all ages, as well as the attitudes and perceptions of others, are separate from women's experience of menopause itself. Women's knowledge of menopause was examined as well. Menopause is also viewed both as a crisis or distressing time as well as a positive experience. It is seen as a normal process of aging. Menopause has been viewed purely as a physiological event, including
being described as a pathology or disease state. The possibility of predicting onset of menopause for individual women has also been addressed.

One cluster of themes fits in both the individual and societal groups because of the two groups' nonlinear interactive relationship. Rather than arbitrarily putting psychosocial correlates in one group or the other, the cluster containing psychosocial correlates was placed in both groups to illustrate the relationship between the two groups. Many of the factors under this heading are interrelated, such as psychosocial factors and sociocultural factors. The following are specific societal variables related to menopause. Life patterns and work status have been examined as well as female sexuality. Menopause has been viewed as a status passage or developmental transition for women. Fictional portrayals of menopausal women are seen as reflective of societal attitudes as are women's status and roles. The difference between the terms menopause and climacteric are also discussed in this context.

Besides the psychosocial correlates of menopause, societal factors include attitudes of others toward menopause and social support for menopausal women, also found under individual factors since they affect both the individual and society. Under this category in societal factors,
however, is added medical perceptions and knowledge of menopause. The category labeled "Policy" encompasses the debate about research methods, often with an emphasis on women's experiences, and health care policy. The medicalization of menopause (the making of menopause into a condition requiring medical treatment) is a controversial topic, and it encompasses whether women seek medical care for menopause as well as the issues of control, politics, economics, and self-care. Similar to the category of sociocultural variables is the one describing menopause as myth, stereotype, and folk model. Nursing's knowledge of menopause, attitudes toward it, and role in care and research of menopausal women have also been examined. Bodily reductionism, which is related to both sociocultural variables and the complexity of the phenomenon, has been denounced as the separation of women's bodies and minds in the research and treatment of menopause.

Thematic analysis is subjective, especially when the collapsing of clusters of themes is involved. Some categories changed as new data became available, and these relatively arbitrary groupings may continue to change as the literature on menopause changes.

The literature review leads into a definition of menopause. Kaufert and Gilbert (1986) argue that,
...in the case of 'menopause', it has been the medical researchers who have tried to take over the word by stripping it of all its social and cultural baggage and giving it a precise definition as a woman's final menses. This particular usage proved too narrow, and even in the medical literature, 'menopause' tends to be used more broadly as the label for a period of time preceding and following upon the last menstrual cycle. (p. 8)

This definition can be expanded to allow it to encompass all women experiencing natural menopause, including those who have had hysterectomies but whose ovaries are intact, and to incorporate the normalcy of this developmental process. Menopause is a normal developmental process of change in physiological gynecological functioning which occurs during the period of time preceding and following the last ovulatory cycle. This is both a physiological and a psychosocial definition. It is physiological because the process depends on physiological functioning. However, because this process occurs in the context of women's lives, there is a strong psychosocial component as well. Laboratory tests are the most objective indicators of gynecological changes indicative of menopause; the indicators most commonly used by women, health care professionals, and society are
signs and symptoms such as the cessation of menses, hot flashes, and vaginal dryness. Women on hormone replacement therapy, especially those taking it prophylactically, will have masking of these symptoms, so that it cannot be easily determined at which stage in the process these women are. Because there is no universally accepted definition of menopause, particularly one that allows for both the biological and the psychosocial context of women's lives, conceptual clarity is needed in research studies on menopause.

Realm for Data Collection

Rodgers' method of concept analysis requires the identification and selection of an appropriate realm for data collection. The consensus of most of the literature is that women's experience should be the focus of further research. When menopause is viewed through many different reductionistic "windows", the total picture is lost (Koeske, 1982; Stimpson, 1982; Dan, 1982; Voda & George, 1986). Other problems with data collection involve generalizability and also timing of data collection. Generalizability is a concern because so many individual and societal factors impact on menopause. One woman's experience or even a specific group of women's experiences cannot be generalized to all women's experiences of menopause. Timing of data collection, depending on where women are in
the menopausal process, also affects women's responses. Recall bias is one factor at work here that affects the reliability of the data.

A number of studies have been done on different women's experiences of menopause. It is important to begin to focus on the needs of women experiencing menopause, including working women. Along with an increase in women's lifespans, there has also been an increase of women in the work force. Many remain there until their sixties or after, and many may have hit their professional peak around the menopausal period. If more women are experiencing menopause in settings other than the home, nurses need to find out what aspects of menopause are problematic to women, and which aspects they would like help with. These women constitute a large, presently unexplored population. Nurses need to find out what help these clients want in order to best serve their health care needs.

In preparation for a more in-depth future data collection, a very small field study of four women was conducted to determine if revisions were necessary in the wording of an open-ended questionnaire that will explore working women's needs during menopause. Although revisions were required in interviewing technique, the results of the study showed that all of these subjects found hot flashes to be the most distressing menopause-related
symptom. One woman said, "I mean it got to the point of being absolutely aggravating because it was happening four or five times a day and I would feel absolutely drenched" (11/15/91). She talked about the problems of getting dressed and made-up for a presentation only to become drenched from a hot flash. "When my mother went through this, she wasn't working at the time. She was just at home, so it was kind of cute, because she wasn't at work and it didn't really interfere" (11/15/91).

A surgical nurse described the embarrassment that occurred when she had a hot flash while she was scrubbed in surgery. "Probably the most embarrassing thing I ever did was, I scrubbed on a hand case, and I stood up to get something off the back table, and it was all wet where I was sitting... and it looked like I wet my pants... but this is hard to deal with" (10/8/91).

Areas Requiring Further Exploration

Aside from the problems these women had with distressing symptoms at work, there were other commonalities that will need to be explored further. They all saw menopause as a normal, expected event in their lives; they did not dread it or consider the event itself distressful. It was associated with symptoms that were a problem for these women. Those women who sought help from a physician for the symptoms had waited several years before they
asked for assistance and started on estrogen replacement therapy. The reason for their delay in seeking assistance also needs to be explored - is it due to the women's perception of menopause as a normal event, fear of risks associated with exogenous estrogen, perceptions that symptoms would not continue as long as they did, or other factors?

Another area requiring further investigation relates to unexpected benefits from estrogen replacement therapy. Two women on estrogen said that they had not realized until after they had gotten a full night's sleep that their sleep had actually been interrupted every night by hot flashes. Do these interruptions in sleep affect women's functioning during the day? And all the women had many questions about menopause, hormone replacement therapy, and symptoms, leading to the conclusion that their needs for information are not met despite their interaction with the health care system, with both physicians and nurses.

An interview done four months later using revised interviewing techniques yielded the story of a different menopausal experience for a 51 year old woman. Uncertainty was a key theme in this interview (uncertainty as to when she began menopause, uncertainty as to what symptoms were attributable to menopause) as it was for the other women. She started the
interview by saying, "Well, I've gone through it, I've been going through it for two years, I think... I don't think it's hot flashes, but I get, like, warm..." (3/20/92). Unlike the other women, she came right out and described the experience as great because the symptoms weren't "bad". (Menopause may be different for this woman because she does not have a job outside the home. The other women were career women.) She does describe symptoms she attributes to menopause, both psychosocial and physiological. The psychosocial symptoms, however, she acknowledges may not be due totally to menopause, but may be due to what she calls transitions in her life. These mid-life transitions seem to serve as part of the context for the experience of menopause. She is not interested in taking any drugs not only because she believes in holistic medicine, but also because she states her symptoms are too mild to require medical intervention.

The pilot phase of data collection, as well as the lack of studies of the menopause experience of working women, indicate that working women's experience is an appropriate realm for data collection. The study of women's needs during menopause is a subset of the field of women's experiences of menopause. In particular, various groups of working women experiencing menopause comprise the potential samples for data collections.
Due to the results of the field work, women on hormone replacement and those who are not should all be included in the studies so that clarification of areas found to require further investigation can be made.

Attributes of Menopause

The attributes of menopause, then, are that menopause, a complex phenomenon, is a normal, developmental process with associated risks and benefits, and with psychosocial and neuro-hormonal changes which occur during the time preceding and following the last ovarian cycle. These attributes may be inhibited by the use of hormone replacement therapy. Note that these attributes apply to natural menopause and not early surgical or other iatrogenically induced menopause. Menopause can be likened to puberty in that puberty is also a normal process that varies in time of occurrence and duration for individuals, and has potential associated pathologies.

Development of a Model

Using this definition of menopause as a normal process, menopause can be viewed as a portion of a woman's reproductive lifespan. Bronfenbrenner's ecological theory (1979), originally developed as a theoretical perspective for human development research, can be adapted to
produce a model that views menopause as a normal part of a woman's reproductive lifespan. The interaction between societal and individual factors occurs at various levels, from the microsystem, or individual physiologic level, to the macrosystem, or the level of society or culture.

The ecological environment can be seen as a nested arrangement of concentric circles that surround the linear path of a woman's developing reproductive life span. The microsystem described by Bronfenbrenner would be the genetic and other biological factors in the makeup of a woman's life. The mesosystem consists of the transactions between the woman's reproductive lifespan and two or more settings with which the woman actively interacts at this level, such as work, family, and her immediate health care providers. The exosystem would be the overall health care system she uses and friends of friends, and the macrosystem refers to the environmental level of society or culture as a whole.

It can be seen from the literature that many levels of environment have an impact on the development of a woman's experience of the menopause, both physically and psychosocially at all levels, both individual and societal. In this type of model there is interaction between the woman and the environment in both directions. This would allow for environmental influences
from prenatal effects at the microlevel through a multitude of transactions over a woman's entire lifespan. Intervention can take place at whatever level of environment women require assistance with, from the microsystem to the macrosystem.

A theoretical framework of this type avoids the reductionistic traps that both the biomedical and the psychological, societal, and cultural models (including the feminist model) for viewing menopause fall into (Posner, 1979). Bodily reductionism views women only as their separate, component parts of body and mind, rather than as a complex, interrelated whole. Biomedical models which view menopause as purely a physical condition requiring medical treatment, psychological models, which view menopause purely as a mental condition, societal and cultural models (including the feminist model) which view menopause purely as an event shaped solely by forces outside the woman, all ignore the way these factors interact. Menopause involves physical, psychological, and sociocultural factors. Ecological theory also takes into account the findings that women view the menopause as a normal event and do not subscribe to a biomedical or psychosocial model (Kaufert & Gilbert, 1986), although what Koster (1991) calls "an accelerating medicalization" (p. 11), due to the heavy promotion of
hormone replacement therapy, may be occurring. Further research is needed
to clarify whether women view hormone replacement as merely an available
form of symptom relief for a normal event or as a necessary treatment of
menopause as described by the biomedical model.

References, Antecedents and Consequences

Using this model, the antecedents and consequences for menopause
occur at all environmental levels, individual and societal, because of the
multitude of interactions between the individual woman and her
environments. These antecedents and consequences differ for individual
women because of each woman's unique blend of micro, meso, exo, and
macrosystems, although commonalities can be found. Thus, due to the
complex nature of menopause, there are many antecedents and
consequences of menopause that differ for each individual based on her
unique individual and societal characteristics. There are many unique
individual and societal factors that comprise a woman's antecedents to
menopause. Also, references, or the time span in which the application of the
concept is relevant, vary from individual to individual, as menopause is a
normal developmental process that occurs at different times and has different
durations for individual women.
However, while duration and symptomatology may vary, there are still common antecedents and consequences. Antecedents include menarche, ongoing menstrual cycles, developmental maturity, and for some women, pregnancy. Consequences are neurohormonal and physical changes associated with a decrease in estrogen, such as cessation of menses and the various sociocultural and psychosocial changes associated with the neurohormonal and physical changes.

Related Concepts

Related concepts can be identified as the individual and societal variables found through the literature review and thematic. As can be seen by the placement of menopause in a woman's reproductive lifespan, aging is a concept strongly related to menopause. There are related variables on both the individual and societal levels, due to the complexity of the concept. For example, individual women's experiences are related as are control/politics/economics, which are on a much broader plane. All these factors at different environmental levels both influence women's experiences of menopause and are in turn are influenced by individual women.
Identification of Model Case

A model case can be identified using the attributes from Figure 3. A 52-year-old woman has experienced the cessation of menses for twelve months, after two years of increasingly irregular menstrual cycles. She views menopause as something expected and normal, and is happy to no longer be bothered with monthly menses and contraception. She is not happy, however, with the associated symptom of vaginal dryness, which causes pain with intercourse and predisposes her to frequent vaginal infections. She experiences hot flashes only as night sweats, which are disruptive to her sleep; she is grateful that they do not occur during the day while she is at work. She is confused by all the controversy about estrogen replacement therapy in the news, and is not sure whether that is something she wants to use. Further research is needed to identify commonalities for specific groups of women. It is important, however, to keep in mind the dispositional nature of the concept; as knowledge and attitudes change over time, so will the concept and its "model" cases.
The concept of menopause can be viewed from many perspectives, all of them encompassing a small piece of the whole picture. There is an increased interest in women's health research due mainly to the previously predominant focus of research on men's health issues, the increasing demand by women for such research, and recent federal funding priorities in this area. There has been an increase in the number of studies on the menopause, but many have serious limitations, as will be discussed later. This chapter will examine the perspectives or frameworks used to guide research on menopause and the way these perspectives influence the results.

Models For Viewing Menopause

Several different models exist which provide opposing perspectives for viewing menopause and drive research. The two most popular are the biomedical model and the psychosocial model. The perspective one uses to view menopause influences how one defines and operationalizes the concept. The biomedical model views menopause as a deficiency disease requiring
medical treatment. This is often referred to as the medicalization of menopause, since it defines menopause as an illness requiring medical treatment in all cases. Kaufert and Gilbert (1986) studied Canadian women and found that the women in their study did not view menopause as a deficiency disease requiring medical treatment and thus rejected the biomedical model.

In a more recent study of Danish women, Koster (1991) found that while most women do not view menopause as a deficiency disease, there was an increasing acceptance of hormone replacement therapy. Yet the shift in these women's attitudes about hormone replacement suggest that menopause was viewed as a condition requiring treatment. It is possible that these women still do not accept the biomedical model, but rather view menopause as a normal process with concomitant risks and benefits that may require prophylaxis such as hormone replacement. This is a more pragmatic view that still allows for the rejection of the biomedical model per se.

The psychosocial model of menopause, which is often called the feminist perspective, views the menopausal experience as psychologically, socially and/or culturally produced. This model attempts to circumvent the belief that anatomy is destiny and that women are driven solely by hormonal
changes by considering problems associated with menopause to be psychosocial. The problem with this model is that the focus is primarily on psychosocial adaptation, and little attention is given to physiological factors. Women's reports of problems with menopause are not taken seriously and their problems are considered to be "all in their heads" (Kaufert, 1982). This primarily psychosocial model is as reductionistic as the biomedical model which considers menopause purely biological. Both of these models fail to address the complex nature of women, menopause, and the multiple levels of mind-body interaction (Koeske, 1982).

Methodology

Much has been written in recent years about menopause. Many of the articles are non-data based literature reviews. Of the research studies, excluding the purely physiological, which will not be covered in this paper, thematic analysis shows that these studies fit into five general categories: epidemiology, attitudes toward menopause/perceptions of menopause, women's experience, aging/normal process, and psychosocial correlates. Interestingly, each category does not necessarily utilize only one model. The following literature review will show that there are limitations in the studies and gaps in knowledge that need to be addressed in future research.
**Epidemiology**

Epidemiology is a broad category containing studies related to associated risks and benefits of menopause as well as associated patterns. Studies in this area have used the biomedical model, the psychosocial model, and an integration of the two. Some examples from this category are as follows.

In a study highly publicized in the popular press, Ditkoff, Crary, Cristo, and Lobo (1991) studied 36 women aged 45-60 post-hysterectomy and found that one group, on estrogen, had a significant improvement in depression scores and on a measurement of income management. (It is not clear when they underwent hysterectomy or if it included oopherectomy.) The authors concluded that estrogen replacement after menopause improved the mood and psychological functioning of well-adjusted, healthy women. The conclusions were generalized well beyond the findings, however, as there were only 12 women per group for a total of three groups, they had all had hysterectomies, and the women started with normal scores on the tools. (There is no reason given for the sample size or group size.) It is not clear what a significant difference on a depression tool or income management tool means when both scores are in the normal range. It is not clear what
income management has to do with mood. There seems to be no basis for the authors to suggest that estrogen replacement was a factor in improved mood or income management. Also, depression is only one component of mood. No rationale is given for the choice of a test-retest interval of three months. In addition, the use of unopposed estrogen limits the generalizability of the findings, as most women on hormone replacement therapy take estrogen in combination with progestin. It can also be questioned whether this study was ethical, since the unopposed estrogen was given to women who were all asymptomatic. Yet these findings were widely disseminated in newspapers and magazines.

Kaufert, Gilbert, and Hassard (1988) researched the symptoms of menopause and measured the physical and psychological morbidity among 477 Canadian women. They found that the only significant relationship between any symptom and menopausal status was between vasomotor symptoms and menopausal status. Before conducting their study, they cited the following methodological problems with collecting menopausal symptom data in others' studies: "These were lack of care in the use and interpretation of retrospective data, inadequacy in the measurement of psychological morbidity, and failure to control for the impact of cultural stereotyping on
Koster (1990) studied the use patterns of hormone replacement therapy in 597 Danish women and found that the use of hormone replacement therapy is becoming increasingly accepted and is increasingly prescribed prophylactically before menopause. Climacteric complaints such as hot flashes, and not prophylaxis, however, were the chief reason women gave for starting hormone replacement therapy, but 40% of them discontinued treatment, mainly because of side effects or lack of effect. An important follow-up study would address why women discontinue treatment and identify what their treatment expectations were and which ones were not met.

McKinlay, McKinlay, and Brambilla (1987) investigated women's health status and utilization of health services associated with menopause in a prospective study of 2500 women and found that menopausal health status and utilization of health services were not related to menopause, but were related to prior health status and utilization behavior. This sheds an interesting light on the typical view of the middle-aged woman as an over-consumer of health services, and also adds weight to the argument that women view menopause as a normal, expected process, not a disease.
Interestingly, studies by Notelovitz have not been so widely disseminated, despite his strong research designs. In 1990 he studied the role of exercise in the prevention of cardiovascular disease and osteoporosis in several studies with sample sizes from sixteen to thirty-three women. He found that exercise alone wasn't a panacea, but in conjunction with a healthy lifestyle, it was a useful additive and even in some cases an alternative to hormone replacement therapy. His findings are important not only in that hormones alone are no panacea without other lifestyle changes, but also that exercise may be an alternative to hormone replacement therapy, at least for the prevention of osteoporosis. This is the type of information that needs to be disseminated to doctors and nurses who distribute hormone replacement therapy, so that they can adequately counsel their clients.

A very biomedically oriented study was conducted by Schmitt et al. (1991). They studied factors influencing decisions related to hormone replacement therapy in order to increase the number of women deciding to use hormones. (It was their belief that hormone replacement therapy was medically necessary for all menopausal women.) They found with their sample of two hundred sixty-five women that women divided into four groups based on the factors influencing their decisions related to hormone
replacement therapy. They reported that women's decisions were significantly related to their educational level, perceived experience of stress, attitude toward menopause, and their use of other medications. Although this study was interesting, no reliability or validity was reported for the tool devised by the authors.

Another widely disseminated study was conducted by Stampfer et al. (1991). They studied estrogen replacement therapy and cardiovascular disease in 48,470 women using a prospective longitudinal study and found that the overall risk of cardiovascular disease was 0.56 in women taking estrogen as opposed to a 1.0 risk in women not taking estrogen. The findings of this widely quoted study may have limited generalizability since the women in this study, unlike many women on hormone replacement therapy, were on unopposed estrogen (i.e. without progestins) and received higher doses of estrogen than are used today. Thus far, the results of studies on the effects of combined estrogen-progestin therapy on cardiovascular disease are equivocal as to whether adding the progestin increases or decreases the risk of cardiovascular disease (Lichtman, 1991).

The Minnesota Reproductive Health study is a data base covering over 40 years of women's reproductive histories, which continues to collect
data under the Tremin Trust. Information from this data base has been used for a number of studies. Using these data Treloar (1974; 1981) attempted to identify factors which might be indications of whether a woman is experiencing menopause or not. He reported no significant predictive factors were found which would help women predict when they would experience menopause and how long the process would last. Others who used the same data set were Wallace, Sherman, Bean, Treloar, and Schlabaugh (1979) and Whelan, Sandler, McConnaughey, and Weinberg (1990). All their studies are of interest in that they are attempts to help women predict when they would experience menopause, as well as predicting when women can stop using contraceptives to prevent pregnancy, although they do not report any conclusive results.

Walfisch, Antonovsky, and Maoz (1984) studied the relationship between biological changes and symptoms and health behavior during the climacteric in 47 Israeli women. They found that that climacteric symptoms are psychological and cultural artifacts, not the consequences of biological changes. This was determined by studying the symptoms a woman reports, her utilization of health services, and her perception of her health. There was a small sample of 47 used, and the tools had no reported reliability or
validity and were developed using symptoms from the literature. There is tremendous bias in using symptoms from the literature, in that they are developed from the small percent of women who seek medical care, and therefore are not necessarily representative of the majority of women experiencing menopause.

Attitudes Toward Menopause/Perceptions

Attitudes toward menopause studies are based on Fishbein and Ajzen's theory of reasoned action (Ajzen, 1985). One has to believe this theory to accept the importance of studies based on it. It is not universally accepted that attitudes drive behavior. These studies tend to utilize the psychosocial model. There are two major problems with most studies in this category. Many of these studies use Neugarten's scale, an instrument for measuring attitudes toward menopause which consists of 35 statements women can agree or disagree with (Neugarten, Wood, Kraines, and Loomis, 1963). It has no reliability or validity data and was developed from symptoms in the literature in the sixties, which were based on the symptoms experienced by the small percentage of the population of menopausal women who sought medical help, not a representative sample of menopausal women. Others use their own scales, often based on Neugarten, again with no reliability or
validity. The basis for these tools is again often the symptom literature, which is a source of bias. These studies include Avis and McKinlay (1991), Cowan, Warren, and Young (1985), Ferguson, Hoegh, and Johnson (1989), Frey (1982), Leiblum and Swartzman (1986), Millette (1981), Neugarten, Wood, Kraines, and Loomis (1963). Muhlenkamp, Waller, and Bourne (1983) utilized a vignette approach with semantic differential and based the bipolar adjectives on symptoms derived from Neugarten and others. Due to this problem with existing measurement tools, Bowles (1986) developed her own Menopause Attitude Scale and established psychometrics for her sample. Use of this tool needs to be replicated in other populations in order to expand its usefulness.

Engel (1987) used established instruments (Life Experiences Survey, Index of Sex Role Orientation, and the Perceived Health Status) to measure the impact of menopausal stage, current life change, and attitude toward traditional women's role on perceived health status. She found that perceived health status did not improve with advanced menopausal stage, that current life stress had an inverse relationship to perceived health status, and that attitudes toward women's role had a more complex relationship with perceived health status than the predicted linear one.
Schall (1989) developed a strong correlational design to study knowledge of menopause and attitude toward menopause in nurses and non-nurses and reported that the only significant difference between nurses and non-nurses was that the non-nurses had scored significantly higher on tests of knowledge of menopause. This finding has interesting implications for nurses, who care for perimenopausal and postmenopausal women in a variety of settings.

Women's Experience

Women's experience of menopause has been cited by many authors as an important focus for future research (Dickson, 1990; Formanek, 1990; Bell, 1990; Bowles, 1990; Notman, 1990; Hamerlynk, 1989; MacPherson, 1990; Buck & Gottlieb, 1991; McElmurray & Huddleston, 1991; and Koster, 1991). Not all research on women's experience is qualitative. Kaufert and Gilbert (1986) studied women's experience and the medicalization of menopause (acceptance of the biomedical model) using a cross-sectional mail survey of 2500 Canadian women and found that in general, for women menopause was not a highly medicalized process. Koster (1991) studied change of life anticipations, attitudes, and experiences in 336 middle aged Danish women using questionnaires and longitudinal analysis. She studied a
cohort of women at age 40, age 45, and age 51 through menopause. She found that the majority of the women did not report loss of health, youth, or sexuality in relation to the climacteric. Instead, social, cultural, and psychological factors, unrelated to hormonal changes were found to be most significant to these women's quality of health and sexuality during this period. This study helps to put menopause in the context of a woman's life.

The other studies of women's experience are qualitative. Buck and Gottlieb (1991) did a grounded theory study of eight Mohawk women's mid-life experiences, in which the four major issues experienced at mid-life by the sample related to the concept of time and whether the women were "in synchrony" or "out of synchrony". Kay, Voda, Olivas, Rios, and Imle (1982) did an ethnographic inquiry of the menopause-related hot flash in Anglo and Mexican-American women. Quinn's (1991) grounded theory study of women's subjective menopausal process developed a theory of the menopausal process she labeled Integrating a Changing Me. Dickson (1990) studied the interrelationship between the knowledge in scientific/medical discourses and the knowledge in the everyday discourses of mid-life women regarding the closure of menstrual life, using critical theory. She found that a link can be drawn between the scientific and medical
conceptualization of menopause (which views women as deviant and biologically inferior) and the language and meaning of menopause in the discourse of mid-life women.

McKeever (1989) looked at the informal explanatory models used by perimenopausal women to explain their menopausal experience. She found four informal models that explain why certain practices are employed by menopausal women: 1) a developmental perspective that views menopause as a process in development, 2) a rational (mind over matter) model, 3) an aging perspective that links with the negative myths and stereotypes about aging women (these women were regretful), and 4) a failed expectations perspective where women felt the experience was out of control. Keller (1992) did a qualitative, life history study to explore naturally occurring menopause for four women. She found that there is a stigma of menopause that mothers need to lift by sharing their experience, to give this time of life a healthy perspective and to destroy the myths surrounding menopause and the silence surrounding women's lives. Except for Buck and Gottlieb (1991), who studied Mohawk women, and Kay, Voda, Olivas, Rios, and Imle (1982), who studied two ethnic groups, the qualitative studies used convenience samples of white, middle class women. None of these studies
contain any rationale for sample size, that is, if saturation was reached.

Aging/Normal Process

The category which views menopause as a normal aging process is represented by a study conducted by Jackson, Taylor, & Pyngolil (1991) who studied the relationship between climacteric status and health symptoms in 522 African-American women. They reported that women experiencing premature surgical menopause were at higher risk for physical and mental symptoms. In other words, it was the women who underwent early surgical menopause who were at higher risk for physical and mental symptoms, not the women who underwent menopause at the expected time of their life.

Psychosocial Correlates

Psychosocial correlates of menopause were examined by three studies. Except for Jackson's study, these studies all fit the psychosocial model. Jackson (1990) studied the social support and life satisfaction of 120 black climacteric women and found that a relationship exists between specific components of social support (relation with male companion, relationship with children, relationship with relatives, and involvement with friends) and life satisfaction. The author does not discuss whether the effects of social support are different for climacteric black women than for any other women.
Lock, Kaufert, and Gilbert (1988) studied Japanese women's experience and the relationship between symptom experience and menopausal status. The sample used was a cross-sectional survey of 1,141 non-hysterectomized Japanese women. Symptom reporting in this middle-aged population of Japanese women is generally low. (It is not clear from the results of this study alone whether it is the reporting of the symptoms that is low or whether the occurrence of the symptoms themselves is low.) Most importantly, they found that the assumption that menopause is a universal experience at any level, even physiological, should be subject to serious questioning. Generalizations about menopause in American women, at any level of experience, should not be assumed to be the experience of women in other cultures.

Wilbush (1981) studied the linguistic aspects of the climacteric by tracing the development historically of the concepts of climacteric and menopause. He found that the use to which doctors put words that describe clinical entities determines our attitudes toward those clinical entities (referring to menopause). So linguistically describing the experience of menopause biomedically influences us to view the experience biomedically, too. This linguistic study ties in social aspects of the concept, and is related to
Dickson's study discussed under women's experience.
As can be seen from the literature review, there are many directions of study that have been taken by both the biomedical and the psychosocial schools of thought. All of these directions are necessary if we are to obtain information about a concept that is as complex as menopause. All that we can obtain from each study is a small piece of the whole developmental process. Physiological level studies, which have not been addressed in this paper, are as important as the personal experience level studies, and these are both as important as the sociocultural level studies. We are not able to measure all these levels with one tool or methodology. We can only measure each level individually and try to get a feel for the whole from each piece. The only problem to be avoided is the reductionistic thinking that views menopause as only biologic or only psychosocial.

There can be no question about the importance of the concept of menopause to nursing. It is a universal experience for women in their midlife. Schall (1989) has shown that nurses' knowledge of menopause is less than
the knowledge of non-nurse women. Cowan, Warren, and Young (1985) found that nurses, like physicians, had different perceptions of menopause from lay women. It is imperative that nurses address both their own lack of knowledge about menopause and the general lack of knowledge about menopause. Satisfactory models need to be developed for the conceptualization of menopause and as a basis for programs of research. Articles about women's midlife health abound in the popular women's magazines as a response to women's desire for accurate information. Nurses need to determine these needs and determine how best to help women meet them, or they will be ignoring the health care needs of a large, underserved segment of the population.

One way to determine menopausal women's needs is by hearing their stories in their own words, by hearing their experience. This can be done with qualitative methodology using phenomenology, the study of lived experience. Qualitative methodology does not assume objectivity as does quantitative methodology. Dickson (1990) discussed the ways one's perceptions influence one's research and stated:

If the metalanguage of menopause research were read carefully, the scientific dispositions toward the world of science, women and
menopause would be revealed. From the two major conceptualizations of menopause, the underlying assumptions about women and menopause can be seen to lay the foundation for the scientific epistemology selected to explore these beliefs about women and menopause; this selection process affects research outcomes.

(p.171)

Even the biomedical and psychosocial views are very subjective. Popkewitz (1990) talks about the logic of science as a problem of social epistemology. He says there cannot be objective science among interested social scientists. This can be seen in the directions "objective" studies on menopause take, depending on the view of the researcher. Phenomenological investigation, then, is no less "scientific" than empirical methods, and will yield rich data about the complexities of the experience of menopause for women which can be used to direct nursing care and future research. As cited earlier, there have been few studies using limited samples describing women's experience of menopause, and all of them have cited the need for more exploration of this area to further our knowledge.

Philosophical Beginnings of Phenomenology

Phenomenology was developed by Husserl, a German philosopher, at
the turn of the century, in response to natural philosophy and objectivism. He believed that it was naive to try to be objectivist because everything we do is an interpretation or perception. Edie (1987) describes Husserl's phenomenology as follows:

   Objects arise only in experience; there are no objects in the strict sense in the physical world at all; all objectivity is phenomenal... The phenomenological reduction reveals that there is a category which is more profound and more primitive than the notions of "being" and "nothingness, namely, the category of object of consciousness or phenomenon. (p.13)

   In other words, to fully understand something, one must move to a phenomenological attitude where human beings make a contribution to how things appear to them. So in phenomenology one acknowledges the importance of subjectivity. From there one moves to reflection on the subject, a reflection which takes account of both the observer, their experience, and the object itself. As Solomon (1972) explains it, "phenomenology, we might say, is always a describing of objects for consciousness (i.e. as one sees them) rather than for science or for common sense" (p.12). Edie says, The structure of the phenomenon ...can be analyzed, and this is the
role of reflection in phenomenology, but its structure is constituted (in a "passive synthesis", says Husserl) prior to any contribution of thought.
(pp. 83-84)

He continues, "The world has no meaning in itself because meaning always involves consciousness" (p. 86). In other words, phenomenological reflection on women's experience of menopause would take into account the woman experiencing it, her experience of menopause, and menopause itself.

Phenomenological Reductions

There are two phenomenological reductions involved in this method. One is epoche, which is a focus on the reality of the experience of the object rather than the reality of the object itself. (One brackets out the question of reality). Solomon describes this reduction: "The phenomenological standpoint is marked by an insistence that one describe one's world ... without any presumption that it is either real or imagined, or that it is shared with other persons or is private" (p.15). This has a good fit with the area to be explored, experience of menopause. One can put aside the question of whether the symptoms women experience and attribute to menopause are really due to menopause and focus on the experience itself. The reality is not the most relevant factor; the interpretation of the experience is. This allows
an acceptance of a woman's experience as she interprets it. All she needs to do is try to describe all the elements in her experience as carefully as she can. (This is a very descriptive method.)

The second phenomenological reduction is the eidetic reduction. This reduces the data to that which is essential for the meaning of the experienced object.

The phenomenologist is concerned with the description of what is essential in phenomena - what is necessary for there to be any experience whatever...For every particular object we see, we also intuit an essence...Essences are what make a thing "what it is".

(Solomon, 1972, p. 27)

There is no clear-cut essence of the experience of menopause, as can be seen from the literature cited earlier. This reduction asks what it is in the experience that makes women interpret it as an experience of menopause, for example information a woman has read or information a woman has received from a friend or relative. It asks what are the necessary conditions that motivated the woman to assign that meaning (menopause) to that experience. In discussing the mind-body connection, Merleau-Ponty, a French philosopher, added a dimension to phenomenology that is very important to
the study of women’s experience of menopause. He argued that perception involves both the mind and, just as importantly, the body. In *The Phenomenology of Perception* (1970) he discusses perception as the source of all our knowledge of the world: "Perception is not a science of the world...it is the background from which all acts stand out and is presupposed by them" (pp. x-xi). He says,

The union of body and soul is not an amalgamation between two mutually external terms, subject and object, brought about by arbitrary decree. It is enacted at every instance in the movement of existence..

( pp 88-89)

These thoughts are mirrored in those of Koeske (1982) who discusses the need for an integrated biosocial paradigm for menopause research due to the complex nature of body-mind relationships. It is increasingly seen in menopause literature that we cannot separate the mind and the body into reductionistic pieces, but that the experience of menopause involves complex interactions between the two. Merleau-Ponty also discusses the importance of our experience of ourselves as sexual beings, and that this affects our perceptions. Sexuality is an important variable in the experience and perception of menopause as well.
Subjectivity

Merleau Ponty also stresses the importance of subjectivity of perception in The Structure of Behavior (1963).

Perspective does not appear to me to be a subjective deformation of things but, on the contrary, to be one of their properties, perhaps their essential property. It is precisely because of it that the perceived possesses in itself a hidden and inexhaustible richness, that it is a "thing." (p. 186)

Context

Both Merleau-Ponty and Husserl talk about the dimensions of perceptions and the context in which we see things. Context means that one perceives more than what is immediately present, that one perceives in relation to the past and future as well as in relation to oneself. Merleau-Ponty states, "...our knowledge depends on what we are..." (1963, p. 223). We perceive our experience in full context and perception is a function of that. Women's experience of menopause depends very much on context. Using the model derived from ecological theory, one can see that the context of women's experience of menopause ranges from individual genetic and biological factors all the way to the society or culture as a whole.
Philosophically, phenomenology fits well with the investigation of women's experience of menopause. It takes a subjective look at individual experiences and looks for the essence of those experiences. It accepts women's perceptions without questioning the reality of the public event which the perception claims to be about. And it allows an examination of women's experience in the context of their lives.
CHAPTER IV

POPULATION AND SAMPLE

Career Women

The pilot study of four working women's experience of menopause indicated that menopause affected their lives at work as well as at home. While there are no data yet to indicate that the experience of menopause is different for women who work than for women who do not, or that the woman's work orientation (e.g. career vs. job or occupation) makes a difference, with the large number of women in the work force in this country, it is an area that needs to be explored. This chapter will focus on the choice of career women as a population that requires further study. It is important to bear in mind that context is important in experience, and that the context of career women's lives differs from the context of non-career women's lives.

Pilot Study

The pilot study of four career women conducted as part of the concept analysis was used to determine if revisions in protocol were needed, particularly in interviewing techniques. Revisions were required in
interviewing technique such as eliminating leading questions and eliminating trying to provide information on menopause during the interview.

Aside from the problems these women had with distressing symptoms at work, there were other commonalities that will need to be explored further. All saw menopause as a normal, expected event in their lives; they did not dread it or consider the event itself distressful. However, it was associated with symptoms that were a problem. Those women who sought help from a physician for symptoms had waited several years before they asked for assistance. The reason for this delay also needs to be explored. Is it due to women's perceptions of menopause as a normal event, fear of risks associated with exogenous hormone therapy, perceptions that symptoms would not continue as long as they did, or other factors not yet delineated?

Another area requiring further investigation relates to an unanticipated effect from hormonal replacement therapy. Two women on estrogen said that they had not realized until after they had gotten a full night's sleep that their sleep had actually been interrupted every night by hot flashes. Do these interruptions in sleep affect women's functioning during the day? All the women had many questions about menopause, hormonal replacement therapy, and symptoms, leading to the conclusion that their
needs for information are not met, despite their interaction with the health care system.

Identifying the Sample

Career Characteristics

Many authors study women and careers, but it is difficult to find a definition of career. Gutek and Larwood (1987) see career as something that encompasses the entire adult life cycle and passes through stages of development over time. Betz and Fitzgerald (1987) define four characteristics of a legitimate career: 1) it is paid and accompanied by such benefits as the accumulation of retirement income, 2) it has opportunities for advancement, 3) it has job training requirements and job security, and 4) it would be considered a legitimate career for men. (The last characteristic is not widely held by all authors, as many differentiate between traditional and nontraditional women's careers, all of which are considered careers.)

Many authors have distinguished between types of female vocations. Osipow (1983) discusses homemakers, women in traditionally female careers, and women in male-dominated careers, and states that the last two are both career oriented in that they are committed to out of home vocational activities. In discussing applying current male-oriented career development
theories to women's career development, he states,

...so much social change is occurring in the area of sex and vocation that any theoretical proposal made now is likely to be premature, as would any generalization about women's career development.

(p.271)

Career Development

Betz and Fitzgerald (1987) did a comprehensive survey of the literature and found six factors that influence women's career development. They include cultural, subcultural, and familial factors; the influence of education and related sex bias and barriers; the influence of counseling interventions including counselor bias; sex differences in abilities and achievements; personality variables including self concept and sex-role related characteristics; and vocational interests, needs, and values. At present the authors feel the deck is stacked in favor of stereotyped, traditional female career options against the nontraditional choices. The authors state that as societal attitudes and norms change with increasing numbers of women entering the work force, the factors influencing women's career development will almost surely change. Interestingly, they say, "There is as yet no satisfactory theory of the career development of women... Further
advances in our knowledge of career development will require theoretical innovation and synthesis" (p. 250).

Northcutt (1991) says that career development and career choice are affected by gender.

Women must decide if they will juggle the roles of career/spouse/parent, and if so, must give some thought to how that combination could possibly be structured. Choosing to combine roles sometimes results in restrictions of career choice, due to the covert limitations of some careers. (p. 24)

Career Orientation

Most authors tend to describe women's orientation to their careers using the terms career orientation or career salience. Greenhaus (1971) defines career salience as the perceived importance of work and a career in one's total life. Masih (1967) adds to this definition the requirement that the career be ascribed a priority above all other sources of satisfaction in one's life, including family. Richardson (1974) defined career orientation as being highly career motivated with the perception of the career role as primary in one's life. She found that women separated into two groups. The first, which was closer to the traditional definition of career orientation, was highly
career motivated and perceived their career role as primary in their adult lives. The second were work-oriented women, who were women with well-defined occupational aspirations who placed a high value on both the career role and their marriage and family responsibilities. While her sample was college students who were not yet in the work place, it indicates the difficulties of judging the career orientation of women who juggle multiple roles using traditional male career standards. Marshall and Wijting (1980) also defined career centeredness as a lifestyle where career is valued as more important, including offering more satisfaction, than other areas of one's life, especially the family.

Other authors have identified the unique situation in which career women find themselves. Stamp (1986) recognized that women face particular pressures that men do not. Bishop and Solomon (1989) found that while level of career commitment was similar in MBA students, older women students (over age 29) had a more external locus of control than older men students, which was hypothesized to be due to older women's experience in meeting obstacles to career establishment and advancement. (Again, the sample for this study was comprised of students and not men and women already established in their careers, so these findings are not generalizable
to women for whom career is but one of their roles.) Poole, Langan-Fox, and Omodei (1990) attempted to construct a model of career orientation in women from different social backgrounds, and concluded that there are multiple determinants of career orientation, and that more study and more models are needed.

Hochschild’s (1989) study of working women found that at all levels of career and occupation, women still had primary responsibility for housework and child care. Menopausal women may have primary responsibility for the care of aging parents, the household, children remaining or returning to the home, and even grandchildren. As Masih (1967) concluded in his study of career saliency, sex differences were highly significant, and the criteria used to judge career salience could be biased in favor of the occupational world of men. (The criteria for career salience are biased in favor of the occupational world of men.) The criteria for career salience do not fit the career woman who juggles many roles and responsibilities, including the menopausal woman, and these standards need to be changed.

**Identifying Career Women**

What then are the factors important in identifying career women for the purposes of learning about their experience of menopause? The
characteristics set out by Gutz and Larwood (1987) and Betz and Fitzgerald (1987) are useful criteria in conjunction with self-identification as a career woman. It is not necessary, and perhaps not accurate, to measure a woman's career salience or orientation using standards based on male career characteristics. All that is required is that a woman be a career woman, not the degree to which she is one. With the characteristics as a general screening tool, women can be asked if they consider themselves to be career women to eliminate those women who consider their occupation "just a job". For example, a hairdresser might fit all of the characteristics of a career woman and consider her job a life-long career, with advances in salary and position as her career develops over time. On the other hand, a nurse who works "freelance" for a nursing agency only when she needs the cash and has no interest in the further development of her nursing career would not be considered a career woman.

Sample Selection

Sampling was purposive; volunteers needed to be not only career women experiencing a natural menopause, but willing and able to discuss the experience. Volunteer women from the National Association for Female Executives were asked to participate in interviews. Using their directory,
leaders in local units were contacted to request the opportunity to attend a meeting to explain the study and ask for volunteers. One local unit leader agreed to participate and to allow recruitment at their business meeting. At the local unit meeting, the purpose of the study and what would be required of volunteers in terms of interviews were explained. Several women volunteered; other women said they either didn’t know if they were experiencing menopause or just weren’t interested. In order to increase the sample size, more women were recruited from the professional group Women in Careers, and through fliers distributed in women’s coffee houses and a church in a Chicago suburb.

All of the women who participated stated that they were career women experiencing natural menopause. To capture the totality of the menopause experience of career women, women taking hormonal replacement and women who were not taking it were included. The women who said they were having no problems were hesitant about participating, saying that their experience might not be useful for the study. Data collection was continued past saturation, the point at which no new themes were identified, because each woman’s experience differed within the main common themes. Data collection was stopped at nine subjects, when new themes stopped evolving.
When volunteers were identified, an appointment was made for an interview with each individual at a time and place convenient to them, quiet enough to allow for tape recording without extraneous noise. Initially in the interview, the purpose of the study was reinforced, informed consent was obtained, and the women were reminded that they could withdraw from the study at any time. (The Institutional Review Board reviewed the proposal and did not think it necessary to obtain informed consent as there was no chance of harm to the volunteers, but it was used as a means of reinforcing the participant’s rights; see Appendix A.) Volunteers were to be told that they wouldn't be identified, as names were not attached to tapes or transcripts in order to protect anonymity.
CHAPTER V
DATA COLLECTION AND ANALYSIS

After signing the consent form, the women were asked to fill out a demographics sheet (see Appendix B). Table 1 contains the data from these sheets. All of the women were white, with ages ranging from 33 to 59. All but one were married, and the majority were taking some type of hormonal agent. Open-ended interviewing techniques were used to elicit information. Women were initially asked to share their experience of menopause. This was difficult, as many of the women wanted to be asked specific questions and given some direction. It was important to avoid doing this in order to avoid putting the interviewer’s interpretation into the volunteer’s experience. Interviews were tape recorded and transcribed by a professional transcription service, and field notes were made at the time of the interview.

The interviews were analyzed individually for themes. First, each interview was read through in its entirety three times. On a fourth reading, initial themes were identified. The interviews were then reanalyzed by confirming or changing the initial themes and consolidating them into broader
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<th>4</th>
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<td>Provera</td>
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<td>1 yr.</td>
<td>7-8 yrs.</td>
<td>2 mos.</td>
<td>off/on</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
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<td>Writer/Editor</td>
<td>Business Owner/Publisher</td>
<td>Account Rep.</td>
<td>Financial Planner</td>
<td>Systems Analyst</td>
<td>Faculty/Nursing</td>
<td>Florist/Owner</td>
<td>Teacher</td>
</tr>
<tr>
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<td>10 yrs.</td>
<td>24+ yrs.</td>
<td>20 yrs.</td>
<td>12 yrs.</td>
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HRT = Hormone Replacement Therapy  
ERT = Estrogen Replacement Therapy
concepts. Most of the themes were left in the women's own words in order not to confuse their interpretation of the experience with the researcher's interpretation of their experience.

Two peer debriefers were used for questioning themes identified as well as future directions for interviews and analysis, and providing catharsis for the researcher. A peer debriefer, described by Lincoln and Guba (1985) as a "...noninvolved professional peer with whom the inquirer(s) can have a no-holds-barred conversation at periodic intervals" (p. 283). The analysis then continued until saturation was reached. The two peer debriefers each analyzed two of the interviews; there were no discrepancies between the themes they found and the themes found in the original analysis.

The next step of analysis was to look for commonalities and individual differences in the experience of menopause as described by the women interviewed. While there were some commonalities in the experience, there were no aspects of menopause that were universally present for everyone. The major themes that were most common in the experience were uncertainty and confusion, seeking medical help, consequences of the experience, what is helpful, effects of the experience on work, and their mother's experience.
While these were nearly universal themes, the particulars differed from woman to woman.

Uncertainty and Confusion

Uncertainty and confusion affected most of the women in some way. The problems ranged from not recognizing the changes they experienced as attributable to menopause to not being able to get any clear cut answers from health care providers and other sources. There was confusion about which changes were due to aging and which were due to menopause, which reflects the confusion in the literature mentioned earlier. Subject 1 said that she didn’t realize that she was experiencing menopause.

I think my experience began before I realized it was menopause, and I think it began as an emotional roller coaster. I judged myself as pre-empting to emotional on occasions, or feeling weepy and vulnerable, sometimes quite aggressive, and attributing it to things that would happen around me, and never truly acknowledging that it was something going through me physically.

(7/23/93)

She also was not sure what changes were attributable to aging and what changes were attributable to menopause. She said,
I’m not sure what I attribute a lot of these things to, I just tell my family that I am getting old and that I am a cantankerous old lady... I see the women in my age, 50-plus, and that’s why I don’t know if I would attribute it to menopause, maybe I would attribute it to age.

(7/23/93)

Subject 2 said, “All right, my experience in menopause began before I was even aware I was experiencing menopause” (7/30/93). The uncertainty and confusion in her experience can be attributed to her doctor and her therapist, who did not identify her symptoms as attributable to menopause, and treated her for unrelated illnesses.

Subject 3 also experienced uncertainty. “I think I began noticing some changes in my attitude and physical well-being last year, but I didn’t know what it was” (8/18/93). She didn’t expect menopause to come in her forties: “It feels like a rather young age, I kind of didn’t expect to deal with it in my 40’s...” (8/18/93). Her experience did not fit the pattern she expected, either.

What I thought menopause is, is that there is less menstruation, they are further apart, you have less bleeding, and it just slowly decreases and decreases and you have to deal with hormonal
changes.

So I had this pattern in my head and it doesn’t look anything like it at all. I don’t get hot flashes, but I get cold flashes, and I don’t know what that’s about, but we joke about it now, there is somebody in the room goes, “Excuse me, someone turn on the air,” you know, they’re sweating profusely. I, on the other hand, suddenly gets freezing, and my temperature drops really low, and my hands get really cold and I start to shiver, and then it disappears. Have you ever heard that before?... My God, I thought you never heard of anything like that before. So it makes me feel very peculiar... (8/18/93)

Subject 4 experienced uncertainty not only due to identification of changes as related to menopause (“I don’t think I realized what they were when they first started”) but due to the lack of information on menopause and hormone replacement therapy available. “I don’t know how long to go on them, to stay on these things, I haven’t found that out yet, when is the end of menopause, I don’t know” (8/18/93).

Subject 6 exhibited uncertainty over several issues related to her experience. First, she was unsure of whether she was actually experiencing menopause. “The reason that I’m talking to you is because I’m 44 years old
and menopause is inevitable and I don’t know if I’m in it, but I think I am” (1/8/94). She’s not sure if the warm feelings she experiences are hot flashes.

I haven’t had the experience of being drenched in the middle of the day during work hours. I have had, I don’t know if I recall the experience of hot flashes, but they must be. All of a sudden I’m very warm. (1/8/94)

She also wonders about her femininity.

You wonder if you’re still feminine and attractive and all that... I got a little speech from my doctor after he told me I wasn’t making Progesterone anymore. You know the weight gain, being really sick about gaining weight, and beauty isn’t really that important and okay, you’re going downhill from here, kid. (1/8/94)

Subject 7 also experienced uncertainty; hers was related to the inability to differentiate between the effects of life experience versus the effects of menopause and to the confusing information available to women on issues related to menopause. First she says, “I can’t say whether there are mood differences or not, life stresses and home circumstances have changed over the last few years, my kids are all gone, so it’s hard to say” (1/24/94).
Later, when she talks about what she has read, she states,

And then I read about calcium and that's another area of controversy in terms of how much calcium is absorbed and what kind of calcium is the best kind of calcium to take, what's the dose. I guess that's a real concern, not concern, real confusing to me, that there is, can't find a bit of advice that is not contradicted by somebody else... but I wish, it's a simple thing is this calcium the best calcium? Some say yes, others say no. Is it useless? Now that's the latest thing...

Also questions in my mind about cholesterol and its relationship to menopause and estrogen replacement. The last thing I read was that estrogen replacement therapy reduced cholesterol, but then garlic and red wine is supposed to be doing the same thing...

I would be happy if my daughter's generation had clear information and open forums to talk and exchange, just like we have for sex education. (1/24/94)

Subject 8 experienced uncertainty about when menopause starts and whether she's in it.

I'm not really sure when menopause really starts, if it starts when you miss a period or if you start getting hot flashes. You know, I just
feel I'm in it because of all the heat and the sweat and the chills.

(2/3/94)

Seeking Medical Help

Not all of the women sought medical help for the same reason or obtained what they considered satisfactory results. All of the women interviewed saw their medical doctor as their primary source of health care during menopause. The reasons for seeking medical care were as varied as their experiences were. Not everyone had the same expectations of their doctor, especially in regard to whether they wanted hormone replacement therapy (HRT) or not.

Subject 1 sought professional help for her symptoms, which she did not attribute to menopause.

Well, at the time I wasn't sleeping and probably a little earlier than 44, maybe 43, at the time I wasn't sleeping and I had a marvelous amount of energy. Unfortunately, I don't have that energy any longer, I'm not sure it was real energy, I think it was a lot of nervous energy and some weight loss, most of it was a lack of sleeping. (7/23/93)

She also described another symptom.
I also had a problem, I constantly had to urinate, that was a real problem,... but that was another thing waking all night going to the bathroom, and I know I’m not the only person experiencing this... but urinary problems, when I thought it was really something major wrong with me and which they have all assured me there is not, but nevertheless, I don’t drink a lot of liquid to begin with, and I can’t cut down on it, that’s insane.

On the other hand, I could go to the bathroom three or four times a night and either get up from being uncomfortable or get up from being hot, so... (7/23/93)

The first physician she saw, a family physician, had an unsatisfactory attitude. It literally drove me to the doctor. I went to one at first to a family physician, who gave me tranquilizers that helped me sleep at night, and assured me that they were fine and not habit-forming, and then when I ran out of them and I would use them, I thought, “This was insane, right now I can’t sleep without them.”

And so was his attitude, when I asked him if I was going through a change of life, he told me it was a very natural process and... since his wife had been through it, I could go through it also. (7/23/93)
For an unrelated health concern, she went to a female gynecologist at a women’s health clinic who was more helpful than the first physician about menopause, and gave her information to enable her to make educated decisions about her treatment.

So, instead of going back to my physician, I went to a women’s health clinic and saw a female gynecologist who tested me and said, "There’s really no concern here, you would have had other symptoms. However, you are going through change of life, and let’s address that." And when I relayed the story that I had already heard from my doctor and she said, “Oh, that’s really not so.”

So I did go to a menopause symposium that they had at the women’s health center and read material and then decided to go on the estrogen replacement therapy.

...so I think the ERT has really reduced the anxiety, I do sleep better, I don’t sleep great but I do sleep better, it’s eliminated waking up in the middle of the night in a pool of sweat.

It’s also eliminated the daytime sweats and some of the emotional rushes I was getting...I put on weight, I don’t like that.

That’s a real issue, and apparently I’m not alone in the issue, because
the physician told me the same thing... On the other hand, she says some women experience no weight difference, but I'm gaining weight in places that I never gained weight in before, so it makes it kind of interesting.

...Well, I think it's harder for me to work the weight off, I don't do as many physical things, I know I could not spend an hour a day working out, I work out a couple days a week, but I can't do a daily routine. I can't get up early, early and be up late, late, late. I like to cat nap, sometimes I find I'm just so tired that I just announce I have to go to the bathroom. I can fall asleep standing upward, whatever, so I have real bouts of exhaustion. (7/23/93)

Subject 2 also received what she considered to be inappropriate treatment from the first physician she saw as well as from her therapist. She was experiencing job stress and harassment at work.

But how this relates to menopause, in the past I probably would just be able to say fuck it, but this really drives me, it drives me to the point where I was going to have a nervous breakdown. I got ulcers, I was just completely beside myself, I thought I was going crazy, I was totally stressed out, and I couldn't relax when I was home, I couldn't
sleep at night, and I was, you know, thinking about running my car into an embankment or something. You know, just to get out of these situations...

Normally I think I’m a very resilient person who’s always managed a lot of different roles. I was widowed when I was 24 so I raised all these kids by myself for nine years, and, you know, worked two jobs. I was pregnant with my last kid when my husband was killed. So I really have been able to manage them with I think what everyone thought with great ease, I’ve been able to do it, but this situation really got me, and I finally felt so suicidal I went to see a therapist. Actually I went to see my physician and went to see a therapist and both of them said, “You’ve got to get out of that job...”

At no point did anyone ever suggest to me that this might be related to menopause... so they put me on beta blockers. No one ever said, “Are you going through menopause, maybe you should be on Premarin or something.” (7/30/93)

She continued to feel out of control and depressed, unable to handle stress, and needing mental space for herself. She saw another doctor after they moved who was not helpful and had poor interpersonal skills, and then
went to a gynecologist who recognized her experience as menopause and successfully treated her.

So finally I went to the doctor, a doctor up here. First time we go to the doctor up here, I never met him before, it was an HMO, he comes in and says, "Do you mind if I bring a medical student in to observe this exam?" This was like the first time I ever met this guy and I just lost it and started crying, and he says, "I really think you should go see a therapist because you seem awfully edgy, and I also want you to see a gynecologist, too." He never mentions the word "menopause" to me. But I know I'm feeling edgy, I'm feeling like a perfect bitch.

So, he's right, I am edgy, this is getting to me. So anyway, I finally go see a gynecologist and all he says, "I think you might be going through menopause." And I go, "Huh, menopause? Menopause?" He says, "Yes, I think I'm gonna try putting you on this Premarin stuff and see if that doesn't help you."

...since I started taking this Premarin, it's like a wonder drug. I mean I feel, I'm very irritated about what my last two years have been like, but like right now I'm able to concentrate, I'm able to write, I'm not feeling like a walking powder keg all the time, the hot flashes have
really eased up, not totally, but I’m able I think to have just more
feeling of control of my body. (7/30/93)

She also had an unexpected change in her sex drive; she had blamed
her loss of interest in sex on her husband.

I just lost interest in sex. I was, I felt like I had given up and I
attributed it to thinking, okay, I’m giving up on J. He’s a lousy lover,
you know, I’m bored with this relationship, and we’re really close
friends, so let’s just concentrate on that aspect of the relationship, and
then, he was asking me, he said, “You know, you really don’t seem
nearly as amorous as you used to seem.” I said, “That’s right, I’m not
interested, forget it, just leave me alone.” And all of a sudden, he
started getting a little bit more interested, too, I think, but after I started
taking the Premarin, my sex drive really came back and in fact now...
it’s been like a honeymoon ever since then, and I’ve been taking this
hormone now for about two-and-a-half months I think, so hey, I’m
feeling, you know, interested enough in sexuality where I feel like
bringing it up as an issue, even making waves about it,... It didn’t even
feel like it was worth investing my emotional energy in it, it was just
going to be lousy... When I did begin to deal, I’m more in control of
myself, more in control of my body again, more sexual again then, that was an important factor. (7/30/93)

She did not experience problems with vaginal dryness. "...I know that can be a symptom, but for a long time we’ve used a lubricant, so that hasn’t been a noticeable issue" (7/30/93).

Subject 3 also had difficulty with the first physician, a general practitioner, whom she consulted about the changes that she noticed. He did not recognize the onset of menopause.

I think I began noticing some changes in my attitude and physical well-being last year, but I didn’t know what it was. And my doctor, previous doctor, said to me, there is no way you can be doing any kind of menopause or pre-menopause, because you’re only 44, 45. So it all must be in your head.

Last year I think it caused me to be rather depressed because I think I have a lot of energy, and I didn’t feel I had the same amount of energy. I got tired faster, had difficulty focusing in on things, couldn’t sleep, had difficulty sleeping, I’d sleep like two or three hours at a time and I got up and then, so I was taking like catnaps and, and that also added to my discomfort.
Suddenly after years, I’ve never had menstrual cramps in my life, and never really quite understood when other women would take a day off of work, you know, or complain about having menstrual cramps, because, I can’t even tell, I’ve never monitored my menstrual cycle. It came and went and it was always very smooth and the bleeding was very light, and all of a sudden I had these severe menstrual cramps, I mean severe to the point where I was on the floor in a fetal position. (8/18/93)

She found the initial general practitioner’s attitude toward her experience demeaning. He did not view her as an individual.

This doctor that I left, his way of dealing with you, he’s a general practitioner, not a gynecologist, says, well, I joined the rest of the world. “Now you have as much energy as everyone else.” Which didn’t make me feel any better. Now what is that supposed to mean? Like when everyone gets tired, I say I’m really getting tired at 8:00, he says, well, most people get tired at 8:00, but that’s not how I live my life, that’s not what I’m used to, and that’s not how I planned my day, and I thought I had cancer. It was demeaning. (8/18/93)

After trying to handle these changes on her own after her concerns had
been dismissed by that doctor, Subject 3 switched doctors.

And I thought, well, maybe I can control this on my own, you know, kind of handle it, but it was exhausting me, and I would get...

What I know now from my gynecologist, I switched doctors, is what she calls "ghost" cramps. What that means, I get these menstrual cramps that feels like I’m going to get my period but it never comes. So, sometimes when the menstrual cramps come in June, I was getting them at least three or four days. That’s a pain in the ass. It was very uncomfortable, it takes your breath away, it stops you from enjoying life and interferes with work, it’s hard to get up in the morning after not sleeping, and my body is getting so uncomfortable.

So you kind of want the menstruation to start, and then it’s over.

And there are some months when I get my period every other week, and then it will be six weeks or eight weeks, it’s just irregular, and I’ve been bleeding profusely, you know, like changing tampons every hour...

So, I have two woman doctors now, my gynecologist and general practitioner, and mostly they’ve only been able to say, "Yes, that happens", or "try this and if this doesn’t work" and my
gynecologist put me on Vitamin D and I think the cramping goes or something she said... You know why she gave me the vitamin E? My breasts were very, very sensitive to the touch, and I was feeling a lot of discomfort, even in my clothes, and I've never had that before. Have you had that? I don't know what that's called but the Vitamin E was working, and I actually took it because I like to know it's working, so I took it for a while and I felt better. Then I stopped taking it for a month and I found that the pain was reoccurring, so, I think it's better.

(8/18/93)

She goes on to describe what she expects of her doctor. "I'm happy to find a doctor that uses a number of methodologies in treating me other than medication and what-not for diet and sleep and exercise and vitamins and all of that feels good" (8/18/93).

Subject 4 experienced insomnia, hot flashes, and constipation before she saw her male gynecologist. She had seen him earlier when she had vaginal dryness.

Complications started getting bad years before I started thinking about it, so I wasn't into thinking about menopause at that time. It must have started early, earlier than everything else, and I was also having...
dryness, dry in my vagina was very dry, and intercourse was impossible, but I knew that was a problem, and I wasn’t worried about it necessarily.

And the pills help a little, they don’t, that didn’t get cured as much as my other things, but it definitely helped... I asked him about it before, I think, because we were waiting for the periods to stop, and I was still having them. So he told me I could use some cream, which I was not too successful with, I’m still not real good with that. (8/18/93)

He suggested hormone replacement therapy and she had immediate relief.

Well, I started with the typical symptoms, that probably came slowly, and I don’t think I realized that’s what they were when they first started. I couldn’t sleep, which was the most difficult one for me, I think, I had trouble falling asleep, that’s what sent me onto hormones, I think, also.

I had hot flashes, but they were not extreme. I was very constipated, but then I’ve always been that way, but I hadn’t been much since my children were born, I was much better for some reason. And then years ago, I started getting constipated again, and I think that was part of it also, but I didn’t realize it at the time, because my
periods were still coming, so I was having some of these other things coming along, too, and I didn’t necessarily equate them with menopause. But with much respect, I’m sure they were.

Those were my symptoms, and then my periods did taper off, and I hadn’t had one for about eight or nine months, and then my doctor suggested I go on this hormone, so I did. Everything was cured. I took the first pill, which, after talking with my friends have not always worked quite that well. (8/18/93)

She was worried about the dangers of HRT.

I take the pills, I’m careful. My mother thinks the little trouble she had was she wasn’t careful about them, so I know I try to keep taking them on time, don’t overdo them because I guess you can hurt yourself... It’s not good for you to take two a day, or, you have to count them out. And the doctor said if you’re not sure you took one, don’t take another. To be careful. (8/18/93)

She said, “I haven’t gained weight, and I haven’t, one of my friends was bloated, and I just haven’t noticed anything I don’t like. So I can only say positive things about these little pills.” (8/18/93). Subject 5 had an uneventful experience, but she wanted to start on hormone replacement
therapy as prophylaxis for osteoporosis. The first doctors she saw wouldn’t prescribe it for her.

Well, it’s been very uneventful, very gradually my periods started disappearing, I was in my 50’s, I believe, yes, like 54, 55, and I never experienced any hot flashes... And it was very uneventful, they just began disappearing and that was the end of it...

About, I was like early 60’s, I, my mother had osteoporosis, and I am very fearful of having osteoporosis, so I had heard that this was something that could alleviate osteoporosis, so I went to the doctor, and they were very uncooperative at the time, they said, “No.”

One of them even said there was a kind of relationship between that and the incidence of uterine cancer. I did some more checking, and I talked to my original obstetrician,..., and this is somebody I respect a great deal, he’s a professor at the University, and he said, “That’s ridiculous, who told you that?” And I told him the name of the doctor who was an internist, and he said, “Let him take care of internal medicine. He’s wrong in my opinion. You should go ahead and take it.” He felt if there was a correlation, it was minimal. So I, I’m on it, I’m on it now. (10/1/93)
As a result of this, she switched to new internist, a woman.

Subject 6 sought medical help for very painful periods. She had unacceptable break-through bleeding from estrogen given to her for painful periods. She then experienced heavy bleeding. She changed doctors and was given birth control pills. She went off those for personal reasons. She is now on Progesterone, which, after an initially bad experience, has relieved her symptoms, although she has concerns about taking it. Her doctor doesn’t offer her any other alternatives except surgery, which she finds disturbing.

My experience, about four years ago I went to a doctor and I was concerned about having very painful periods, and she was a new doctor and decided that I should be on Estrogen.

She took a blood test and said that my FH was high and put me on estrogen, which turned out to be, I didn’t know anything about it at the time, that turned out to be real stupid, because I experienced break-through bleeding for the first time in my life. So I went off that.

Last January a year ago I started having trouble with bleeding, I just, my periods stopped and didn’t stop, and I bled for a month and I went to see the doctor, they put me on birth control pills and that worked. Because I don’t need birth control pills, I had a tubal ligation
and went off the pill, and started experiencing the same thing recently. Went back to the doctor, they did a cervical biopsy this time, and the results from that were that I was told that my, I’m no longer producing progesterone so my uterus is siphoning different parts of the body, and I’m having a hard time getting tissue, so the doctor put me on progesterone for ten days, so from day 16 to day 26 I take progesterone and I understand there are side-effects from that, one of it is depression.

... But anyway, it worked for the first month, and so I’m going to continue to.

What ended up is the first time after the cervical biopsy then they put me on progesterone. The first period I had, the first regular period I had after that was what they called a non-surgical D and C and it was a very bad experience. The pain and the bleeding and the flooding and we were doing Christmas shopping and I had to come home twice and the last time I just stayed home. I had, you know, I was walking through the store and my jeans were covered with blood, so, it’s a very negative experience.

So that’s where we are today, I’m on progesterone and it’s
working so far. Apparently my body’s making estrogen. I don’t really have other avenues for suggestion, my doctor suggested that I could do some kind of surgery, I guess there’s a new surgery they’re doing, a new procedure, something with the lining, he doesn’t seem real interested in doing it, he said he wasn’t sure about if there hasn’t been enough studies about that procedure. He didn’t recommend it. He also mentioned that someone COULD have a hysterectomy, which I’m upset about. (1/8/94)

Subject 7 had a D and C shortly before her periods stopped due to heavy, irregular bleeding, and found menopause itself to be a relief.

Okay, I guess I have to go back to premenopausal menstrual history, which made it a relief to have this incidence of real heavy bleeding at irregular times during the menstrual cycle, not predictable. So bad that sometimes all my clothing, bed, and so forth were saturated. (1/24/94)

She took an active part in deciding whether or not to treat her menopause. She experienced hot flashes, which were sometimes bothersome but never terrible, changes in sleep, and irritability sometimes, as well as a cystocele which she attributes more to childbearing than to menopause. She
went on estrogen replacement therapy based on what she had read, heard, and advice given to her by health care providers. She talked about her physician’s uncertainty about estrogen replacement.

Well, listening and reading and getting the best advice from both my internist and a gynecologist, and a nurse-midwife, and just being open to the chances I don’t really get because of my body probably not at risk for osteoporosis, at least according to what physicians say, but heart risk and information from risks from some cancers, it seemed almost that I would go one visit to the physician and he would say, “I think you should get on estrogen replacement therapy.” And I would go the next time, “Oh, I just went to a conference and there was this probe and we’re not sure, you have to make a decision.” (1/24/94)

She expressed concern about the lack of knowledge and indecision of health care providers in regard to estrogen replacement therapy.

Well, I guess probably concern about estrogen replacement therapy still have not been resolved to my comfort. It almost seems that every month there is a new finding that the trade-off may put a person at more risk for one situation, and improve other possibilities.
Particularly not knowing about heart risk and things is a concern, and
to go to the same health care provider year after year and one time
bitterly encouraged, and other times, “Well, we hear some new data,”
you have to weigh this and you have to weigh that, and I think that
information is scary. (1/24/94)

Subject 8 had distressing feelings of extreme heat and chills as well as
heavy periods. She talked to her doctor about oopherectomy because the
bleeding was so severe. She found it frustrating to deal with the doctor in the
HMO, especially since her trusted gynecologist had died.

Okay, what I have been dealing with is extreme heat, very hot,
about ten days from my period to just chilled to the bone the day after
my period starts. Heavy periods from the first day with blood clots the
size of grapefruits to oranges, down to plums, and then constant
bleeding almost as if I was urinating...

And it lasts anywhere like that from five to seven days, and then
the period usually lasts nine days, and that’s about where I’m going at
this point.

I start with my leg and I have almost a rash on my legs from the
heat, it’s so hot, and I wake up and my nightgown, I can wring it out,
and my pillow is also sopping wet.

In order to cool off, I take a shower, and then that causes more bleeding, so, that's probably that.

The chills, I just need tons of blankets, I'm just worn out and tired and exhausted... It doesn't happen every month, but it is a good average of every other month...

I'm tired, I feel crabby, there's no help that's come out of it, I just tend to ask the doctor if he can just give me a, take my ovaries out... I really would like to, because I feel I have no blood left, I feel like I'm drained emotionally and just shot, it's exhausting as the way it is...

And also my temperament is usually very even keel, and usually I get on the high energy level, and I know when I'm coming down about five days from my period, Doritos and M & M's are real helpful, and I eat a ton of food, I put on two pounds, and I feel edgy, but my sister's a doctor, and so she says ibuprofen works and I've been taking that in the last year-and-a-half... But that's the only medication I've taken for that.

...No, I didn't really ask him to prescribe anything, he wasn't even real keen on a D and C or anything either. We belong to an
HMO/HAP, you know, and I think they tend to go away from anything that would help that way unless I really was... I'm not so frustrated that it's deterring my lifestyle to the point of not causing me to do things, so I think I'll wait until something like that happened...

And my gynecologist that delivered our children has died, so I feel like I'm left without my friend to help me through it. And that just happened about a year ago, so I didn't talk to anyone really except the regular GP. And I haven't gone to a gynecologist since then.

...Also, being with the HAP/HMO, because that's what D.'s job offers, I'm satisfied with it for my kids, but I have to go through a general practitioner to get to a gynecologist, that they pick for you, I haven't really gone beyond that, so I guess when I get fed up enough, but I don't know of anybody that I like...It is an obstacle, and I don't know if they would help me or not. (2/3/94)

She said the effect of all this has been to "just grin and bear it, live with it..." (2/3/94).

Subject 9 was given Premarin and Provera by her doctor which she stopped taking after six months because she said her quality of life was better without it.
...and I was like Dr. Jekyll and Mr. Hyde on this stuff, and my periods were so uncommonly heavy... and I haven’t been back yet, so I know I’m going to get it. I take calcium supplements, I exercise, I’m very careful about my diet, stuff like that. I don’t take anything because I feel great.

He felt being blonde, Slavic, I have no heart disease in my family, no osteoporosis on either side, well I’ve had a lot of cancer in my family, the breast, and just not only quality of life was better without it, but intellectually I felt I was running a less risk without it than when I was with it....

I had mood swings before. I was like that all the time when I was on the hormones. And even when he tried cutting back I had it. I had painful periods which I had all my life, so I wasn’t real happy to have a regular period.

I didn’t have any physical need to take it. I don’t have hot flashes, or maybe once in a great, great, great, great while I have it. I have a high energy level, my mood is more level than it has been in my entire life, which, just no reason. (2/11/94)

When she describes how she felt while taking the hormones, and her doctor’s
attitude, she says, "Nobody seemed to care how I feel" (2/11/94). She made her own decision to discontinue the hormones, based on her experience, and is happy that she did.

These women sought medical help for a variety of reasons. No two women had exactly the same experience of menopause. It was difficult for both the women and their doctors to recognize some of the symptoms the women described as attributable to menopause. This led to inappropriate treatment for many of them. This is especially distressing when you consider that these women have full-time careers, as well as families, that they manage while they undergo treatments that may be a waste of their time and energy and may cause iatrogenic problems. What makes the issue of treatment even more complicated is that the response of women to such "standard" treatments as hormone replacement therapy varies from very positive to very negative.

Consequences of the Experience

All the women talked about the consequences of their experience. These ranged from personality changes to changes in values. One woman found that menopause had no effect on her, while two women found it to be a positive experience. Subject 1 talked about her personality changes.
I have less patience for a lot of piddly things that I probably would have overlooked before, and I have less patience for people who, who, I probably had this feeling before, I have less patience for people who don’t do the best for themselves in their situation, although now I’m more vocal about it. I think I’ve become more forceful as an adult woman, I don’t know. Menopause means something to do with being 50. So, I think I’ve had a lot of personality changes. (7/23/93)

Again there is difficulty separating the effects of menopause from the effects of aging. “I see the women in my age, 50-plus, and that’s why I don’t know if I would attribute it to menopause, maybe I would attribute it to age. I think women my age and older would not stand for that” (7/23/93).

She found that the experience gave her more understanding of what other women were going through. Speaking of one woman who is going through menopause, she said,

...she is experiencing a lot of effects of menopause that I think if I was 40 years old and she’s 51 that she was telling me, I would think, “What a lot of excuses.” But now that I’m on the throes of it, I could understand and it makes me more sympathetic that you can have high blood pressure and be less patient with people who are just kind of
asking, and I understand a lot of the ups and downs, the weight gains even though you think you are eating properly, and the lack of energy, this need to have your time, your space and your accomplishments, an identity, a success story for yourself. (7/23/93)

She said that menopause puts you off balance. “You really have to keep your balance. You’re off balance, and you’re not sure if it’s something happening biologically or you’re just losing your mind or was it a bad day, or do you have an overload...” (7/23/93).

She found menopause to be a common thread among women.

I have a feeling that it binds me with a lot of other women. I think that when women are frank about it or touch on that area of conversation, that there seems to be this common thread as if we were all younger and everyone had a child and in kindergarten so you all had something in common, and maybe someone was going off to college and you had something in common, or whatever the life cycle is, this seems to be one of them and it really does make us, I don’t want to say sympathetic because that’s a really bad word, but it does bind us in some way to recognize each other’s needs immediately, or recognize how the other person feels immediately. (7/23/93)
Subject 2 talked about being able to gain control of her life after finally learning the cause of her problems and starting on hormone replacement therapy.

One of the things I found was that I was having a hard time concentrating, and I attributed it partly to the job stress, which had pretty much make-upped it, but it was a little bit like I think I remember starting my period, there was a lot of emotional ups and downs, a feeling of being on some sort of emotional roller coaster or wave that I couldn’t control, and a lot of thoughts would come into my mind, really depressing thoughts, you know, about my marriage, about how society was just turning on me, a lot of stuff like that, that just came out of nowhere, partly circumstantial...

...I think when I started taking the Premarin and when I started realizing I was going through menopause, that allowed me to really take a look at where my life was going and what I needed to do for myself. And then I was feeling sort of victimized by these emotional, this emotional overload, I sometimes didn’t feel able to take charge of my life. When my emotions began to settle down, I said, “Okay, here is what I’m going to do.”
After I read that book I said I need to make sure I get enough calcium to avoid osteoporosis. I need to make sure that I take care of myself, that I have time to get exercise every day. I'm going to go on a weight loss program, so I started going to Weight Watchers.

So across the board, I am really trying to take time for myself, time to do the work I want to do, instead of the work I feel I should do financially, and set my own priorities. I think now that I realize this is what I was going through, the illusion that my life is going to go on forever or at least my youth was going to go on forever, that illusion is no longer there. I am in some sort of transition point in my life, where if I want to have the health to enjoy longevity, that I need to seriously make changes right now, reduce the amount of stress that I feel, you know, exercise, watch the osteoporosis thing, and you know, probably work on some of the things in our relationship a little bit more to make sure that we're really communicating. (7/30/93)

Subject 3 found that her goals and values have changed.

The whole process has sort of turned my focus into myself. I find that my goals and values have changed somewhat, it might have something to do with age, but I realize that for years here health is the
most important thing and wisdom and all of that comes after, and I think I really didn’t believe that for a long time...

I truly know now that if you don’t have good health, it doesn’t matter how wise you are, you can’t look forward to what you want to do. So I’m taking my time off, I find I’m not looking at late hours, I’m trying to delegate better, I don’t know how well I’m doing, but I’m getting there, so hopefully I can focus, use my energies on what’s important. (8/18/93)

She was not sure how much of this change is attributable to menopause and how much is attributable to aging.

Well, in the positive, in the positive, I think that it’s helped me deal with an issue that I needed to deal with, and that’s being a workaholic. It has forced me to look at my work habits in a way that I have not been able to do for myself. So, I think that’s been a positive result of that.

So, that looking at my health, eating differently, my sleep and my rest, giving myself permission to rest, which I need more of. One of the things I will be doing is looking for a couch to put in the office so I could take an afternoon nap. Isn’t that great? I think maybe it’s
forced me, sooner than I intended. Maybe I really think I should have dealt with this a long time ago. The work is not the main focus of living, and has helped me change.

I’m now working so I could live, I’m not living to work, which is really a big difference in how I live my life. So I think in that way going through this menopause has been very helpful, too. (8/18/93)

She found herself redefining what being an older woman meant now that she had reached this point in her life.

Only, you know, when you think of menopause you think of an older woman, and I wasn’t sure I was prepared to think of myself as an older woman, so I’m re-defining for myself what older woman means. It’s somewhere in the 90’s and what I am hearing from talking to women that’s been helpful is that when you’ve gone through menopause, on the other side of it, have rediscovered some energies that are a different kind of physical ability that you didn’t while you were in the midst of it. (8/18/93)

She sums it up by saying,

I feel myself working for many, many, many years, and so I want to be able to maintain my energy and I’d like to know more
about the medical standings and the physical, and not just throwing
drugs at us that have side-effects that we don’t know about down the
road. (8/18/93)

Subject 4 saw no effect of menopause on her life after her symptoms
were successfully treated with hormone replacement therapy. She said, “It
hasn’t impacted my life in any way...The things that bothered me got cured
and that was it” (8/18/93). Subject 5 was concerned that she never
experienced any hot flashes as a consequence of menopause.

Well, it’s been very uneventful, very gradually my periods
started disappearing, I was in my 50’s, I believe, yes, like 54, 55, and
I never experienced any hot flashes. People always mentioned it to me
and I used to wonder. In fact, I even went to a library to read up
about it, and see if I was abnormal because I didn’t experience it, but
then I checked with a gynecologist and he said, “Don’t worry.” Okay.
(10/1/93)

Subject 6 felt that she was no longer on an even keel due to her
hormonal imbalance.

I think any time your hormones get out of balance you’re out of
power. It’s really hard to keep your perception of the world even.
You’re arguing with your husband or someone, you don’t know if it’s the hormones or the situation you’re in, or both, whether that’s valid or not. I read once that women as they grow older over 40 they have more testosterone so they’re more aggressive, so I’m wondering, sometimes I do feel more aggressive and I don’t know if that’s hormones or experience I’ve had. There’s a lot of wisdom and experience I’ve had at this point, having raised two children and started a career in my thirties. (1/8/94)

Again, the issue of menopause versus aging is raised. She also felt the experience put a strain on her marriage.

Well, I’m sure it’s a strain on my marriage, because I’m concerned and not in the best of... I know the weekend that I was going through the non-surgical D and C we went to a party and... I think it’s hard for him to understand. (1/8/94)

Subject 7 found menopause a welcome relief after a difficult pre-menopause.

I guess I just did not feel any disappointment about losing fertility,...I have no desire to be an in vitro fertilization candidate...

I guess having the last few years of menstrual history being so
difficult, I just kind of welcomed this particular change. (1/24/94)

Subject 8 felt satisfied with her life and number of children, but was unsure whether it is a result of menopause.

I don’t know if this really attributes to menopause, I’m very satisfied with my sexuality and my female attributes as far as my children, I have two girls, I’m happy with the number of children I have, and five years ago, that wasn’t enough. You know, but I’m satisfied with where I’m at that way, so I feel like I’m mellowing out my desire to be a mother again, or, you know, to have babies, it’s all gone. (2/3/94)

She also brought up her family history of breast cancer and cysts/lumps on the arms and legs that she attributes to menopause.

Little lumps, and I don’t want to do anything because I use my hands so much, that I don’t want, until it grows and comes in, it doesn’t ever go away, but it does slow down.

And it’s the same type of hardness on my breast, and it doesn’t go away. I’ve had mammograms and things like that, so I just have to kind of wait my turn and see what happens. (2/3/94)

Subject 9 had experienced a difficult premenopause but found her
menopause to be much different.

In my pre-menopausal years, my late 30’s, I had some period problems, heavy bleeding, a lot of emotional ups and downs, sensitivity to...even my environment had lots of stuff going around. Once I really kind of wandered in my menopause where my periods were infrequent, I feel great. I don’t have any problems. (2/11/94)

After having a bad experience with hormones, she went off them and said, “I can’t imagine why anyone wants to give me a pill to bring all that back” (2/11/94). She later said, “This is a good time of life” (2/11/94).

What is Helpful

Lack of information and lack of support were problems encountered by most of the women. Not everyone found the same things helpful; two women found Silent Passage (Sheehy, 1993) to be helpful, while another woman got nothing out of it. One woman expressed a lack of trust in doctors and drug companies who treat menopause.

Subject 1 said that what helped her through the experience of menopause was knowing that it’s normal, the hormone replacement therapy, and her husband’s support.

Understanding I wasn’t the only person going through it, that I
wasn’t the only person experiencing the ups and downs, allows you to at least tell yourself you’re okay, that you’re normal, the medication has helped a great deal, my husband has been very encouraging and understanding, so where I think I’m making this sort of heroic effort to be calm, he never noticed that I wasn’t calm. He says, “You must be doing a wonderful job because I never noticed that you were having any problems.” So it may be something internal... (7/23/93)

For Subject 2 what helped was knowing what was normal.

It helps to have a little bit of knowledge about what’s going on. It’s actually easier to put some perspective on it if you know that it’s menopause, and if you know that this is a symptom and that it’s kind of normal or it’s at least normal for me. I’m sure there’s a whole range of responses... it’s just emotionally comforting to know what’s going on, it’s psychologically making me feel less isolated. (7/30/93)

Subject 3 also found knowing what’s normal and what other women have experienced helpful.

...but what I am grateful for is that more women are in business like I am, and I meet a lot of women at business events and meetings that were at least talking about it, so that some of the things are
reassuring...

I had to deal with depression last year. Now that I kind of know what it is, I don't feel like I'm putting as much pressure on myself...

I think that other women also experience the same thing, there is some validation with what I'm dealing with. It feels like a rather young age, I kind of didn't expect to deal with it in my 40's, so that's been helpful, to talk to other women. I've read a couple of books, which have not been helpful.

...Also, I talk and I'm pretty open, and there's women I'm around are pretty goal oriented and direct and free and open, and so we talk about the facts of value changes. We're all dealing with growing a business and developing a career, and everyone is coping with how does these physical effects and emotional effects hamper, so that's what we all experience in our business and our career growth...

...I'm grateful women are teaching each other what they know and taking each other seriously. (8/18/93)

She added, "Being able to manage your pain and cramps...that's extremely important" (8/18/93).

Subject 4 said that the hormone replacement therapy was what was
helpful to her.

So for me, at least in this first year, it's been just very helpful to me. I don't know what will happen next or if anything else will happen, but at this point, I'm very comfortable to be on them and they make me feel better. (8/18/93)

Subject 5 felt that attitude and reaction were important.

I think I have a good, I have a good attitude, I think, I think so much in life is the way you react to, not what happens to you, but the way you react to it, and if I would have had hot flashes, I would assume, "Well, what does it mean?" I would have gone to the library and done some research, I would have talked to a couple of physicians or somebody and I would say, "Well, okay, maybe it's nothing, maybe it's temporary, maybe I could just deal with it.

...I'm very active and I'm very active in my work and very active in my career, and I enjoy financial planning, because if though it's a career change for me, I enjoy doing it. I think, I think if you're happy with what you're doing and you get up in the morning and you're very enthused about the day, it makes a difference. (10/1/93)

Subject 6 was concerned about the quality of information women
receive on menopause from physicians and drug companies.

...it’s really hard to get information. I did read Gail Sheehy’s book and that was helpful, and because we are part of the Baby Boom generation, there is a lot of interest but as I said before, I think that people are trying to make money because it is such a large group of people and I don’t really trust that we’re getting honest information from drug companies and doctors and I think that a lot of people are in cahoots.

...there’s a lot of conflicting information and you don’t know who to trust. I don’t even think it’s a good idea to trust the AMA. They seem to be in cahoots with the drug companies...

...I guess I’m just going into this not being very trusting. I’m reading all the information about it, being very skeptical. (1/8/94) She found that going through the experience alone, without support, was difficult.

I have no one to talk to about it, my mother is dead... I don’t have anyone in my family to talk to.

And the women I’ve approached to talk about it don’t want to talk about it. These women are older than me, I know that they,
something is going on...

I don’t share this with my sons, and I don’t really have too many people to talk to.

...I have even thought about a support group. I don’t know what that would be like. ...not a bitch session, but talking about if there is anything, any commonalties, any experience, what they can talk about their feelings. (1/8/94)

She goes on to say that acceptance and information are the most helpful.

Acceptance and information, articles in magazines and newspapers I think, reports on television to get it out there so, so it becomes less a stigma and more a natural process... acceptance in general. And maybe because of the women’s movement and because of the Baby Boomers. And maybe when they can shake the stigma they’ve had for probably 2000 years this process. (1/8/94)

Subject 7 found that having few people to talk to about this experience was difficult.

Well, I’m a person who could not ask my own mom about her experience because at 34 she had a hysterectomy, and I guess in
those days they gave her estrogen one time and that was supposed to hold her, and it was probably a massive dose. So, I guess I’m like a lot of people in my age group where there weren’t, my sister is younger, a number of my friends have had hysterectomies, so there weren’t people outside of perhaps a few at school that I could talk to about what was going on. (1/24/94)

She thought that exercise was helpful.

Also, from what I read, I know the value of exercising, walking is something I really am comfortable with and enjoy,… I’ve taken to aqua-aerobics, and that’s, that seems to meet my needs, but probably not as often as I need it. (1/24/94)

She said, “I would be happy if my daughter’s generation had clear information and open forums to talk and exchange, just like we have for sex education” (1/24/94).

Subject 8, who had heavy bleeding, didn’t find anything helpful besides waiting it out and considering surgery.

Just grin and bear it, live with it, and this is, this has been coming on for over a year, but I mean in the last ten months or so, it’s a real strong, you know, it’s there all the time.
I was growing up in a household of boys, and my mother, she probably didn’t know she had a period, isn’t very sympathetic very much. She’s getting more so because the kids see that or if I jump on a bed or something, and oh my gosh, the sheets are just covered and, you know, he’s got to be there all night with me, so that kind of grossness is evident.

And I mean there is sympathy, but you just grin and bear it and keep going, and that’s the way it is. I don’t want my girls to be afraid that this is going to happen to them either, they know what happens because if they see me laying with my feet up on the bed or something, just to stop the bleeding or hope it calms down a little bit, that’s what I like it to be.

And I don’t know if the doctors would do anything at my age for me or not, I haven’t really looked into it, but one of the gals that works for us also hemorrhaged, she’s 42, and she was rushed to the hospital and she had her ovaries taken out. Her uterus taken out, I don’t remember which one. She said she was so glad, because she also has a similar problem. (2/3/94)

Subject 9 mentioned both having friends to talk to and having a job as
Having good friendships, to talk to people, because I had a more difficult time pre-menopausal deal, and I was in Bible studies then, and that was very helpful where we could talk about things. Having a job is extremely helpful. I imagine I would have some trauma in terms of what am I going to do with myself, kind of which isn't just menopause, two of my kids are gone, so I don't have which one would call, they seem to go together, empty nest. (2/11/94)

**Effects of the Experience on Work**

Not everyone had effects on their work from their experience. Besides the change in attitude that was mentioned earlier, Subject 1 also found that the effect of HRT on her body affected her work.

It's also eliminated the daytime sweats and some of the emotional rushes I was getting. Going in to negotiate with my boss, could make my blood pressure what I felt like go up to something astronomical, so all of those things have been under control.

...Horrible, embarrassing, uncomfortable, it's nothing like sweating to death and it's an air-conditioned office, really sweating to the point where your clothes are wet.
I also felt it was a disadvantage for me to get flushed and flustered over doing some negotiating that I would have preferred to remain calm and cool, so it made quite a difference in that. (7/23/93)

She talked about needing more recognition than before; again she was not sure what was due to aging and what was due to menopause.

I like to know, and it’s never been my nature and I’m learning how to do it, I have to be recognized for the things I am successful at, so, and in work, I am a real team player, but I learned how to toot my own horn and I want my accomplishments recognized where I was just one fish in a pot a few years ago. I want them singled out. I’m not sure that the attitudinal, because I’m 50 and don’t give a damn, or if it’s because a lot of the physical changes has made me change, emotionally. (7/23/93)

Subject 2 found that menopause had a tremendous impact on her ability to handle extreme stress and harassment on the job. Once she was on Premarin and felt better, this helped her make decisions about her career future.

It made me never want to have a structured job again. It made me never want, I felt I could not take the stressful deadlines, and
working for other people’s deadlines especially. I have an extremely low tolerance for bullshit right now, I just will not work for an editor who calls and places unrealistic expectations in terms of time.

(7/30/93)

She described a disastrous job interview before she was treated appropriately, when she was on a beta blocker.

I was right in the middle of all this job stress, and I absolutely flubbed the interview. It wasn’t just an interview, they had me teach a class, but here I am on beta blockers, and it was an absolute, it was a disaster... Then he nevertheless called me six months later and I went in to do an interview again, I mean to teach a class again. He said, “M., this is amazing.” He said, “This is night and day, what did you do, why didn’t you do this before, we would have hired you?” So he offered me a job teaching summer school... and I just said, “No thank you.” I really don’t want to work in a stressful situation. I mean it made me make a professional choice that rather than a standard job where you are paid by the employer and you have to put up with whatever they might want to dish out to you...

This menopause, I won’t say this menopause did the way I
reacted to my job situation was a result of trying to cope with my own emotional ups and downs, made me feel like I just didn’t want to do that again, and in the end it’s probably better for me professionally because I really do want to write fiction again. It’s just clear to me that I, I don’t want to go back and put up with that stuff, and put off and try to do some of my own writing for a number of years. (7/30/93)

She had a change in focus and priorities, and was not sure how much of it was the effect of menopause.

Subject 3 found that her cramping interfered with work.

That’s a pain in the ass. It was very uncomfortable, it takes your breath away, it stops you from enjoying life and interferes with work, it’s hard to get up in the morning after not sleeping, and my body is getting so uncomfortable.

...Well, my whole entire career, I’m a pretty determined person and I can’t sit down and finish a project and sit down and get it done. I find that my drive or ability to sit down and some kind, I’m somehow distracted or wavering, and I’m not just exactly, I know I’m in pain, it’s harder to focus. (8/18/93)

As mentioned earlier, she also changed her priorities on work, trying to
change her present status as a workaholic. She found this to be a positive change.

Subjects 4 and 5 mentioned no effect of their menopause experience on work. Subject 5 was very happy with her career. Subject 6 found it difficult to deal with the effect of her heavy bleeding on work. She said that it was not okay to be menopausal.

...and at work I missed some days at work because of that, a Monday and a Tuesday and I did not tell my boss what was going on, even though he’s nice enough, I didn’t feel comfortable talking in the office, because I come from a generation where women were jeered and stuff like that, it’s not okay to be menopausal or have a period or.

...Okay, as relates to my career in a male dominated field I work with a lot of engineers... Not a friendly place for a woman to be, certainly not with menopause. (10/1/93)

Subject 7 tries to incorporate positive images of menstruating and menopausal women when she teaches nursing students.

I think there is an awful lot of ridicule of women both at premenstrual time and in menopause. In my teaching I try to make some comparisons with the students about old wives’ tales and myths
and the fact that we don’t know much about male menopause,... And you hear the humor and the comments, “Oh, she’s crabby, she’s getting her period”, or, “It must be that time of her life.” (1/24/94)

Subject 8 described the effects of her edginess and heavy bleeding on her job. Her employees are all women who are very supportive of her.

During the day I’m edgy, in the evening at home it’s a different situation. And I don’t really see, my stress level has been less at work this last year than I had two and three years ago, so I don’t attribute any female going out of my mind stuff with the stress I had at work. We’re a high volume store, we go through all kinds of stuff, we sell $400,000 worth of flowers a year. So that’s a lot. There’s a lot of billing problems and things like that. But I don’t, I really feel like we have a common groove, we all have children and if we have to give or take a little bit, you know, the other one picks up the slack.

...the flood comes 5 to 7 days during my period, and then I’m so melancholy ’cause I just want it to be over with.

And then, too, you know, how do you dress? And I tell you I was sitting down, I worked all day and sitting and I soaked the chair in a restaurant, and that was so embarrassing, and the girls at work, they
once got a sweater so I could tie it around my waist to walk out of there. It was like when you’re in junior high.

...It was worse in the summer when I had pale blue pants on. You just figure, “Oh my gosh.” Now it’s almost a joke. We have to laugh about it or I would be in tears. They’ll say, “She’s got her period”, I’ll just say, “I really need to sit down.” And they’ll know why.

I think if they needed it, too, we’d all be sympathetic to them. I really wish I was done with it. (2/3/94)

Mother’s Experience

All of the women brought up the issue of their mother’s experience when discussing their own. Subject 1 felt guilty that she had not supported her mother during her mother’s menopause. She thinks her mother’s experience would have been better if she had known more about her body and about menopause.

Okay, this is in regards about my mother, I feel guilty for the lack of things we did when my mother was going through menopause. We didn’t have any sympathy, we didn’t give her any encouragement, I think my mother is from a generation where she didn’t allow herself to
think that she deserved any sympathy or understanding, and it was almost a joke that she was uncomfortable or hot or she was cold, or she was sad, and there was all these mood swings, she would go from being very happy to being very sad, or very emotional or you know, I would say I was having a bad day and I just wanted to lie down and cry.

We didn’t allow her those good graces and on the other hand, my mother is curious of how I’m going about my menopause now, and I think that she would have had a happier senior life had she been able to recognize the changes that she was going through, and even if she had no medical help to recognize and understand them and realize she wasn’t alone, I don’t think my mother ever shared how she feels and she still doesn’t, and when she does, she puts herself down as if she has guilt when she says she has a need, or she has guilt when she had a pain or she has guilt or she goes to the doctor... But she takes the medicine, but she doesn’t question why it’s given to her or how it’s reacting with something else, or she doesn’t have a real understanding about her body and her attitude is, “That’s the doctor’s job.”

...That’s her attitude, but that was the attitude she had all these
years, and she sticks with it, she doesn’t question, she doesn’t have any estrogen replacement, because I wonder at age 76 if it’s necessary, although she does take estrogen vaginal suppositories for moisture and such for herself to keep from getting dried.

Other than that, she hasn’t allowed herself a little compassion enough to be compassionate for her. (7/23/93)

Subject 2 tried to get information from her mother and her mother-in-law but they were not helpful. “No, because I asked my mother-in-law, I asked my mother, ‘What’s menopause like for you?’ And they said, ‘Oh, we don’t have any trouble.’ And in fact, my mother-in-law apparently had horrible migraine headaches, but they don’t remember this” (7/30/93).

Subject 3 said that her mother is still experiencing symptoms of menopause.

But my mother still has these sweating things and she says she’s still somehow going through this menopause. Her doctor says that’s totally impossible. She’s sixty something, and she couldn’t still be having sex, so I truly believe, being young, we don’t know anything what’s going on here... (8/18/93)
Subject 4 said that she is very careful about how she takes her HRT due to the potential danger involved with them. Her mother had some trouble with them and now is off and doing fine.

I didn’t mind going on them, ...I didn’t like what I was feeling, so I thought well, my mother’s never been on hormones, and she’s going to be 80 Sunday, so, she did it without, look at her. But I’m not her, and I was uncomfortable, and apparently, I’m not sure what was offered to a woman her age at her time, but she did go on hormones a few years ago and she needed a D and C she started bleeding, so she was just a little concerned, and then she didn’t do it again. (8/18/93)

Subject 5’s mother had osteoporosis, which made her fearful; this prompted her to search for a physician who would give her HRT. Subject 6 felt confused and alone because her mother was dead and there was no one in her family to talk to about menopause. Subject 7 couldn’t get information from her mother because she had had a hysterectomy at age 34.

Subject 8 described her own experience to be as horrible as her mother’s had been.

...but as a kid I remember her laying on the couch with her feet raised up and actually with a diaper on, because the blood was just
coming out to the point where it was just urination with her also, so I mean it's nothing that is not new news to me, I was aware of it as a girl. I didn't realize how horrible it would be. (2/3/94)

She said that her mother is not very sympathetic.

She also discussed the other problems her mother and grandmother experienced at menopause.

I did talk to my mother. I should say they took cysts under my arms are big, and my grandmother on my mother's side and my mother have had, my grandmother died of cancer, breast cancer, ovarian cancer and bone cancer, my mother has had all her cysts in her arms and her breasts taken out, so I watched very carefully...

(2/3/94)

This family history of cancer is of great importance to her.

And Subject 9 talked about her mother's experience and how it differed from her own.

Good. My experience is good. And yet a negative mindset determines and you hear doctors say, if you didn't think it was going to be terrible, it wouldn't be terrible, and my mother had menopausal symptoms until she died at 67, as long as I can remember, and
vacillated about taking hormones and didn’t. She had a terrible, terrible time, so I’ve been extremely negative, and I’ve seen TV programs and I would be skitterish and emotional and cry and didn’t trust and have hot flashes and sometimes incapacitated... So I had everything going for me to make me emotionally not deal with this. Even now I keep thinking, maybe it’s going to happen to me yet, maybe next year this whole thing is going to go bonkers... (2/11/94)

Summary of Findings

The experience of menopause is different for each of these women. While the same major themes ran through most of the interviews, the specifics of each woman’s experience varied, sometimes greatly. Uncertainty and confusion were present to some degree in eight out of nine interviews, but the areas of uncertainty and confusion differed. Seeking medical help varied in the reasons for seeking help, the type of care received, and the outcome. For one woman not taking HRT was a positive outcome, for others it was taking HRT that was positive.

Consequences of the experience of menopause were positive for all but one of the women; gaining control and maintaining balance were frequent components of this theme. These positive aspects were a result of
having sought and received what some women felt was appropriate
treatment; if they had been interviewed earlier in this process, their answers
would probably have been different. The theme of aging vs. menopause as a
cause of their changes was mentioned as unresolved by several women.

Helpful factors in common included support from other women and
getting adequate information, both of which were spoken of often as ideal
conditions rather than reality in their experience. The effects of the
experience on work were different for each woman for several reasons, one
of which was whether her symptoms were under what she considered
adequate control. One woman made a serious change in her career as a
result of menopause. Although the interviewer did not ask specifically about
their mother’s experience, all of the women brought up their mothers, either
to say that they were unable to get information on their mother’s experience
or that their mother’s experience was the same as theirs or that it differed.
CHAPTER VI

CONCLUSIONS

Discussion of Findings

There was no universal experience of menopause for the career women interviewed. All of the women had different reasons for seeking medical help and their symptoms, which were widely varied, were not readily recognizable to them as attributable to menopause. Even their physicians did not always recognize that they were experiencing menopause. Their expectations of medical intervention varied, as did their individual reactions to HRT as well as to menopause itself.

The symptoms the women did attribute to menopause were not always among those commonly expected. One woman attributed her constipation to menopause, a symptom which is usually thought of as a factor of diet, aging, and other functional causes, not a symptom of menopause. She stated that she experienced relief of the constipation with the Premarin she was taking; this is not a therapeutic effect cited by the manufacturer of the drug. Her attribution of constipation to menopause illustrates the importance of listening.
to women telling their own experience and not using preconceived notions of what a woman's menopause should be. And, as cited by other women, the use of women's experience raises the difficulty of sorting out changes due to aging from changes due to menopause. Is this sorting possible and is it even necessary?

Women also tend to feel atypical if they experience a relatively uneventful transition through this period. Three of the women stated that they would be happy to participate in the study, but that they didn't think interviewing them would be useful because they had had no problems with menopause. Why do these women feel that they are in such a minority?

What do women expect the experience to be? One woman said that she had expected to have a terrible time because of what she had heard from family, friends, and the media, yet she found it to be just the opposite. She said that mindset and anticipation meant nothing to the reality of her experience.

Identifying the Essence

The six common themes of uncertainty and confusion, seeking medical help, consequences of the experience, what is helpful, effects of the experience on work, and their mother's experience do not point to commonalties that were the essence of the experience of menopause for all
these women. Yet, if there is no definitive essence, why did all of these women eventually interpret their experiences as menopause? Their symptoms were not alike and they did not all have pieces of the experience in common. Perhaps this is why there was so much uncertainty and confusion associated with menopause, not only on the part of the women, but on the part of their doctors as well. This is a major problem not only for women who are in the middle of the experience and can’t identify it, but for their health care providers.

Even from a phenomenological point of view, the experience is still so underdetermined that essential characteristics cannot be identified. Science at this point is lagging behind women’s experience. From a biomedical point of view, certain essential characteristics can be identified, but these are not identified in women’s experience. Nurses, who as a group are not vested in protecting the biomedical model, are in an ideal position to help women during menopause. Not only is more research for the purpose of identifying the essential characteristics necessary, but health care providers who recognize the confusion women experience and women’s needs at this time are also important.
Validation of the Model

The findings support the usefulness of the adaptation of Bronfenbrenner's (1979) ecological theory as a model for viewing menopause. It is important to recognize that each woman's experience is tied in with all aspects of her life, from a basic physiologic level to a sociocultural level.

The microsystem, consisting of genetic and other biological factors, is important when women discuss their mother's experience, looking for familial tendencies, and when they discuss their physical symptoms, such as heavy bleeding or hot/cold flashes. The mesosystem consists of transactions between women and their family members and women and their work. It also included transactions with their health care providers, which some women described in great detail as critical to their experience. The exosystem includes overall health care systems, including the HMOs alluded to by two women. These transactions were not seen as having a positive effect on their menopause. And the macrosystem, society or culture as a whole, was mentioned by several women as having an effect on their experience by influencing the way others view menopause and menopausal women.

These four systems were all important pieces of the experience. Each
woman is affected by all levels of her environment, all of which impact her unique experience. There are commonalities and differences in each level of the environment for each woman, as reflected by the commonalities and differences in their experience. It is not only the microsystem that affects women’s experience, as the biomedical model professes. And it is not just the sociocultural level that determines a woman’s experience. The experience of menopause is determined by all levels of systems, as are other experiences in a woman’s life.

According to the model, aging and menopause occur simultaneously. Because menopause and aging are occurring at the same time, and are affected by the same variables, not all of their effects can be separated. It is especially difficult to separate the two because of the relative dearth of information on menopause.

Limitations

The sample was a fairly homogeneous group of white career women ranging from ages 33 through 59. All but one woman said that they were participating in the study in the hopes that they would be helping other women experiencing menopause. Not all of the women were at the same point in their experience. Some women were just starting menopause while
others were artificially postponing the experience with HRT. The woman's stage of menopause might have affected her perspective on the consequences of the experience. The woman who was still in the midst of heavy, irregular bleeding did not see menopause to be positive an experience as the woman who was no longer having that particular experience.

This study needs to be replicated with other groups of women, both in terms of job orientation and in terms of race and sociocultural background. The fact that the women were all living and working in the Chicago metropolitan area means that the experience also needs to be studied with women in other geographic locations.

Implications

All of the women were pursuing their careers and intended to continue doing so. Menopause had an effect on some of the women's work, not only at a physiologic, microlevel, but at a cultural level as well. Our society views menopausal women in a negative way, often as a joke. One woman said that being menopausal was not acceptable in her male-dominated field.

The implications for health care providers, including nurses, are clear. It is important to find out what a woman's actual experience of menopause is
before trying to help her. Not all women have the same experience, and not all women perceive the same experience in the same way. There is no universal characterization of menopause, and it is not helpful to tell women that there is.

The women in this study wanted information that was unbiased, that would help them judge for themselves whether what they were experiencing was "normal." They wanted to have control over their bodies and their experience. They did not want to have to waste time finding a physician and treatment that they felt was appropriate. They all were not pleased with the attitudes of their doctors, their coworkers, or of society in general. These women are very busy and very goal-oriented. They know what outcome they desire and they will not accept less.

None of the women interviewed thought of anyone in the health care field who could help them besides physicians. Nurses were mentioned only once as a source of information. While some of this may be due to the limitations on the prescriptive powers of advanced practice nurses in Illinois as well as problems with insurance coverage, much of it is due to the fact that women still perceive physicians as their best source of information and treatment. This is interesting in that the women did not tend to view
menopause using a biomedical framework; they tended to see the other factors, or systems, which affected their experience. What it does mean is that nurses are not visible, and perhaps not accessible, to women going through this very universal experience. And this means that women are receiving fragmented care from medical specialists, rather than treatment of the whole woman, as depicted in ecological theory and nursing models. Nurses need to become more active in this area of women’s health and more visible to consumers. As mentioned earlier, they have no vested interest in promoting the biomedical model that fragments a woman’s experience into pathological pieces.

Menopause is tied in with all aspects of a woman’s experience, not just with her reproductive organs. The ease or difficulty of her transition is a function of more than her physiology. There should be recognition of the ambiguities that feed into the experience, including the various levels of ecological theory that affect it. Because there are no essences of the experience of menopause that are identifiable at this time, more studies are needed to focus in on describing them in order to make this transition clear and smooth for women.
APPENDIX A

CONSENT FORM

Project Title: Menopause: An Exploration of Career Women's Experience

I, ____________________________ , state that I am over 18 years of age
(Name of Volunteer)
and that I wish to participate in a research project being conducted by
Elizabeth S. Carlson, M.S.N., R.N.C., O.G.N.P.

I have been informed that the purpose of this research is to explore career
women's experience of menopause and that participation in this research
requires taking part in one or two interviews about my experience of
menopause.

I acknowledge that Elizabeth S. Carlson has fully explained to me that there
is no perceived risk involved; has fully explained to me the need for the
research; offered to answer any inquiries which I may make concerning the
procedures to be followed; and has informed me that I will be given a copy
of this consent form.

In the event that I wish further consultation, I realize that I may contact the
Chairperson of the Institutional Review Board for the Protection of Human
Subjects for the Lake Shore, Water Tower and Mallinckrodt Campuses of
Loyola University (telephone [312] 508-2471.)

I freely and voluntarily consent to my participation in the research project.

______________________________ (Signature of Investigator)  (Date)

______________________________ (Signature of Volunteer)  (Date)
APPENDIX B

DEMOGRAPHICS QUESTIONNAIRE

Thank you for participating in this study. Please answer the following questions. All responses will be kept confidential.

Date: 
Age:
Race:
Marital Status:
Number of Children:
Last Menstrual Period:
Hormone Use: What Type:
How Long:
Career: How Long:
Where Employed:
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VITA

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is, therefore, accepted in partial fulfillment of the requirements for the degree of Ph.D.

10-5-94  [Signature]  
Date  Director's Signature