THE CHANGE: WOMEN'S CONSTRUCTION OF THE MEANING OF MENOPAUSE--A GROUP PROCESS

by

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Abstract

Despite the universality, inevitability and normalcy of menopause, little is known of women's experiences. In particular, little or nothing is known of the meaning women attach to menopause. Despite (or because of) this lack of information, a controversy currently exists as to how women can best negotiate menopause, and as to the risks or benefits of hormone replacement theory.

Research methodology was guided by recent studies on women's unique ways of knowing, valuing and construction of meaning. Menopause was explored within the framework of a group format with five post-menopausal coresearchers over a nine-week period. The women narrated their stories, listened to the stories of the other group members, reflected on their experiences and discussed those they had in common. Individual follow-up interviews were conducted 3 months later during which the coresearchers validated the transcript and offered additional perspectives. Despite widely varying experiences of menopause, 20 common threads were located. This study details a strong developmental and transitional component to the coresearchers' menopausal experiences, as well as the impact of a menstrual taboo and negative stereotype.

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CHAPTER 1 - INTRODUCTION

The experience of being puzzled establishes the start of an inquiry. Puzzlement with respect to menopause centered on why such a natural, inevitable and universal process should elicit the responses it did--both from myself (who was passing through the phenomena), from other women (both in and out of the experience), and from men. When the subject was raised with women approaching a menopausal age, the response received was almost unanimously, "Don't paint me with that brush. I'm not there yet." As often as not, the subject was quickly changed. From men, responses ranged from blank looks to amusement and/or the relating of a joke about menopausal women. From women actually in menopause or beyond, responses varied widely. At one extreme was what appeared to be embarrassment and/or a desire to avoid the subject. At the other were obvious signs of relief and a gratefulness that the subject was of sufficient interest to be raised as a topic of conversation. These responses were far removed from those of other previously-experienced life events which had been characterized by physiological change: adolescence, pregnancy or childbirth. In addition, there was surprisingly little information on the subject given its universality. What was available appeared to bear little resemblance to women's actual experiences.

From discussions with women in menopause, and from personal experience, it was clear that unique and puzzling dynamics were in operation which did not have ready answers. It was also obviously a process infused with cultural meaning. Even the words to describe related feelings were difficult to find. Aside from questions with respect to

physical experiences, the question of meaning seemed central, yet difficult to access. It was at this point that, for me, menopause became a research topic. Part of the puzzlement was that menopause was like breathing, yet one had obvious cultural meaning and the other didn't. Answering why that should be so and discovering the nature of that cultural meaning marked the beginning of a considerable journey both for myself and for the women who shared their stories of menopause.

It is rare to take the time to reflect on the meaning and significance of our experiences. Instead we more often respond to and comment on our experiences from a nonreflective position. Within the process of this research, five women told of their experiences of menopause. They listened to the experiences of the others, and contemplated and reflected on what their experiences meant to them within the context of their lives. This process involved 18 hours of group time and 2-3 hours each of individual, follow-up time. What emerged from this explorative and reflective process was a portrait of menopause which often bore little resemblance to the most prominent literature.

The writings of a few, such as Cobb (1988b), Posner (1979), Stimpson (1982) and Weideger (1976) have suggested that elements of shame and a negative stereotype were intertwined with the subject of menopause. Weideger has noted that there is a school of thought which suggests that menstruation and menopause are simple, biological events, and to say more is to make too much of a small thing. She argued, however, that:

> Certainly, menstruation and menopause are biological events,but they are neither simple nor narrow in scope. The ramifications of the cycle of female sex hormone

> production take us beyond the realm of the biochemical and physiological. Menstruation and menopause are part of our emotional and social experience as well. (p. 14).

Kincaid-Ehlers (1982) noted that the word "menopause" did not exist in English until the last quarter of the 19th century. Previously, and continuing to at least the late 1950s, this experience was popularly referred to as "the change of life." Menopause is a process which usually lasts 5 to 7 years, and most commonly begins somewhere between ages 40 and 50 (Cobb, 1988b). Today, when women speak of menopause they are referring to the whole range of expectations, feelings, and reactions that surround the process of the cessation of menstruation. In contrast, standard dictionary definitions of menopause parallel a medical definition and refer to a point in time when menstruation ceases, not to a process. The former description of menopause as a many-facetted process will be used throughout this thesis.

Menopause is experienced by all women who live long enough. At the beginning of this century, most women died either before commencing or in the midst of menopause. Today nearly all women can expect to experience both menopause and 25-30 post-menopausal years (Jovanovic, 1987; Weideger, 1976).

When menopause occurs naturally, a woman only knows she is or has been in menopause in retrospect. Often a woman will experience a wide variety of physiological and/or emotional changes and never consider that she may be in the process of menopause. This knowledge may come only when she ceases menstruating or is told she is menopausal by her physician.

Women's reported experiences of menopause range from minor problems to those requiring medical intervention in order to maintain a former lifestyle. "The signs of menopause and their intensity differ from one woman to the next, as do manifestations of the menstrual cycle such as length of cycle and amount of flow" (Weideger, 1976, p. 6).

Only a generation ago menopause was rarely mentioned in public. Even among women the topic was not commonly discussed. The origins of this silence lie deep within the history of women, the value placed on women's bodies, on youth, and on the roles of women in our culture. In one of the relatively few books written for women on the subject of menopause, Cobb (1988b) commented on how strange it is "that we should be educated in the intricacies of sexual intercourse, pregnancy, and childbirth--which are not experienced by *all women* --and yet be left virtually uneducated about a process that touches *each one* " (p. 5).

A consequence of this silence is that menopause has been "surrounded by myths and fears deeply entrenched in our culture" (Walsh, 1987, p. 147). Although menopause has been brought into the open by the women's movement, a great many women continue to remain reluctant to discuss either their menopausal status, or their experiences and feelings, in an effort to avoid being labeled "menopausal." They fear inviting the negative stereotype of the complaining or hysterical menopausal woman (Cobb,1988b). When menopause is discussed, it is in the somewhat more socially acceptable context of menopause as a physiological problem (Weideger, 1976).

Menopause is currently the subject of considerable controversy. The debate centers on how women can best negotiate the process of menopause. On one side are those who define menopause as primarily a physiological

condition and treatable through the administration of hormones to replace those lost as a result of the aging process. How this treatment should be administered, to what degree and with what implications to a woman's health remains controversial, as is the question of risk versus benefit.

On the other side are those who view menopause as primarily a developmental process. They consider the experience to be influenced by historical, cultural, and social considerations as well as by heredity and individual physiology. Within this school are those who believe menopause has become medicalized--i.e., viewed by both the medical profession and women as an experience requiring medical intervention. This school of thought points to the fact that there is controversy around the safe use of hormones. They question whether it is the interests of pharmaceutical companies that are being served when hormones are suggested or advised for menopausal women (Bell, 1987; Kaufert & Gilbert, 1986; McCrea, 1983; Walsh, 1987).

Despite these issues, which have serious consequences for women, literature and research on any aspect of menopause has been scant. The majority has been conducted by the medical profession and has focused on physiological processes. Subjects such as the precise nature of the interaction between hormones and emotions remain unclear.

Also scant is research outside the medical sphere--in particular, that which explores women's felt experience. What is available suggests that a woman's experience of menopause is influenced by a combination of biological, psychological, sociological, cultural and individual variables (Lock, 1986b; Weideger, 1976).

While debates continue over the risks or benefits of hormone use and the role of pharmaceutical companies, women, whose lives are most greatly

affected, are experiencing this process in an informational vacuum. In a rare account of an in-depth, personal examination of menopause, Downing (1987) wrote:

> I knew almost nothing of the distinctively female ways of navigating this passage and felt myself to be confronting a transition for which my culture had somehow conspired to keep me unprepared. I felt alone, uninformed, somewhat afraid--and yet also curious and expectant. I was on the brink of a centrally important life-change and had no knowledge of the myths or rituals that had helped women throughout history live this transition with hope, dignity, and depth. (p. 3)

The language of Downing's account is unusual in the literature and contrasts sharply with much that has been written. Typically, for women there remains "a veil of mystery surrounding this natural womanly function. At worst it is labelled a disease and shrouded in fear. At best menopause has become a catchall for all the physical and emotional problems of women between the ages of forty and fifty-five" (Golden, 1984, p. 74).

Today a woman is confronted with a bewildering array of expert opinions as to how she should proceed to negotiate menopause. *U.S. News & World Report, May 23, 1989* , reported that, "the benefits [of hormone therapy] are so great, contended the specialists [on menopause], that even women who breeze through menopause without any troubling symptoms should consider hormone supplements" (p. 72). On the other hand, *Time, August 14, 1989* , had a story headline which read, "Hard Looks at Hormones: Drugs to ease the toll of menopause are linked to breast cancer"

(p. 48). As Cobb (1986) pointed out, "The decision about whether to seek or to accept hormone therapy remains *the* crucial issue for most menopausal women" (p. 17). Women make this decision without the benefit of guide posts provided by rituals, myths and the recorded history of the personal experiences of other women. At best, their knowledge of menopause is that it is predictable, involuntary, and negatively viewed by a culture and its media which devalues aging in women (Cobb, 1988b; Weideger, 1976).

Purpose of Study

Within a group format the menopause experiences of five women were explored in-depth toward ascertaining the meaning they attached to their experiences. This study was guided by the principles of phenomenological research. It was designed with consideration of women's ways of knowing and construction of meaning as provided most particularly by the research of Belenky, Clinchy, Goldberger & Tarule (1986); Gilligan (1982) and Miller (1986).

Rationale

An examination of the literature clearly revealed that women's experience had been translated *for* , rather than *by* women. Thus, women have not had the opportunity to define their experience of menopause. Gergen's comments on research (in Mishler, 1986) seemed particularly applicable to research on menopause. He suggested that the aim of scientific research should change from the search for general laws to efforts to sensitize persons to important factors that may broaden their perspectives and/or increase the range of alternatives that they consider

with respect to their experiences. New or broader perspectives originating with women could only serve to benefit women, especially given the dynamics of and surrounding menopause.

Choice of methodology was also guided by the principles of critical psychology, in particular as outlined by Sullivan (1984). From this perspective, the meaning of a part cannot be perceived until the meaning of the whole has been grasped (a concept also central to hermeneutics). In relating this to menopause, this concept suggested that any aspect of menopause could not be understood until the whole of the experience had been examined within context. The concept of context, from this perspective, would range from and include the immediate situation of a woman's life within the framework of her life as a whole. It would also include the social-cultural context in which she lived. Thus, an examination of menopause in context appeared to be central to an understanding of meaning.

Throughout history we have portrayed ourselves through the telling of stories (the recounting of our experience). The emotions, the ups and downs, the plot, the themes all convey to others the meaning of our experience. The verbalizing of our experience provides us, the tellers, with another perception of ourselves as we hear our voice, feel, see and hear the responses of others--thus we make sense of and locate the meaning of our experience. As noted by Cochran & Claspell (1987), life is punctuated by overlapping and interweaving beginnings, middles and endings. The narration of stories of menopause suggested facilitation of access to meaning for both the teller and the listener.

Menopause is a complex and poorly understood experience. While most research has focused on the physiological process, there are a few

studies which originate with women and attempt to address the totality of a woman's experience of menopause. Information obtained from these latter studies has been derived from surveys, questionnaires and short interviews. The complex variables surrounding menopause suggested that these methods may not have been conducive to the providing of a comprehensive picture of women's experiences of menopause. As such they may not have adequately reflected the *meaning* women attached to their menopausal experiences.

Within the nonmedical literature were consistent references to menopause as a transition period and/or a rite of passage (Cobb, 1988b; Dyer & McKeever, 1986; Greenwood, 1989; Patterson & Lynch, 1988; Thomson, 1986). However, the relationship between current understandings of these concepts and women's experience of menopause had not been explored. "One of the myths of menopause is that one enters it, weathers it, and goes back to being the same woman, only older. This is to deny the essential truth of menopause--that it is a crucial stage of development on the road to maturity, and that the experience will change us" (Cobb, 1988b, p. 17). What are these changes? What role does menopause play in women's development? What do women see themselves moving to, and from? What is being lost and what is being gained? What is being prepared for? For what purpose, and to what ends? Answers to these questions lie within the meaning each woman attaches to her experience. Meaning can only be determined when depth of experience is explored. Women's experiences appeared to suggest a dynamic process of complexity and depth. This contrasted sharply with the static and uni-dimensional portrayal most often found in the literature.

Recent studies have highlighted women's struggle for the words/"voice"/ language with which to express their experiences within the framework of their unique ways of knowing, valuing, and construction of meaning (Belenky et al, 1986; Gilligan, 1982; Miller, 1986; etc.). In *Toward a New Psychology of Women* , Miller spoke of women's difficulty in finding a conception, a formulation in which to state their feelings when their life experience had been translated and defined by those who have not had that experience (as has been the case with menopause). "There is no easy leaping over the only systems of thought and language that we have inherited. But we are now becoming increasingly aware of the need for new assumptions and new words" (p. xxi). In her epilogue Miller concluded:

> There are many things that women know but have not yet put into words. The powerful reasons why women have not done so are still with us. . .It is important that women start from their own experience, especially when it may not "make sense." As women continue to do so, I think we will find that the prevalent systems of thought are inadequate. Even the words available will be inappropriate, both the scientific and the common words. (p. 142)

Duras (in Belenky et al) also concluded that, "women must find their own words to make meaning of their experiences and this will take time" p. 203).

These factors, coupled with the indications of a negative stereotype, the history of silence and the dominance of the medical paradigm led to a consideration that women may not have ready access to the words or to the perspectives with which to consider the meaning of their experience. In

speaking of the process of women accessing their voice, Belenky et al (1986) noted that through listening and responding, through dialogue and sharing, women draw out the voices and minds of others. In the process, they often come to hear, value and strengthen their own voices and minds as well. It is through this process that women are able to *recognize* their self and thus access their voice.

The above considerations led to a rejection of an interview-focused methodology. Rather I chose to elicit women's experience of menopause and the meaning of that experience within the framework of an extended group process. A group format allowed for the construction of shared concepts. As Belenky et al (1986) pointed out, within a group, meaning can be accessed and negotiated and "members can nurture each other's thoughts to maturity" (p. 221). The intent was to move beyond mere narration and discussion of menopause to the "construction of meaning" and the accessing of shared experiences.

Secondly, when group members share a common experience, narrative accounts arise naturally. Mishler noted that "one of the significant ways through which individuals make sense of and give meaning to their experiences is to organize them in a narrative form" (p. 118).

A further advantage to use of a group was that the power, and the limitations of the researcher would be diminished. This was considered to be a significant factor given women's experience of having had menopause defined and interpreted by those who had not had the experience. Women have a dominance of *impersonal* knowledge regarding menopause (i.e., that originating from experts or authorities), but little *personal* knowledge (i.e., that originating from the experience of those known to them and articulated and defined by them). A group format allowed the

development of such personal knowledge through narratives, discussion, clarification and construction of meaning.

The advantages of using a group were considered to be greater than the potential disadvantages, such as the possibility that the stories or opinions of individuals would be over-run by the group--that the group might move to consensus and thus threaten the loss of individual perspective. Further rationale for use of a group is provided in the Summary Discussion of the following chapter.

In referring to the large body of new literature on the psychology of women, Miller (1986) wrote of "the growing tendency to focus on the close study of women and to describe women's lives and women's development in terms in which it is lived, rather than to force it into the categories which we have inherited. . . .The close study of women's experience can lead eventually to a new synthesis which will better describe all experience" (pp. xviii-xxi). The development of a new synthesis, through close study of the terms in which menopause is lived, formed the perceptual guidelines and framework for this exploration of women's experience of menopause.

CHAPTER II - LITERATURE REVIEW

There are two central, broad-based perspectives on menopause: (a) menopause as primarily a physiological event, and (b) as primarily a bio-socio-cultural process. Regardless of the perspective, the vast majority of the literature has focused on the cause and presence or absence of physical symptoms. It has rarely addressed the question of the meaning of menopause for the women who experience it.

The perspective of menopause as a physiological event is associated with the medical community and may initially appear to be irrelevant to a question of meaning. The following is provided as a rationale for a review of pertinent medical literature and a focus on the language of that literature.

Martin (1987) and Salk, Sanford, Swenson & Luce (1984), among others, have noted that the cultural context in which we experience our bodily processes has been strongly influenced by the medical community's perceptions of these processes. These perceptions are deeply entrenched in both our culture and our history. The medical perspective on menopause plays a role, both directly and indirectly, in shaping the cultural context of the experience of menopause--as perceived by women themselves (before, during and after), and by those who interact with women in menopause. The history of the relationship between menopausal women, medicine, and medical research forms an integral part of the medical perspective on menopause --and, therefore, of the cultural context in which women experience menopause.

An important source of evidence of the nature of a perspective is the language of that perspective. As noted by Lakoff & Johnson (1980),

language is central to the cultural context of our experiences and descriptive language plays a central role in defining our everyday realities. How an experience is defined, described and labeled within a culture has enormous implications for the meaning and value which is attached to it (Martin, 1987). These definitions, descriptions and labels provide us with road maps for our experiences and determine our expectations and our strategies for coping with what we experience. As Sullivan (1984) pointed out, we use language as a "lens" for understanding.

As noted above, there are two central and broad-based perspectives on menopause: (a) menopause as primarily a physiological event, and (b) menopause as primarily a bio-socio-cultural process. From the first perspective, how a woman experiences menopause and what it may mean to her are individually determined by her physiology and/or psychic make-up. This is essentially a medical-model perspective. Literature from the fields of medicine and psychology have been placed in this category. From the second perspective--menopause as a bio-socio-cultural process--how a woman experiences menopause and what it may mean to her are considered to be heavily influenced by her cultural and social environment. The difference between the two perspectives is one of emphasis and focus. From the first perspective, difficulty with the experience would be seen to result from physiological or psychic disturbance, breakdown or failure. From the second, difficulty with the experience may be located individually, but the root source would be more likely to be attributed to women's socio-cultural environment.

Within this chapter, menopause will initially be reviewed from a historical perspective (ancient and post-ancient to 20th century). A review of the literature from a physiological/intrapsychic perspective follows, and

has been divided into: (a) an overview of the medical literature (as all remaining literature on menopause essentially emerged in response to the medical perspective), and (b) a discussion of the psychological literature. The bio-socio-cultural perspective has been divided into three subsections: (a) women's studies literature, (b) cross-cultural (anthropological) studies, and (c) material which has emerged from the women's health movement. At the conclusion of the physiological/intrapsychic section and bio-socio-cultural section, the orientation toward menopause inherent in these perspectives has been summarized. As noted by Cochran & Claspell (1987), this is the process of making a central implicit feature more explicit, with the intent of investigating for meaning. These sections are followed by brief overviews of menopause in relation to theories of development, fictional perspectives on menopause, and the popular literature on menopause. A summary discussion of the literature and its relation to this study's methodology concludes the chapter.

Menopause from a Historical Perspective

Ancient History

Prior to the 20th century, shorter life spans generally meant that women died before or during menopause. However, there have always been women who experienced and lived beyond menopause. We know little of the meaning of menopause from these early women as traditionally females have not been the recorders of history and only rarely have they had their experiences recorded. Their perceptions of their menopauses can therefore only be pieced together from diverse sources.

Downing (1987) noted that the mythology of the ancient Greeks included three seasons: growth, flowering and ripeness. The goddess, Hera, was considered in three aspects: maiden, wife, and post-connubial woman. Persephone's life was also divided into thirds. Hecate, the goddess of crossroads and transitions, was known to have three aspects. The realm of the soul was considered by the Greeks to be ruled by a triad: maiden, mother and crone. Downing noted that there has long been, and continues to be, "three seasons to a woman's life, irrespective of whether she is heterosexual, homosexual, or celibate, quite apart from whether she has ever conceived or borne or nursed a child: from birth to menarche, menarche to menopause, menopause to death" (p. 14).

A reemergence of Witchcraft as a Goddess-worshipping religion has resulted in renewed interest in and availability of its ancient teachings. These teachings also refer to the "triple nature" of women (Farrar & Farrar, 1987). From these teachings came the concept of The Crone as a woman who had passed menopause. She was considered to be a wise woman with the "wisdom of evolution stored in every cell of her body." She possessed the "power to end, to lose as well as gain, to destroy what is stagnant and decayed" (Starhawk, 1989, p. 93). The Crone also had the ability to heal herself and to project healing power to others.

Hecate was also considered a Crone, a Goddess of death and rebirth. As a lover, she was considered an authority in the secrets of deep emotion and passion. She possessed security in emotional knowledge, as well as being a psychic healer and mediator of emotions (Morgan, 1986). Her function as a "midwife to the psyche" was to "assist people who are no longer where they were and not yet where they hope to go" (Hall in Noble, 1983, p. 76).

According to Daly (1978), The Crone represented the archetypal "separatist" who pared "all that is alienating and confining" away from the self. The Crone listens with her "inner ear" and becomes "not only an initiate, but also a teacher, a way-shower to others."

Nobel (1983) has written that The Crone represented a stage of life in which wisdom was sought--a time of introversion and spiritual seeking where a woman searched for the feminine source of life:

> Biologically, the Crone represents the menopausal phase of a woman's life, where she can begin to think seriously of spiritual meaning, and embark on a quest that had previously been out of reach if she was engaged in the usual female functions of childbearing and rearing. (p. 78)

Starhawk (1987) described a croning ritual for "each woman who reaches menopause. The ritual marks a woman's passage into a new stage of life: the Crone stage, in Witchcraft considered the time of life when experience and wisdom bring a woman into her full power" (p. 297).

As far as we know, the Crone was also honored by at least the Mayans, Aztecs, Pueblo Indians, and North American Indians as well as the Celts. Within each of these cultures she was known for her wisdom, teaching and healing powers (Morgan, 1986).

Post-Ancient to 20th Century

Throughout history, women have been affected in one way or another by medical and scientific views of female bodily processes (Martin, 1987, Posner, 1979). The historical roots of the influences operating on women's experience of menopause are intertwined with the history of scientific, medical, and cultural perspectives on the human body, on

women's bodies in general and on menopause in particular. An examination of these views follows, in lieu of direct access to the historical words of women themselves.

Berman (1984) examined the origins of current views of ourselves, and of our relation to ourselves and our world. He noted that from the time of the ancient Greeks to the 16th century, mind and body were not viewed as separate entities. Women and men were not viewed as separate from nature or from the world in which they lived. They were, instead, considered to be active participants in nature. Consciousness was considered to reside in the body, and in nature, as well as in the mind.

The assumption that mind and body, subject and object, were radically disparate entities grew out of the scientific revolution of the 17th century. Our ability to think began to be seen as separating us from the world in which we lived. As we were separate from nature, we were also separate from our bodies. The location of our thought processes, our mind, came to embody our consciousness. While we perceive and are aware of our body and its functions, the essence of ourselves, our "I," is not our body but our consciousness, which is located in our mind. The separation of mind ("ourselves") and body became accepted as abstract truth, and remains today (Berman, 1984).

Martin (1987), an anthropologist, extensively examined the history of medical perspectives of women's bodies. Laqueur (in Martin) found that medical literature from the ancient Greeks until the late 18th century viewed male and female bodies as structurally similar in that it was assumed that women's internal organs were analogous to men's external ones. Rosenberg (in Martin) added that "the body was seen, metaphorically, as a system of dynamic interactions with its environment."

Two subsidiary assumptions governed this interaction: first, that "every part of the body was related inevitably and inextricably with every other" and, second, that "the body was seen as a system of intake and outgo--a system which had, necessarily, to remain in balance if the individual were to remain healthy" (p. 30). Martin noted that given these assumptions, changes in the relationship of body functions occurred constantly throughout life, though more acutely at some times than at others. Menopause was one of these changes--a necessary adjustment in order to maintain balance so that women could remain healthy.

This long-established perspective came under severe attack at the beginning of the 19th century. The Industrial Revolution had given rise to a metaphor of the body as a factory. Bodily processes began to be described in economic and production-related terms (Berman, 1984; Martin, 1987). Differences between men and women began to be seen as fundamental and based on discoverable biological distinctions.

"Laqueur argues that this attempt to ground differences between the genders in biology grew out of the crumbling of old ideas about the existing order of politics and society as laid down by the order of nature" (Martin, 1987, pp. 31-32). Emphasis was placed on differences between the sexes, rather than similarities. These biological differences were considered to be centered on differing sex hormones. Hormone-related differences began to be seen to dictate men's and women's social roles. The established order of industrialized Europe became dependent on the maintenance of these social roles (Martin, pp. 32-36).

The fundamental differences between men and women were centered on two hormonal processes: menstruation and reproduction by women. With menopause these hormonal processes ceased. At the same time,

many 19th century medical accounts saw menopause as a crisis likely to bring on an increase in disease (Wilbush, in Martin, 1987). Given the proximity to death, menopause was also strongly equated with aging and dying. According to Fuchs (in Patterson & Lynch, 1988), "the notion that personality disorders were menopausally related emerged in the early 1900s, concurrent with Freud's (1963) view that menopause often reinforced and promoted anxiety neuroses. Changes in personality, especially depression, irritability, and a quick temper, were considered the first signs of approaching menopause" (p. 185).

The development of modern scientific medicine in the 20th century expanded on the metaphor of the body as a factory comprised of economic functions of increasing complexity. Information was seen to flow from one bodily department to the other. This communication system was ordered hierarchically. These departments, in order to function effectively, were controlled by two systems: the nervous system and the hormonal, or endocrine, system. This control was maintained through a complex signalling system. The signal-response metaphor is found almost universally in current texts for premedical and medical students (Martin, 1987).

In 1945, Helene Deutsch, in *The Psychology of Women*, wrote of menopause from a Freudian perspective. She equated the loss of reproductive capacity at menopause to loss of service to the species. Menopause was seen as a general dissolution resulting in the disappearance of a woman's individual feminine qualities. "Everything she acquired during puberty is now lost. . .her beauty vanishes, and usually the warm, vital flow of feminine emotional life as well" (in Downing, 1987, p. 30).

The history of medical attitudes toward menopause, beginning in the late 1800s, was extensively examined by McCrea (1983). She summarized that during the 19th century, Victorian physicians viewed menopause as a sign of decay; with the advent of Freudian psychology in the early 20th century, it was viewed as a neurosis; and as synthetic estrogens became readily available in the 1960s, menopause became a deficiency disease. McCrea concluded that the roots of this disease definition of menopause could be traced back to the synthesis of estrogens.

Interest in the youth-enhancing properties of estrogen began in 1889 when a French physiologist reported that he experienced renewed vigor and rejuvenation after injecting himself with extracts from animal testicles. A few years later, as menopause was known to be equated with a drop in estrogen levels, a woman was treated for "menopausal insanity" with an injection of estrogen.

In the decades following, at least in terms of published literature, a relationship between estrogen, menopausal women, and the medical community became established. According to McCrea (1983), this relationship began in earnest in 1943 when an estrogen extract from the urine of pregnant mares was developed. This exogenous estrogen was inexpensive and easy to administer. By the early 1960s, exogenous estrogen was widely available in North America. By the mid-1960s the benefits of estrogen replacement therapy (ERT) were being widely proclaimed as miraculous in a fight against aging.

As noted by Eagan (1989), McCrea (1983), and others, in 1966 a widely-read and excerpted book, *Feminine Forever* (Wilson, 1966), heavily influenced both medical and lay perceptions of menopause. In it, Wilson gave a portrayal of menopause not unlike that provided by Deutsch

(1945). He described menopause as a hormone deficiency disease similar to diabetes and thyroid dysfunction, and also as a malfunction threatening the "feminine essence." Wilson advised that ERT should be begun, for most women, before menopause, to prevent hot flashes, loss of memory, melancholia, nervousness, headache, indigestion, backache, and neurosis. Under the threat of such frightening futures for women, many physicians considered estrogen replacement to be the only sensible route through the experience of menopause. According to McCrea and Eagan, a number of prominent U.S. physicians supported Wilson's claims, advising that the majority of menopausal women were acutely estrogen-deficient and would benefit from ERT, even if they were without symptoms.

In the late 1970s, the prescription rate for estrogen decreased following publicity about the increased risks associated with ERT and the inclusion of a warning in prescription packets that estrogen might be injurious to health (Berkun, 1986). By the end of 1976, papers in prominent medical journals had linked use of estrogen with incidences of gall-bladder disease, endometrial and breast cancers and with higher levels of risk factors for coronary disease (Kaufert & McKinlay, 1985).

Despite these concerns, use of estrogen rose again in the early 1980s. Grossman & Bart (1982) suggested that this rise was due to indications that ERT might prevent or retard osteoporosis. The rising rate of hysterectomies was thought to be another reason for the rise in estrogen use. Berkun (1986) reported that it was estimated that half the women in the U.S.A. would have had a hysterectomy by the time they were 65. A further development which encouraged continued use of estrogen was established when hormone replacement therapy was introduced. In order to reduce the link between cancer and estrogen treatment (at least in

relation to endometrial cancer) progesterone was added to ERT, resulting in hormone replacement therapy (HRT). A controversy currently revolves around the degree of risk or benefit to women of ERT or HRT use, the extent of medical and pharmaceutical involvement in women's menopause and the role of social and cultural factors in women's experience of menopause.

To summarize this historical overview of menopause: in the years prior to the 19th century, menopause appeared to mark a departure from the roles of childbearer and mother, and entrance to roles of wise elder, healer, educator and mediator. During the time of the ancient Greeks, menopause was considered a period of adjustment, a time when a woman's body sought to balance and adjust itself to a new, nonfertile role. Identity, selfhood, and consciousness were considered to reside in the body as well as the mind. Mind and body were not separate. Thus, a woman, undifferentiated from her body, would, at menopause, be going through the process of seeking the balance and adjustment necessary for her upcoming new roles. Women, along with all other living creatures, were participants in nature, and, as such experienced seasons of their lives.

In the 19th century the body began to be conceived of as analogous to a factory. Mind and body began to be considered as separate entities. Anatomical systems were considered independent. Menopause became an event likely to bring on disease. Freud viewed menopause as often reinforcing and promoting anxiety or neurosis. 19th century definitions and descriptions of menopause gave a portrayal of physiologic breakdown and resultant psychic confusion. This disease definition of menopause appears to have remained essentially unchanged through to the 20th century.

This historical look at menopause is by no means exhaustive. A detailed examination of the meanings which have been attached to menopause throughout history is not available in explicit form as women's experiences have rarely been recorded in the past.

Physiological/Intrapsychic Perspectives

Medical-Model Perspective

In a recent Canadian study by Kaufert (as reported in Cobb, 1989), 500 women were interviewed regarding menopause. Of these, 90% agreed with the statement that menopausal women should see their physician. Kaufert's findings confirmed the writings of Salk et al (1984), who determined that women, as well as their physicians, viewed menopause as an experience warranting some degree of medical attention. Martin (1987) pointed out that women, in particular, are considerably influenced by the medical perspective on menopause. These views are transmitted to women, both directly and indirectly, through the language of the medical culture.

The medical community has generated by far the greatest volume of literature on menopause. Within this section, discussion will be restricted to that which is considered to illustrate the medical view of menopause. *The Merck Manual of Diagnosis and Therapy* (Berkow, 1987), a standard physician's reference for diagnosis and therapy, listed menopause under "Common Gynecologic Problems." It defined menopause as "*the physiologic cessation of menses as a result of decreasing ovarian function*" (p. 1713). The Manual described symptoms as comprising a "menopausal syndrome" which may be treated through education regarding menopause

and/or estrogen replacement. When "psychic factors" are present, psychotherapy and, if necessary, medication for depression, anxiety, irritability and insomnia may be prescribed (p. 1714). *Churchill's Illustrated Medical Dictionary* (1989) and *Dorland's Illustrated Medical Dictionary* (1988) essentially echoed the *Merck* definition. According to Kaufert & Gilbert (1986), the 1981 World Health Organization report also discussed menopause as an estrogen-deficiency disease.

The education referred to in the *Merck Manual* was that provided by physicians and is generally comprised of, or accompanied by pamphlets made available to physicians by pharmaceutical companies. These pamphlets are commonly found in the offices of physicians and at public health units. A current and widely available example is *Managing Menopause*, published by Ayerst Laboratories (no date available). In it, menopause is described as a failure to ovulate through a decrease in estrogen production, resulting in an insufficient estrogen supply. A serious complication of this insufficiency was seen as the development of osteoporosis, which was described as a significant problem and risk for menopausal women. The question was raised as to whether it was normal for a woman to spend 30 or more of her post-menopausal years experiencing low estrogen levels. Estrogen replacement therapy was named as being available to alleviate, directly or indirectly, the menopausal symptoms of hot flushes, psychological symptoms, osteoporosis, cardiovascular problems and genitourinary tract problems.

A further representation of the medical community's presentation of menopause to women was a March, 1990, program by the Federation of Medical Women of Canada, B.C. Branch. On entry to the menopause presentation, all participants received an information package comprised of

two pamphlets on menopause supplied by pharmaceutical companies (one being *Managing Menopause* , mentioned above), a placebo sample of an estrogen patch, a questionnaire on menopause symptoms designed by a leading pharmaceutical company and a two-page handout on menopause. This handout stated that "menopausal symptoms occur in about 80% of women. . Symptoms can be divided into specific and nonspecific categories:

I. SPECIFIC SYMPTOMS

(i) Early symptoms: hot flashes, night sweats

(ii) Later symptoms are related to changes in the target organ:

Vulva & vagina - painful sex, blood-stained vaginal discharge, itchy vulva

Bladder & urethra - frequency and urgency of urine, involuntary loss of urine

Uterus & pelvic floor - uterovaginal prolapse (sagging bladder and urethra, sagging rectum)

Skin & mucous membranes - dryness or itching, easily traumatized, loss of hair, minor facial hairiness, dry mouth, voice changes -reduction in the upper register

Cardiovascular - angina, heart disease

Skeleton - osteoporosis (1 in 4 women will get this) - loss of height, humpback, back pain, shortened waist, fracture of wrists, hips, ribs or spine

Breasts - reduced size, softer consistency, drooping

Nervous system - hot flushes, short term memory loss, sleep disorders, altered mood states

II. NONSPECIFIC SYMPTOMS

Psychosocial cultural symptoms, depression, irritability, insomnia, frigidity, headache, apprehension."

Options for dealing with these symptoms were listed as "nonhormonal medications which treat the symptoms without removing the underlying cause" and "ERT" which "treats the underlying cause." ERT was "indicated for the treatment of menopausal symptoms or in women at risk for osteoporosis." Possible problems associated with ERT "include the stimulation of existing cancer." Controversial questions were named as whether or not women with a "strong family history of cardiovascular disease" should take ERT, whether ERT should be used by all women in menopause, which estrogen is best , whether estrogen causes cancer or not, and how long ERT should be continued.

The second edition of a standard menopause reference text for physicians delineated "the comprehensive management of women during years when reproductive hormone activity fades" (Eskin, 1988, p. xiii). Menopause was discussed in terms of hormonal loss, declining reproductive capacity and reproductive failure and loss. Reference was made to the pathophysiology of menopause, and to both menopause and aging as conditions (pp. viii-xii).

Budoff (1987), in an essay excerpted from her popular book, *No More Hot Flashes and Other Good News,* noted:

> Women who hope to continue an active sex life into their late fifties, sixties, and seventies may want to consider HRT [hormone replacement therapy]. Estrogen will not make them young again, but it can have a profound effect on the vagina, which returns to its youthful state very

> quickly. . . .Women who were crying and depressed, although previously they had been the back bone and strength of the family, suddenly rebounded on estrogen replacement therapy. (pp. 154-155)

From a medical perspective, menopause has been generally viewed as psychologically stressful and is often considered to increase a woman's vulnerability to psychic breakdown (Berkun, 1986). What is seen as significant is the physiological loss of estrogen (Lennon, 1982). McKinlay & McKinlay (1987) noted that depression in menopausal women is considered to be common, triggered by endocrine changes and therefore treatable with estrogens.

Menopause is often viewed by the medical profession in terms of the health hazards associated with it. Currently, as indicated in the *Merck Manual* (Berkow, 1987), the major health hazard associated with menopause is osteoporosis, with extended estrogen replacement recommended for its prevention (p. 1714). However, questions remain within the medical community as to the safety of estrogen use. Mishel (1987) concluded that "after 40 years of clinical research on estrogens, there still is a great hiatus and a definite need to learn more about the pharmacodynamic properties of natural estrogens" (p. 16). In an editorial on osteoporosis in a recent *Journal of the American Medical Association* , Williams (1990) commented that, "the question of appropriateness of use of estrogens continues to be controversial" (p. 708).

From the medical perspective, "the most potent method for improving the quality of life for the menopausal woman [remains ERT]. Research must be dedicated to producing therapeutic hormones that are safer and more effective" (Eskin, 1988, p. 25). Mishell (1987), noted the

necessity "to meet an increasing global need for an adequate, safe, and inexpensive estrogen substitution therapy" (p. 16). He cautioned that:

> In the year 2000, some 12% of the world population will consist of women aged 45 or older. . .From there on, their number and relative proportion will rapidly increase. . .Hence, it is rather naive to think. . .that the menopause as a problem mainly concerns the well-to-do Western societies. (p.11)

To summarize, whether described in medical texts or in literature designed for women in menopause, menopause is portrayed as a condition arising from failure and breakdown of the reproductive system. A resulting deficiency in estrogen leads to various symptoms which may be alleviated with estrogen replacement therapy. Prevention of osteoporosis and other disorders, maintenance of an active sex life, and relief from emotional upset were cited as advantages to estrogen replacement. Treatment was considered a physician's obligation on two counts: first, toward enhancing women's quality of life and secondly, to prevent a future burden on the taxpayer which would result if osteoporosis and/or other diseases were not prevented. The normality of women experiencing one third of their lives with a deficiency of estrogen was questioned. A major focus of research was the development of safer estrogen replacement therapies.

Recent literature originating from a medical perspective did not specifically label menopause as a disease. However, the descriptions used both in medical texts and in material provided for menopausal women clearly portrayed menopause as a medical condition, if not a disease. It was described in terms of failure, insufficiency, loss, decline and

breakdown. Menopause was considered a hazard to health in that it was implicated in the future development of diseases such as osteoporosis.

Psychological Perspectives

As with that of the medical model, the literature from the field of psychology also located responsibility for the nature of the menopause experience within the individual woman. Her experience was seen to be determined by her level of self-esteem, life satisfaction, role investment and perhaps by her socioeconomic status.

In 1963, Levit (in Grossman & Bart, 1982) found that "women who were very much invested in their role as mothers were more anxious during menopause than they were afterwards. Thus, the transition appears harder for women who are giving up a role they highly value" (p. 194). Also in 1963, Kraines (in Lock, 1982) found that women who were low in self-esteem and life satisfaction were most likely to have difficulty during menopause. Kraines concluded that menopause in itself was not experienced as a critical event by most women. Neugarten (1968) found that women who had experienced menopause were less likely to consider it a significant event than were premenopausal women, and that upper-middle-class women in particular denied the significance of menopause in a woman's life.

A study by Bart (in Grossman & Bart, 1982) indicated that a lack of meaningful roles and the consequent loss of self esteem, rather than any hormonal changes, seemed largely to account for the incidence of menopausal depression. Lennon (1982) suggested that "women who experience menopause off-schedule (whether early or late) display significantly greater distress and depression than other women their age"

(p. 359). Severne (1982), concluded that, in general, "more privileged women," who had "greater material and educational facilities" and who lived in more stimulating environments "with more resources and more possible choices in life," were "less prone" to difficulties with menopause (p. 246). Parlee (1984) concluded that menopause was a natural transition period in adulthood, which was affected by a woman's self-concept, life-style, sex role and family interactions.

Lennon (1987) summarized three perspectives on the psychological aspects of menopause. In the first, the physiological changes of menopause were seen to result in "increased psychological distress." From the second perspective, "specific life conditions of midlife, when combined with the experience of menopause, can induce psychological difficulties. . . Menopause will be most distressing under specified social, psychological, or cultural conditions" (p. 2). From the third perspective, menopause was "not especially stressful for most women. . .Neither the physiological processes of menopause nor its symbolic meaning cause psychological distress" (pp. 1-3). Lennon's survey research failed to "demonstrate any association between menopausal status and depressive symptomatology. This is the case whether the direct effect of menopause is considered or its indirect effects via social roles" (p. 14).

Morokoff (1988), in a review of studies relating to sexuality and menopause, quoted a study by McKinlay (in press), in which it was noted that "as women progressed through menopause, their attitudes tended to become more favorable" (p. 493). Morokoff also noted that menopause "is a signal event to which general endocrine age-related changes may be tied. Menopause also signals aging and makes it difficult to ignore one's own mortality" (pp. 493-494).

In summary, as Morokoff (1988) has concluded, research on menopause from a psychological perspective is still at the question-finding stage. "While there has been no shortage of documentation of menopausal symptoms and medical treatment for these symptoms, research into the psychological significance of this life stage for women is lacking" (p. 494). The question of meaning has not as yet been addressed. Any depression or distress women may exhibit while in menopause has been attributed to factors other than menopause, such as low self-esteem or loss of role status.

The preceeding has provided an overview of the *position* or *orientation* of the fields of medicine and psychology to menopause. The orientation to menopause inherent in the medical model is one of deficiency and loss. As noted by Cochran & Claspell (1987), *direction* is inherent in position. As a medical condition or disease, the direction inherent in this position is toward diagnosis and treatment. A medical problem requires a medical solution. Needing treatment which she cannot provide for herself, a menopausal woman is dependent on expert-others for diagnosis and treatment. Physicians are professionally obligated to treat and/or to relieve menopausal symptoms. Having a medical condition, a menopausal woman has experienced a loss with respect to some aspect of her health. A body which has a disease (even when health has been maintained) is a body which has betrayed its occupant. A woman at menopause may thus feel that her body is out of control.

When her menopause is a medical condition, particularly when it may impinge on her family, a woman has a responsibility both to herself and to her loved ones to seek treatment. Women who do not seek treatment risk being labelled selfish or martyrs. They also risk becoming a

future burden on the medical system, health plans and the taxpayer if they do not seek treatment and thus contract the diseases treatment may prevent. This degree of irresponsibility carries with it a burden of guilt.

Orientation also determines research directions. A disease definition requires that researchers focus their efforts on improved medications with which to either eliminate the cause or to better or more safely alleviate the symptoms. Such an orientation renders other lines of inquiry pointless.

When menopause is viewed as a condition or disease, the question or possibility of meaning becomes irrelevant. As a condition, it is to be cured or relieved as soon as possible. If, however, the physiological experience of menopause and its attendant emotions have developmental meaning or significance, such lines of inquiry are not necessarily beneficial, and are perhaps harmful for women.

Bio-Socio-Cultural Perspectives

A sociocultural perspective on menopause began to gain prominence in the 1970s. It emerged, primarily, out of the criticism by the women's movement of a disease definition of menopause, and from reports relating estrogen use to cancer. DeLorey (1984) summarized this perspective when she wrote that "menopause is a biological process that takes place within a particular social and cultural setting. . . Because of the symbolic representation of menopause, the social aspects produce profound changes in the way women at menopause view themselves and in turn are viewed by society" (p. 288). Within this section women's studies literature and anthropological literature will be examined.

Women's Studies Literature

The women's movement has, generally, been sharply critical of the medical community, charging that many of women's natural bodily processes, including menopause, have been medicalized (Salk et al, 1984). Medicalization has been defined by Zola (in Salk et al) as the situation which exists when "medical people become the 'experts' on *normal* experiences or social problems" (p. 560). Mishler et al (in DeLorey, 1984) argued that:

> The biomedical model tends to use restricted definitions of health status without regard for social definitions; it assumes that physicians, who are the primary purveyors of health, are experts who are neutral providers, dispensing their product unaffected by social, cultural, or political forces. (p. 278)

DeLorey added that "because the existing system of care is based on this biomedical model, there is in reality no 'health care system,' but rather a 'medical care system,' which by definition perceives life in medical terms" (p. 278).

As noted by Posner (1979), the health "bible" of the women's movement has been the Boston Women's Health Book Collective's (1984), *The New Our Bodies, Ourselves* . Since first published in 1976, this book has served as the conveyer of women's movement perspectives as they related to the health of women. In it, Salk et al (1984) charged that "in a sense, the medical world defines women as inherently defective throughout life, in that we 'require' a physician's care for all our normal female functions" (p. 560). Corbett (1984), also in *The New Our Bodies, Ourselves,* wrote:

> The medical approach "protects" us from the normal discomforts

> and changes of outlook which accompany menopause and other transitions of the aging process. It leads us to believe that these changes are so painful or dangerous that we cannot get through them without drugs and/or surgery; that nonmedical alternatives are ineffective, or that we are incapable of applying them systematically enough to benefit us. Many doctors do to menopausal women what they do to women in childbirth: they intervene to prevent us from really *living* the experience of change. (p. 447)

Siegal, Costlow, Lopez, Taub & Kronenberg (1987) attributed these physician's attitudes to "the medical myth that menopausal women suffer a crisis or a 'deficiency disease' for which treatment is needed" (p. 116).

DeLorey (1984) further criticized medicine in relation to women at midlife:

> As women age, medicine continues to view them as controlled by the endocrine system, and consequently, medical care for midlife women continues to be dominated by attention to hormonal factors. . .Thus, we have midlife women being given estrogen to control hot flashes or to prevent and/or ameliorate thinning of the bones (osteoporosis) when life-style changes such as improved nutrition or more exercise may be as effective. (p. 278)

The role of women themselves in medicalization of their menopause has been discussed by Corbett (1984), Grossman & Bart (1982), Posner (1979), and others. They have noted that this role has been a function of the interplay between women's socialization, negative societal attitudes towards menopause and aging, and of the power of the medical community's definition of menopause as a "condition." On women's

socialization, Jaggar (1983) has written that "traditionally women have been associated with body and men with mind. . .a passive feminine psychology is imposed on females. . .For much of her life, every woman is evaluated continuously [in terms of her body and sexuality]" (pp. 138-142). Salk et al (1984) linked socialization and medicalization:

> For decades many of us are expected to go to an obstetrician-gynecologist to obtain our basic care. We learn to do this without realizing that by doing so we begin to define ourselves and all our bodily needs in terms of our sex organs and reproductive capacities. . .We don't question the role that the physician has taken in our lives because, for one thing, our exposure and acceptance began early. . .All these factors together have brought us into an extreme and enforced dependency on professional experts. (pp.560-561)

Eagan (1989) has added that our society, and particularly the medical community, have a "deeply held belief" that "health and femininity" are "somehow incompatible" with aging (p. 38). Salk et al (1984) also charged that physicians, and the medical community in general, encourage women "to see personal problems as individual isolated experiences rather than as problems [they] have in common with other women" (p. 561).

Siegal et al (1987) noted that "because physicians are often not aware that it is normal for women's experiences of menopause to vary widely, [as they do with menstruation], they often treat the normal signs of menopause as illness" (p. 118). This lack of awareness of women's normal experiences has been seen as resulting from a number of factors. Perhaps most basic has been the paucity of research in general. In 1973, Simone de Beauvoir (in Posner, 1979) suggested that "society looks upon old age as a kind of

shameful secret that is unseemly to mention" (p. 180). Posner added that for "many women in our society, the word menopause has taken on an almost overwhelming meaning, and it has come to epitomize the female's dreaded decline. . .This fact alone may best explain the scarcity of literature on the topic" (p. 180). In addition, criticism has been levied at researchers (both medical and social-psychological), as well as at physicians, for having tended to extrapolate from a minority of women having difficulty with menopause, to all menopausal women. Also, as early studies were examined closely, they were criticized for not having differentiated between (a) menopausal, premenopausal, and postmenopausal women and, (b) those experiencing natural versus artificial menopause (McKinlay & McKinlay, 1973). As a result, much research concerning menopause is biased and fragmented. As noted by DeLorey (1984):

> Most studies are conducted with clinical populations; it is fragmented because many studies are done assuming only a biological, psychological, or sociocultural model of explanation with little integration of the models or awareness of how each relates to the other when attempting to explain the totality of the experience for women. (pp. 283)

Eagan (1989), Grossman & Bart (1982), and McCrea (1983), have documented the prominent role of the pharmaceutical industry in the promotion of estrogen use, and thus the conceptualization of menopause as a medical condition. They have charged that the pharmaceutical industry has consistently minimized the risks of ERT and HRT, while aggressively promoting its benefits. They sharply criticized popular books such as Wilson's (1963), *Feminine Forever* , and Reuben's (1969), *Everything You Wanted to Know About Sex But Were Afraid to Ask* for promoting

estrogen use and a disease definition of menopause. Examples such as Wilson's chapter, "Menopause--The Loss of Womanhood and Good Health," and Reuben's "Not really a man but no longer a functional woman. . . .They have outlived their usefulness as human beings (p. 287)" were condemned for their scare tactics. According to McCrea, Wilson further promoted hormone replacement with statements such as, "In a family situation, estrogen makes women adaptable, even-tempered, and generally easy to live with. . .The estrogen-rich woman, as a rule, is capable of far more generous and satisfying sexual response than women whose femininity suffers from inadequate chemical support (p. 113). Eagan (1989) and Mintz & Cohn (in McCrea, 1983) have noted that Wilson established a foundation to promote estrogens, and that it had been "amply documented" that this foundation was supported by sizable grants from the pharmaceutical industry.

Throughout the late 1960s and early 1970s over 300 articles promoting estrogens appeared in popular magazines (Johnson in McCrea, 1983). During the same period an "aggressive advertising campaign promoting estrogen" was launched by the U.S. pharmaceutical industry. By 1975, estrogen had become the fourth most frequently prescribed drug in the United States (Eagan, 1989). Kaufert & McKinlay (1985) pointed out that "once menopause was defined as a deficiency condition, its treatment with estrogen was not only legitimate, but became an obligation" (p. 129).

According to Weideger (1976), that menopause is considered a disease is basically a function of the social evaluation placed on menstruation and, consequently, on menopause. She has attributed the silence and the negative stereotype surrounding both menstruation and

menopause to a historical, and on-going, menstrual taboo. This taboo "includes the precept that women shall keep these experiences hidden. When we are taught that something has to be hidden, we naturally believe that it contains an element that is not acceptable to other people" (p. 3). Weideger further asserted that menopause cannot be fully understood in isolation from the menstrual taboo. Despite the scope of Weideger's research it does not appear to have been widely incorporated into subsequent literature on menopause.

Posner (1979) and Stimpson (1982) have noted that the women's movement literature has tended to dismiss the physiological component of menopause and has adhered almost solely to a social-psychological-cultural model of menopause. Stimpson has linked this literature to the philosophical underpinnings of the women's movement:

> As we re-mark the meaning of menopause, we must also decide how much the sexes differ from each other. Largely, though not entirely, the American feminist movement has minimized the differences between men and women. It has argued that they have more in common with each other as people than they have separately with members of their same sex. (pp. 269-270)

To summarize, research and literature from the women's movement has focused on what menopause is *not* , rather than on what it is. From the perspective of the women's movement, " a 'deficiency disease' was invented to serve a drug that could 'cure' it, despite the suspicion that the drug caused cancer in women" (Grossman & Bart, 1982, p. 189). Women's greatest difficulty at menopause was seen as overcoming negative cultural stereotypes.

Anthropological Literature

As noted by Beyene (1986), anthropological studies "view culture as an organized system which attributes meanings to reality, thus giving each natural phenomenon a particular meaning and significance" (p. 49). Rarely has the sole focus of these studies been a determination of the meaning of menopause in the lives of women. A notable exception is the work of Davis (1986), discussed later in this section. Most studies focused primarily on the presence or absence of physical symptoms, with widely varying results.

Early anthropological studies which examined menopause in non-Western cultures tended to conclude that the nature of women's experience of menopause was related to her subsequent rise or fall in social status following menopause (Brown, 1982; Flint, 1975, 1982; Flint & Garcia in Flint, 1982; Maoz in Flint, 1982). A change to low status was seen to correlate with an experience of menopause which was negative and physically uncomfortable or disabling. Where menopause was associated with freedom from cultural taboos associated with the childbearing years, women's attitudes and experiences were reported as being positive or indifferent. These findings have been used to suggest that difficulties which women in industrialized countries may experience are correlated with a low status accorded to aging in general and to aging in women in particular. However, in reviewing anthropological literature, Lock (1986) concluded:

> When data on status, roles and self-esteem are examined comparatively, it is apparent that there is considerable variation, and that whereas in some societies the status of mid-aged women does indeed improve (Middleton 1966),

> in others (La Fontaine 1960) it declines. It cannot therefore be assumed that distress at menopause is a phenomenon which is necessarily restricted to industrialized society. (p.2)

Beyene (1986), added that many of the conclusions with respect to role status were "reflections of middle class, Western cultural values, expressing a tacit notion that new roles for women, such as participation in male activities (mentioned by Flint 1975; Griffen 1977, 1982), are a universal measure of status gain for all women. In fact, women in some societies do not necessarily consider male activities to be superior to female roles" (p. 49).

Beyene (1986) investigated and compared the menopausal experiences of rural Mayan Indians and rural Greek women. She found that Mayan village women welcomed menopause, conceived of it as a "natural event" and "ironically" associated this stage with being "young and free." The rural Greek women saw menopause as a "life stage in which they felt free of taboos and restrictions." In addition, a post-menopausal woman was freed from being a "sexual threat to the community and a potential cause of shame for her family, since she was no longer considered sensual and desirable by other men." Like the Mayan women, the Greek women reported better sexual relationships with their husbands. However, menopause was associated with "growing old, not having energy, and a general down hill life course." Experiences with "hot flashes" and "cold sweats" were considered to be natural phenomena causing temporary discomfort but not warranting medical attention. Unlike the Greek women, none of the Mayan women interviewed experienced hot flashes. Beyene suggested that the environment, diet, fertility patterns and genetic factors may be implicated in the variation in how menopause was

experienced among the Mayans and the Greeks. Each of these factors varied considerably between Mexico and Greece. Beyene concluded that the roles of culture and biology in constituting women's experiences and expressions of menopause are often intertwined in complicated ways.

Lock (1986) made similar conclusions in her extensive study of menopause in Japan. She reported that for nearly half the women in her study, feelings of relief at being free from menstruation and fertility were "strongly tempered by concern about aging." Some "clearly expressed sadness." Nearly a quarter of the women interviewed gave unsolicited comments such as: "one becomes a man," or one "loses one's sacred function as a woman" or one's "value as a woman is decreasing" at the time of menopause. Difficulty at menopause was frequently described as a "luxury disease," a problem only for a woman with time on her hands. Lock concluded that "considerable differences in the subjective meaning of menopause [were found], many of which can be accounted for by class and occupational differences." She summarized by noting that menopause is a complex biological event which is also shaped by numerous cultural factors.

Davis (1986) conducted an ethnographic study which specifically sought to determine the meaning of menopause in an isolated Newfoundland fishing village. She considered women's experience of menopause as a collective as well as an individual phenomenon. These included the "semantics of menopause," "lay symptomatics" and "local institutions and the moral order." Davis found that the village women were unfamiliar with the terms "menopause" or "climacteric." In folk usage, the term 'the change' was found to be somewhat equivalent. Age, more than menstrual pattern, was used by the women to define themselves

as "on the change," which was considered to be a normal, natural part of the aging process. Rather than referring to "the change," the women, as a general rule, were more likely to refer to what happens "to your nerves on the change." Menopause was considered by the community to be an experience "subject to a high level of individual variation" which were freely discussed by the women. In lay life there was no "mind/body dualism" nor was there any "marked self/society dualism." Menopause was viewed as "a series of gains and losses." The vocabulary of menopause (blood, nerves, the change) was not unique to menopause alone, but used throughout the lives of women. It was therefore an experience that could be identified with by all. Davis (1986) summarized:

> Since the change is not seen as a disease there is no recovery. It is simply a life stage, albeit a potentially difficult one. . . Although attitudes toward menopause may be negative, menopause has meaning as a status enhancing developmental task--yet another challenge to be faced and overcome by a long suffering and exceedingly durable race. Nerves and blood may be problematic at menopause but they are not distinctive to menopause. (pp. 83-84)

Davis (1986) also found that the level of meaning she was able to access was not accessible through use of questionnaire and survey measures. "Understanding the folk, popular or lay dimensions of menopause cannot take place apart from understanding the role of the local community in the process of negotiating meaning of aging in the social and symbolic contexts of village life" (p. 76).

Cultural variations in menopause within North America were examined by Siegal et al (1987). They concluded that "the dominant

culture in the United States may be more powerful than its subcultures in shaping the experience of menopause. . . .The experience of menopause cross-culturally in the United States is much more the same than it is different" (p. 117). Mannes (in Flint, 1975) noted that just as women have been given the capacity, in our culture, to live longer than ever before into their later years, our youth-oriented society enshrines the 16 year old as a female incarnate.

To summarize, from an anthropological perspective, menopause, like all physiological processes such as menstruation, was seen to be considerably influenced by cultural variables. Perceptions and experiences of menopause varied cross-culturally. Menopause was considered a developmental event--a complex transition involving biological, psychological, sociological and cultural variables. As such, the implications arising from this position were similar to those outlined in the summary to the preceeding section on the women's movement. There was some debate among anthropologists as to whether or not a change in social status accompanying menopause was instrumental in determining the nature of a woman's experience of menopause. Lock (1986), in a review of anthropological research, pointed out that considerable problems existed in trying to make cross-cultural comparisons of a complex biological event such as menopause, which is also shaped by numerous cultural factors. She further concluded that "the meaning of menopause is subject to a wide degree of interpretation and by no means always coincides with the norm that is expected in any one society" (p. 2).

Women's Health Movement

The Women's Health Movement is a somewhat arbitrary "umbrella" term which covers the literature and activities of women seeking alternate perspectives on the care of their bodies and those of other women. It generally originates with women who work with women (for example, nurses, social workers, women's advocates). These authors are not clearly defined as a group and would not necessarily describe themselves as such. They are, however, writers and/or researchers who attempt to incorporate the physiological, the influence of the medical perspective, and the merit of the femininist and cultural perspectives--all with the reality of interaction with actual women. To them, menopause is viewed as a natural developmental process and not a condition. Their literature was most likely to draw on that of other disciplines.

Kaufert & McKinlay (1985) extensively examined research on menopause as related to estrogen research and to the medical community. They concluded that a growing list of diseases seen to be preventable through ERT "implied an obligation on the physician to prescribe estrogen. . . .despite the risk of endometrial cancer" (p. 121). They also charged that "it is in the interest of the pharmaceutical companies" to establish a market in which "women would be kept on long-term therapy, regardless of their menopausal symptoms" (p. 123). They concluded that research showing that estrogen may be beneficial to women's health, rather than being iatrogenic, "has been actively promoted and [is] currently a carefully orchestrated campaign. . .advocating estrogen as a barrier against osteoporosis" (p. 134).

A widely-accepted link between depression and menopause was discussed by McKinlay and McKinlay (1987). They pointed out that many

health professionals and members of the public believe that depression in middle-aged women is caused by endocrine changes associated with menopause and therefore can be treated with estrogens. According to these authors, this belief has "far-reaching consequences--it promotes a stereotype of middle-aged women as naturally depressed, anxious, or otherwise emotionally unstable" (p. 157). In their extensive study of middle-aged women and depression they found that women who had recently had a hysterectomy reported twice as much depression as other women. They stressed the importance of this finding, noting that nearly 30% of women, per year, in the U.S.A., undergo hysterectomies. They reported that women with "positive attitudes" did not experience depression associated with menopause. In conclusion, they wrote that "the general social environment of middle-aged women, as well as worries associated with caring for adolescent children, husbands, and elderly parents or in-laws," created a situation "conducive to depression whether a woman was experiencing menopause or not" (p. 161).

Kaufert (as reported in Cobb, 1989) conducted a survey of 2500 Manitoba women about health and menopause, and interviewed 500 at six-month intervals for a three-year period. Findings included the suggestion that the stereotype of the middle-aged woman with a list of complaints was also accepted by women themselves, despite evidence that most were in good or excellent health. Women taking part in the interviews agreed overwhelmingly with the statement that menopausal women should see their physician. 80% reported that the hot flash was uncomfortable; 38% were embarrassed by them and 37% were emotionally upset by them. Asked to rate the importance of menopause as an event in their lives, 15% saw it as very important and 15% as of no importance. Post-menopausal

women were the most likely to dismiss menopause as an unimportant event. Only 2% expressed regret at the closure of reproductive life, 39% felt relief, and 22% had mixed feelings.

In discussing the medicalization of menopause, Cobb (1986) noted that "most doctors distrust a woman's ability to sustain the kind of exercise and diet required to stave off osteoporosis, and many believe that *all* women should receive ERT for life, or until accurate screening programs are in place, whichever comes first" (p. 19). Noting that when on an ERT regime women often forget to take a pill or use a cream, Cobb suggested that "forgetting is often a reflection of a deep-seated uneasiness with the whole process." (p. 19). She also suggested that women's concerns with menopause and ERT are often difficult to put into words. In 1987 Cobb wrote, "the butt of most jokes about menopause is the hot flash," which is estimated to affect the majority of women in conjunction with menopause. In what may be a related point, Thomson (1986) found that women "blame themselves for being difficult to live with" during menopause.

Berkun (1986) examined the effects of the interaction of middle-aged women's perceptions of their aging process and external factors in their lives on the women's emotional state. She summarized that :

> The data showed that even women who did not have an excessive degree of physical discomfort that could easily be associated with the menopause expressed confusion and anxiety about any bodily changes that ere not associated with a clear organic cause. The major themes. . .were concern about physical deterioration. . .[and] guilt about their inability to control their behavior enough to hide the signs of bodily changes. (p. 381)

Woods (1982), in *The Complete Book of Women's Health*, referred to menopause as a transition, and wrote that for many women menopause "means loss of fertility and aging," which, along with loss of role status, may be associated with negative feelings. On the other hand, some women were seen to "welcome the freedom from pregnancy afforded by the lack of ovulation" (p. 96).

Within the non-medical literature on menopause, it was relatively rare to find concern expressed that menopause may be trivialized or discounted. Two exceptions, as noted in the section, "Women's Studies Literature," were Posner (1979) and Stimpson (1982) who charged that much of literature originating with women has tended to discount women's physiological experience. Dyer & McKeever (1986), in *Women in Health and Illness: Life Experiences and Crisis*, also pointed out an underlying duality and expressed concern over trivialization:

> [A] disease orientation removes the idea that menopause is a normal event and that the woman herself has some control over her own body. On the other hand, an opposing myth. . . defines menopause as a normal event in the lives of women that is completely manageable by the women themselves. Although this view is more positive in its attitude about menopause, it does trivialize the experiences of those women who find menopause a stressful transition. (p. 219)

Duff (1987), in a similar vein, charged that general media reporting about menopause reflected a predetermined media position--that of a 'mind-over-myth' emphasis, which failed to recognize the reality of the considerable distress many women experience with this stage in life:

> Regarded in its veiled past as a potentially depleting period of

> time for women, and shrouded in the privacy accorded other unruly bodily disruptions, menopause has posed a bit of a problem ever since sexual equality became the cornerstone of the women's movement. I am convinced that, in an apparent desire to deny the inequity of the potential for menopausal upset, the media have sought to project a picture of menopausal symptoms as due more to the power of myth than to anything real. (p. 2)

To summarize, the women's health movement literature promoted menopause as a normal, predictable developmental transition which required change and growth. Menopause was considered to be medicalized, and ERT was considered to be over-used. The general health of middle-aged women in, and out, of menopause was stressed. The literature from this perspective was more likely than others to express concern that the physiological experience of menopause not be trivialized.

From the perspective of women's studies literature, cross-cultural studies and the women's health movement, menopause is viewed as a natural developmental process. As with the medical model perspective, this perspective embodies a position, or orientation toward menopause which carries with it a set of implications and direction. Being defined as a natural-process allows for consideration of developmental components. Menopause as a developmental process implies movement from one stage to another. Being a process which leads from one stage to another, it is open to consideration and exploration of meanings which individuals might attach to the experience. This orientation toward menopause has implications in terms of research directions. As with other developmental

processes which have physiological components, such as adolescence, research would continue to seek to understand the physiological processes. It would, however, be more likely to also focus on the meaning of the process. For example, menopause might be researched as preparation for old age, as graduation, as a transition, or as a rite of passage. Treatment and cure are not the focus of research into developmental processes. Treatments or cures are not sought for adolescence, for example. Like other developmental processes, again such as adolescence, menopause would be expected to be experienced physiologically and emotionally with considerable individual variations.

Menopause in Relation to Theories of Development

Adult developmental theory is in its infancy compared to the knowledge available on childhood and adolescence (Stevens-Long, 1984). As noted by Levinson (1986), we do not have a "cultural definition of adulthood and how people's lives evolve within it. In the human sciences, too, we have no adequate conception of the nature of adulthood. We have a detailed picture of many trees but no view of the rest of the forest and no map to guide our journey through it" (p. 5).

Menopause was rarely discussed in the available literature. At most, as in Huyck and Hoyer (1982), it was described as a change women undergo at midlife. The works of Belenky et al (1986), Chodorow (1978), Gilligan (1982), Miller (1986) and others have recently demonstrated that adult developmental theory has established men's experience and competence as a baseline against which both men's and women's development is compared, often to the detriment or misreading of women.

Miller has noted that "our theories of development seem to rest at bottom on a notion of development as a process of separating from others" (p. xxi). "A problem in theory became cast as a problem in women's development, and the problem in women's development was located in their experience of relationships" (Gilligan, p. 7). Gilligan pointed out that central to this issue is that:

> Relationships, and particularly issues of dependency, are experienced differently by women and men. For boys and men, separation and individuation are critically tied to gender identity since separation from the mother is essential for the development of masculinity. For girls and women, issues of femininity or feminine identity do not depend on the achievement of separation from the mother or on the progress of individuation. Since masculinity is defined through separation while femininity is defined through attachment, male gender identity is threatened by intimacy while female gender identity is threatened by separation. (p. 8)

This "self-in-relation" theory is itself in its infancy and while these concepts could be expected to be significant to an understanding of women's menopausal experiences, the topic of menopause has not as yet appeared in this literature.

Fictional Perspectives on Menopause

Fictional literature is another source of perspectives on menopause. For example, Atwood (1989) had one of her characters define menopause as "a pause while you reconsider men" (p. 158). In a more scholarly fashion, a few writers have examined the literary realm in order to learn what, if any, portrayals of menopause exist in narrative form. Kincaid-Ehlers (1982), reviewed the literature and, in an article titled, *Bad Maps for an Unknown Region*, found an absence of middle-aged women in literature in general. She noted that, historically, female characters generally proceeded from their fertile years to old age without an intervening season. On surveying the available examples, Kincaid-Ehlers concluded that "the primary, and lasting confusion about menopause in literature, as it is in life, is the equation of the end of fertility, or fecundity, with the end of sexuality" (p. 25). She also noted, however, that in many literatures "postfertile women are given the freedom of their tongues" (p. 25). A strong connection between menopause and madness was also found. Kincaid-Ehlers summarized that:

> Women are caught in many double binds. Menopause is the pivotal point of a classic one: first we are thought to be emotional, and therefore irrational, because we have menstruated or might be about to menstruate at any moment; then, at menopause and after, we are believed to be emotional, and therefore irrational, because we have stopped menstruating or might be about to stop at any moment. (p. 28)

Stimpson (1982) noted that "when the formal humanities have not evaded menopause, they have approached it gingerly. Informal discourse,

jokes, and folklore have done more with it, but they have been less documented and, therefore, are less accessible to us now" (p. 267). She added that "like the social sciences, the humanities have been guilty of the fallacy of bodily reductionism, abridging women to their flesh and assigning them to a nomothetic realm of nature" (p. 265).

Reuter & Zak (1982) examined psychological theory and the female novel of development by juxtaposing Erik Erikson's theory with the novels of Doris Lessing. They concluded that:

> Both psychologist and novelist have minimized the importance of the physical events of childbirth and menopause, both in terms of their effects on a woman's personality and in terms of their usefulness as bench marks for the beginning and end of the middle-aged developmental stage of women. . .The most significant conclusion to be drawn from this interdisciplinary investigation is that the sequence of development in men and women is markedly different. (pp. 17-18)

While this examination of menopause in fiction is certainly not exhaustive, it can be considered representative. Essentially, menopause is rarely mentioned in fictional literature, and when it is, it appears to adhere to a negative stereotype.

Popular Literature on Menopause

Magazine articles on menopause are relatively rare, even in magazines directed at women, and particularly when the numbers of women in menopause is considered. They tended to focus almost exclusively on physiology, and, in particular, on various aspects of

hormone replacement therapy. Until recently, only the rare book devoted to menopause was available for women. The most popular books, such as those of Cobb (1988b), Greenwood (1989) and Reitz (1977) have a primarily physiological focus, although they do briefly address psychological, social and cultural issues. Only Downing's autobiographical, *Journey Through Menopause*, specifically addressed the question of meaning.

Summary Discussion

With the exception of Davis (1986), previous studies have not specifically focused on women's experience in depth and considered the meanings of menopause. Along with the perspectives provided by historical and other anthropological accounts, Davis' study has provided some possibilities as to what menopause may have meant in more "traditional," or perhaps less complex cultures than ours. It demonstrated the importance of attention to language in the search for meaning. It also suggested that meaning is not easily accessed, if at all, through quantitative methods such as surveys and questionnaires, but rather through in-depth, broad-based, and often time-consuming qualitative methods.

Literature and research questions from the non-medical disciplines essentially use the parameters of the medical model by asking, "*Do* women experience change at menopause?" versus, the developmentally oriented, "*How* do women change? The dominant images of menopause remain those originating from the medical community. Research has been discipline oriented and has rarely examined the interplay of biological, psychological, and sociocultural variables--yet, an overview of the

literature suggests that women's experience of menopause is influenced by *all* these variables. Menopause is, therefore, a complex phenomenon about which relatively little is known--especially in terms of women's actual, lived experiences. As women have historically been silent with respect to their menopause, their experience has been largely defined for them by the medical community. Of the few studies which *have* focused on women's perspectives, the methodology of choice has been surveys and/or brief, structured interviews.

The weaknesses of these methodologies has been discussed by Mishler (1986), in his critique of standard interview and survey-interview practices. Mishler noted that within the interview process, the interviewer has almost total control over the structuring of meaning. The interviewer determines the very questions to be asked, and the position and contextual location of the questions. As noted by Reinharz (in Belenky et al, 1986), by so doing, a researcher runs the risk of starting with labels, and thus excluding experience altogether (p. 202). Mishler noted that interviewers and analysts tend to treat question-answer pairs as isolated exchanges, removed from their context. As "meanings are contextually grounded" (p. 117), meaning is obscured or inaccessible when context is removed. Even interviews that are intentionally unstructured and open-ended may fail to locate or determine meaning in that they may be influenced by a priori assumptions about adequacy of response as well as the practical exigencies of the study. Mishler noted that respondents may learn during the interview how to answer adequately, but briefly, thus running the risk of further obscuring meaning. Finally, Mishler charged that "the standard interview through both its form and the hierarchic structure of the interviewee-interviewer relationship tends to obscure relations between

events and experiences and to disrupt individuals' attempts to make coherent sense of what is happening to them and around them" (p. 120). These weaknesses seemed particularly pertinent to both a study focusing on the meaning of women's experiences, and to the exploration of a topic which has been linked to a history of silence and a negative stereotype. These factors played a role in the rejection of an interview-focused methodology as a means of determining women's experience of menopause.

The rationale for this study's use of a group format arose from a number of considerations. Foremost, as noted in the Introduction, were the works of Belenky et al (1986), Gilligan (1982), Miller (1986) and others. Belenky et al and Gilligan highlighted women's unique ways of knowing, valuing, communicating, and their construction of meaning. Miller addressed women's difficulty in finding a conception or formulation in which to state their feelings when their life experience has been translated and defined by those who have not had that experience--as has been the case with menopause. She also pointed out, as did Martin (1987), that it is difficult to see past the only systems of thought and language which we have inherited.

The work of these researchers provided the foundational rationale for the use of a group--which by its very nature is congruent with women's ways of knowing and construction of meaning. Membership in a group breaks silence and isolation, which have been linked to both women in general and to menopause in particular. As noted by a respondent in Belenky et al (1986), a group allows "everyone to voice things that they think are uncertain. It's allowing people to realize that they're not stupid for questioning things" (p. 221). A group can empower it's participants to

explore that for which they may be individually unclear or unsure, and perhaps allow a deeper exploration of their experience.

An additional rationale for the use of a group was provided by the writings of Taylor (1988), Martin (1987), and Weideger (1976) who pointed to a menstrual taboo in our culture. According to Weideger, this taboo includes the precept that women shall keep experiences related to menstruation hidden. What women hide is touched with elements of shame. Weideger, Martin, and Posner (1979) have suggested that menopause, being related to menstruation, cannot be understood outside the framework of the menstrual taboo. Posner has suggested that this factor has not been recognized in research on menopause. The majority of the few studies which have focused on women's experiences have asked respondents about their attitudes toward and experiences of menopause. Poser pointed out that if menopause has taboo characteristics, such as silence and shame, and given that "taboo implies lack of awareness" (p. 187), it is unlikely that respondents would be willing or able to answer such questions honestly or completely. Martin (1987), in discussing her cultural analysis of reproduction, spoke of the difficulty of seeing beyond that which we live with all our lives. She wrote:

> I anguished over the obviousness of everything the women were saying. Marx explains how people do not notice contradictions in their own society: 'A complete contradiction offers not the least mystery to them. They feel as much at home as a fish in water among manifestations which are separated from their internal connections and absurd when isolated by themselves.' (p. 11)

Martin noted that the problem her research posed for her was to find a vantage point from which to see the water in which she had lived all her life. The same difficulty applied to this study.

Given these possibilities, it may be that surveys and question-asking interviews have, at best, only scratched the surface of women's experiences, or, at worst, provided more of what women expect *should* be their response or experience of menopause. A group setting was seen to be more conducive than an interview format to an examination of a subject related to a negative cultural stereotype. The silencing power of a negative stereotype or taboo is reinforced by isolation. Within a group, members who have a negatively stereotyped experience in common are no longer isolated and may be more likely to openly discuss their experiences.

Considering the above, a group format was seen to provide the greatest possible opportunity for women to explore their experiences, in-depth, in a supportive environment. It was considered a format in which the power or authority of the researcher and academia could be lessened to the extent possible. It seemed reasonable to assume that once group trust was established, a more thorough, and perhaps more complete picture of menopause and its meaning might emerge than was presently available in the literature.

As noted above, a methodology was required which integrated and remained congruent with the knowledge gained from the research on women's ways of knowing, construction of meaning, relating, and valuing as provided by Belenky et al (1986), Gilligan (1982), and Miller (1986), among others. Sullivan (1984) discussed the value of an "emancipatory psychology" with critical intent, which would serve and help name the world of oppressed groups (p. 139). This concept is analogous to Mishler's

(1986) enpowerment of research participants. Both these concepts appeared particularly appropriate to a study of women and their menopause, given women's struggle with "voice," (Belenky et al, 1986), and the extent to which their experiences of menopause have been named and described by expert-others. Research from this perspective provided participants with the opportunity to name their world and to take a stance on/in it.

Rogers (1985) pointed out that "experiential knowledge, no matter how valuable, cannot be communicated directly. We can communicate *about* it, or we can create the conditions that facilitate it, but it cannot be communicated directly" (p. 8). It is in this "knowledge from experience" that the individual and collective meanings of our experiences reside. Asking someone for the meaning of their experience is like asking them, "Who are you?" Such questions generate talking about and around. Answers are facilitated by dialogue. Meaning cannot be communicated directly. The words and the insight required *develop* through the telling of one's story and through discussion--rarely are they there, close to the surface and available to questioning. A small group, sharing a common experience of interest, provided an environment conducive to this process. A group encouraged *more* than a description or narration of a story. It promoted discussion, questioning, a seeking-to-understand one's own experience in relation to that of others. As meaning exists in relation, in context, it appeared appropriate to wrestle with the meaning of experience in dialogue and relation with others.

Narratives arise naturally in a small group sharing a common experience of interest to all. As Mishler (1986) pointed out, "one of the significant ways through which individuals make sense of and give meaning

to their experiences is to organize them in a narrative form" (p. 118). Stories allow the expression of our understandings of our experiences. As a function of the dialectic process, a story becomes a joint production of the teller and the listener, and meaning is negotiated.

What our experiences have meant to us is most often a perspective only gained retrospectively. This study, therefore, focused on women who had already experienced menopause. Being exploratory, its purpose was neither to generalize beyond the study, nor to supply answers. Instead it suggests possibilities and generates broad-based questions that reach beyond current unidimensional definitions of menopause.

CHAPTER III - METHODOLOGY

With the exception of Davis (1986), the meaning women attached to their experience had not been specifically explored. Answers to questions of meaning and of the nature of felt experience required an in-depth examination of women's experiences. As suggested not only by Davis, but by the now obvious complexity of the topic, a qualitative, versus the more traditional quantitative methodology was required. The study's methodology arose from a consideration of the different ways in which women "view reality and draw conclusions about truth, knowledge, and authority" (Belenky et al, 1986, p. 3). Choice of methodology was also guided by consideration of the basic research questions being asked, the available literature on menopause, informal discussions with women, reflection on personal experience, a consideration of possible research methodologies, and a pilot interview.

Given the lack of knowledge of women's experience, this study was conceived of as exploratory in nature. As such, my intent was, and is, the generation of research questions grounded in the totality of women's experience, rather than generalizations or the supplying of answers. Underlying research questions were: What was the nature of the lived experience of menopause? What did the experience of menopause mean to women? What methodology was appropriate to these questions? Yin (1984) noted that the nature of the first two questions constituted a sound rationale for conducting an exploratory study, the goal being to develop pertinent propositions for further inquiry.

This chapter is comprised of details of methodology which include: (a) the "sources of evidence" used in the study; (b) a pilot interview; (c)

coresearchers (concept, criteria, location, selection, screening interviews, demographic information); (d) group design (time frame, location, underlying principles, role of group leader, participant-observation, bias and objectivity); (e) group procedure; (f) transcription; (g) follow-up/ validation interviews; and (h) analysis procedures (underlying philosophy, narratives, themes).

Sources of Evidence

Yin (1984) stressed the substantive value of use of a number of "sources of evidence" in case-study research (a group format being a variation on a case study). In addition to 18 tape-recorded hours of individual narration and group discussion, the following were employed in the process of gathering information on menopause, determination of methodology, and in analysis of the results: (a) pamphlets on menopause available to women in physician's offices, health units, etc.; (b) magazine articles, newsletters and books written for women on menopause; (c) personal experience and numerous informal conversations with women and men; (d) fictional literature; (e) literature from the areas of medicine, anthropology, the women's movement, the women's health movement, sociology and psychology; (f) a pilot interview; (g) follow-up interviews with each participant.

Pilot Interview

As noted by Yin (1984), a pilot interview helps investigators to refine their data collection plans with respect to both the content of the data

and the procedures to be followed, thus assisting the investigator in developing a relevant methodology. This study's pilot interview was conducted by the researcher as part of the decision-making process with respect to determination of an appropriate methodology. The interviewee met all the criteria for the study and was a personal friend of the researcher. The information derived both from the interview process and its content was used in conjunction with the ongoing review of the relevant literature. The final research design was informed both by the prevailing theories and by a fresh set of empirical observations provided by the pilot study.

The pilot interview confirmed the limitations of the interview process with respect to acquisition of meaning in relation to menopause. The potential for a group format became clear in terms of the perspective, depth or totality of experience, and memory jogging which could be reached when a group told their stories, and discussed them together. The pilot interview did not become part of the data base.

Coresearchers

Rogers (1985), noted that within much of qualitative research there are no longer subjects *of* research, but coresearchers or participants *in* research. The concept of coresearchers was in keeping with the philosophies underlying the methodology. Such a concept promoted equality, participation, and trust while avoiding the objectification which the concept of "subjects" engenders. "Our culture tends to 'objectify' people, that is, to treat most people as if they were things. . .To be considered as an object can lead to the deep inner sense that there must be

something wrong and bad about oneself" (Miller, 1986, p. 59). The concept of coresearchers was seen as particularly "empowering" for women, and more likely to facilitate and promote exploration of experiences of a personal and perhaps sensitive nature.

Criteria for Coresearchers

Completion of menopause was the first criterion for coresearchers. In the literature, menopause was often referred to as a transition. The nature of transitions are such that they have often past before they can be named as such. Women who had passed through menopause were considered to be able to provide the most complete perspective on the experience. Questions of meaning require perspective, and perspective is generally obtained retrospectively. "Being through menopause" was defined, as it is medically, as having been one year without menstruation, and that menstruation ceased as a result of natural menopause (versus surgically-induced menopause).

Excluded from the study were women who had had a hysterectomy. The literature suggested that menopause may be experienced differently by these women. They have undergone major surgery, and the experience may have influenced their experience of menopause. Women with hysterectomies have also already experienced the ending of their menstrual cycles which have been a part of their lives for an average of 35-45 years. For women experiencing menopause naturally, the cessation of menstruation constitutes the most visible, tangible manifestation of menopause. Women who have had a hysterectomy are also, by definition, no longer fertile. Although women who have had a tubal ligation are also no longer fertile, the decision was made to include these women both

because of the high number of women who have had one, and because they continue to menstruate.

A second criterion was that each coresearcher have had previous small-group experience, and be both willing and able (to the best of their knowledge) to discuss personal experiences and feelings in a group setting. The rationale behind this criterion was one of expediency. A considerable commitment was being asked of busy women. It was hoped that if the experience of being in a group was not new to the participants, the amount of time spent on group process issues could be kept to a minimum, while not sacrificing necessary trust-building time.

Women for whom English was not a first language, and who had not been enculturated into North American society were excluded from the study. The intent was to limit possible major cultural variations which may effect the menopause experience. The literature had confirmed that menopause is, at least in part, a culture-specific experience.

Location and Selection of Coresearchers

Through networking, notices in women's centers, and a newspaper advertisement, women were sought who were interested in participating in a study group. The purpose was described as that of investigating menopause through discussion of personal experiences, regardless of whether or not they had had difficulties with menopause. Women were told that participation in the research would be likely to promote the growth of a deepened awareness of both their experience of menopause and that of others. It was stressed that the purpose of the group was that of research and not therapy, support or education. Interested women telephoned the researcher for further information. Eventually, five

women who both met the criteria and were interested in the project were located through the network process.

Screening Interviews

At a time and location of their choice, informal meetings were held between each individual woman and the researcher, with the purpose of mutual assessment and the clarification of goals. Each meeting lasted for at least an hour, and allowed each woman to become personally acquainted with the researcher, while facilitating trust and comfort in the research process. An air of mutuality was promoted. The concept of coresearcher was discussed. Candidates were encouraged to ask questions of the researcher. At the same time, the researcher observationally assessed each woman's ability to listen, to respond, to focus on a topic, and to articulate her experience and emotions. Final determination of suitability for the project was made subjectively by the researcher.

Care was taken that the following information was conveyed to each candidate: researcher's goal for the interview, background information on the researcher and the Counselling Psychology Program, the researcher's personal and professional interest in this research, rationale for use of a group, the need for research, the purpose of the group, the use to which the research would be put, and, finally, the value of experiential knowledge and of her story in particular.

A decision was made to waive the one-year requirement in the case of one woman who clearly felt she was through the menopause process although it had been just 8 months since her last menstruation. Just prior to the group's starting date, a sixth woman, who appeared to meet the criteria, responded to the newspaper advertisement and indicated interest in

the group. A time could not be arranged for a personal interview. She was thus only interviewed by telephone and expressed uncertainty as to how she felt about being in a group. She attended the first group meeting and decided not to continue further.

Demographic Information

Within this thesis the coresearchers are identified by pseudonyms. All five women could be described as belonging to a middle to upper-middle class socio-economic group. Ages at time of research ranged from 41 to 59. Two were retired school teachers and were active in organizing or running menopause support groups. The others were a physiotherapist, a landscaper, and a writer. One was divorced, and lived alone, with the remainder married or cohabiting and living with their partners. All had had children and two were grandmothers. Only two had children living at home. One was born and raised in England, one in the U.S.A. and the others in Canada. Each had had experience with considered self-reflection or the counselling process. The times elapsed since last menstruation were 8 months for Rebecca, 14 months for Sharon, 4 years for Lucy, 6 years for Nikki, and 7 years for Ludmila. Menopause was felt by Ludmila, Lucy, and Rebecca to have been "on time," that is, when expected by them. Nickii's menopause began in her early thirties and was very unexpected. Sharon felt she was not on time in that she did not begin the menopause process until her mid-fifties, and did not end until she was 59.

Group Design

Time Frame and Location

The group met for 2 hours each Thursday evening, for 9 weeks, from May 4 to June 29, 1989. Meetings were held in a room donated by Family Services of Greater Vancouver as it was both a central location for participants and offered an atmosphere which was business-like yet comfortable. Two hours was determined to be the optimum concentration and commitment time which could be asked of participants. Meeting weekly was considered to allow for between-session processing and reflecting, sparking of memories, and analysis and synthesis of the various stories.

Underlying Principles

Design and implementation of the group were guided both by the researcher's experience as a group leader, and by Corey's (1985) stages of a group. These stages were pre-planning, design, preparation, inclusion, transition, working, and termination. Each stage was seen to vary in duration, depending on the nature of the group. Characteristics of each of the active stages will be discussed within this section, followed by discussion of the role of the group leader/researcher, the concept of participant-observation, and the question of bias and objectivity.

In the inclusion stage the group leader focuses on the building of trust, safety and inclusion for the members. A climate is created in which feelings and experiences are validated. Member goals or expectations are determined and expressed. These are meshed with the group leader's goals. In this stage the leader is particularly active in the leadership role.

The transition stage is usually of short duration. At this point, initial needs for safety, inclusion and trust have basically been met (although needing to be maintained through the life of the group). Risk-taking by members increases, and they become more talkative and interactive. Concerns regarding inclusion are fewer. Group goals have generally become internalized during this stage. There is increased support by members for each other.

The working stage is characterized by high productivity, commitment to stated goals, problem solving, and flexibility. Conflict or the expression of "negative" emotions may arise toward the leader or others as members feel safer expressing emotion. The leader's role is considerably lessened as the members move toward interdependence.

In the termination stage the leader becomes more involved again. She addresses the fact of closure and the emotions involved in leaving a group. At this stage the members may resist pulling apart. The leader restates the group and individual objectives. The group discusses what has been gained, learned, and experienced.

Role of Group Leader/Researcher

The role of the researcher was to create an environment conducive to trust and openness, such that personal stories could be narrated and sensitive topics explored. As an experienced group leader, the researcher was familiar with the significance and importance of the establishment of group trust, and cognizant of group process issues and patterns of group development. According to Corey's (1985) stages of a group, the degree of leadership involvement was expected to be greater in the early and final

sessions and less in the middle sessions. Throughout, the researcher's role was that of participant-observer.

Participant-observation, Bias and Objectivity

> Participant-observation is a special mode of observation in which the investigator is not merely a passive observer. Instead, the investigator may take a variety of roles within a case study situation and may actually participate in the events being studied . . . [This] technique has been most frequently used in anthropological studies of different cultural or subcultural groups. . .[It] provides certain unusual opportunities for collecting data. . . [such as the opportunity] to gain access to events or groups that are otherwise inaccessible to scientific investigation. . .[and] the ability to perceive reality from the viewpoint of someone 'inside' the case study rather than external to it. Many have argued that such a perspective is invaluable in producing an "accurate" portrayal of a case study phenomenon. (Yin, 1984, p. 86).

Investigator bias and/or influence is a potential problem associated with this technique. Given the dynamics of the topic, the advantages were considered to out-weigh the disadvantages. The group concept itself was considered to act somewhat as a safe-guard in that, per Corey (1985), once in the working stage the role of the leader was expected to be minimal.

Colaizzi (1978) has noted that:

> When someone is said to be objective, it means that his statements faithfully express what stands before him, whatever may be the phenomenon that he is present to;

> objectivity is fidelity to phenomena. . .objectivity, then, requires me to recognize and affirm both my own experience and the experiences of others. (p. 52)

Laing (in Allender, 1987) added that we construct reality by the way it is viewed. Embedded in the concept of participant-observation is the recognition that all research involves bias. Polanyi (in Allender, 1987) pointed out that personal process is a function of all research, irrespective of what starting points are chosen. Sullivan (1984) noted that there are two assumptions which tend to mask awareness of problems that "expert and non-objective" positions pose: (a) that the expert has distance from extraneous relationships surrounding a phenomenon being studied, and (b) that the expert is in a value-free position (i.e., unbiased).

Oakley (in Mishler, 1986) urged that "the mythology of 'hygienic' research... be replaced by the recognition that personal involvement is more than dangerous bias--it is the condition under which people come to know each other and to admit others into their lives" (p. 31). This condition was seen as central to the purpose of this study--the accessing of a depth of experience and the meaning inherent in that experience.

Procedure

All nine sessions were tape-recorded. Procedures for each stage of the group are outlined below.

Inclusion stage. Session 1: (a) clarification of both researcher and coresearcher goals, establishment of group safety, confidentiality and trust guidelines, signing of consent forms; (b) completion of the first trust, safety and inclusion exercise (see Appendix B for descriptions of exercises); (c) completion of Exercise # 2: trust, inclusion, active listening

and paraphrasing skills; (d) completion of Exercise # 3: a time line to facilitate the memory process and to develop awareness of the position of their bodily experiences, including menopause, within the framework of the events in their lives.

Inclusion and transition stage. Session 2: (a) discussion of their experience of the time line exercise; (b) Exercise # 4: sensitivity to emotions and their expression, coupled with practice in the skills of attending, active listening and paraphrasing; (c) Ludmila began telling her story.

Working stage. In sessions 3 - 7 each woman told her story when she elected to do so, and in whatever way felt comfortable for her. The role of the other group members, including the researcher, was to actively listen with respect, and to sensitively seek elaboration or clarification where necessary. The goal was to allow as much uninterrupted narration as possible. Members were given a pad of paper and a pen and were encouraged to make a note if something the narrator said sparked a memory. If a coresearcher did not finish her story in one session, she continued in the next. The previous week's narrator was always asked if she had anything further she wished to add to her story. If a story had sparked a thought, memory or question, the members were encouraged to comment either before or after a narration. Each narrator determined when her story was finished. Upon completion, each group member related how she experienced hearing the narrator's story.

Termination stage. In sessions 8 and 9, the women were asked to reflect on the stories told and heard, and to recall that the group and research goal was to explore a depth of experience and to examine meaning. They were also asked to attempt to fill in any gaps in their

stories, and to examine the "big picture" of their menopause in the context of their lives. Common experiential and reflective/ perceptive threads, as well as differences were generated and discussed, with attention to the question of meaning. Members were asked to free-associate to obvious commonalities, and to generate metaphors and/or symbols for their experience.

Transcription

The researcher transcribed all sessions so as to more completely retain a link between the spoken and the printed word. Every attempt was made to type an accurate portrayal of the spoken word, including pauses, emotions, inflections, etc. Words spoken with emphasis were italicized. Commas were used when the speaker momentarily paused while speaking. A 2-3 second pause was noted by "(pause)," with longer pauses noted by repetition of this notation for each 2-3 second pause. Sentences not closed by a period or other punctuation were those which were interrupted by the next speaker. If an emotion was not clear from the printed word, it was noted in the text. This process was seen to promote congruency with Mishler's (1986) transcription process guidelines:

> Investigators must keep in mind that speech is the intended object of study. At each stage of analysis and interpretation they must be wary of taking their own transcripts too seriously as *the* reality. . .it is important to keep returning to the original recordings to assess the adequacy of an interpretation. (pp. 48-49)

Sessions were transcribed by date and an on-going process of note-taking was maintained relating to obvious common experience and/or reflective threads, questions, meanings, discrepancies, discussion points,

etc. Upon completion of the transcript, which totalled 300 pages, the points at which each woman spoke of her experience were highlighted using a color code.

Follow-up Interview Procedure

Once typing of the transcript was completed, coresearchers were contacted individually and a time and place convenient to each was arranged for verification of the transcript. These meetings took place 3 1/2 to 4 months following the group sessions (on October 12, 15, 19, November 7 and 10, 1989). Coresearchers were asked to read the entire transcript if they wished or had the time, or, otherwise, to simply focus on the colour-coded portions which related to their experience. The transcript was left with each woman for 4 to 7 days. Each was asked to verify that the transcription was accurate. In addition they were asked to note any changes, comments, additions, objections, etc. which may have arisen after reflection on the group process and/or during reading of the transcript.

The researcher again met with each coresearcher individually for 1-2 hours during which comments were discussed. Rather than tape-record these meetings, the researcher took notes and collected any notes made by each coresearcher. The introduction of a microphone and tape recorder at that juncture was considered by the researcher to be intrusive and distancing. These notes were added as postscripts to the transcript, and were considered throughout the process of analysis and discussion.

Analysis Procedure

Underlying Philosophy

Rubin (1983) noted the difficulty in comprehending and talking about a topic which is embedded with a variety of emotional meanings and which may lie outside consciousness. She pointed out that "it becomes especially important, therefore, to be able to hear not only what is said but what is not--to listen for the latent meanings, to decode the metaphors people often use to obscure reality even from themselves, to read the symbolic content of communication that usually tells more than the words they speak" (p. 140). Rogers (1985) used the term "indwelling" to summarize a characteristic common to many qualitative forms of research:

> The scientist develops a mode of indwelling in the perceptions, or the attitudes, or the feelings, or the experience, or the behaviors of the participant. The knowledge gained from this deep empathic indwelling can then be organized in logical and meaningful fashion, so as to yield new discoveries, new approximations to the truth. (p. 13)

Throughout analysis of results the context of each woman's story and the sound of her voice were kept in mind in order to adopt the stance employed by Belenky et al (1986):

> In our contextual analysis we adopted a stance of trying to honor each woman's point of view, method of explanation, and standard of evaluation even as we grouped their responses. We asked ourselves: "What are the problems this woman is trying to solve? What is adaptive about the way she is trying to accommodate to the world as she sees it? What are the forces--psychological or

social--that expand or limit her horizons? What are the metaphors that she uses to depict her experience of growth and change?" (p. 16)

Narratives

Each narrative was considered in the light presented by Ricoeur (in Mishler,1986). He pointed out that "the activity of narrating does not consist simply in adding episodes to one another; it also constructs meaningful totalities out of scattered events. . .This complex structure implies that the most humble narrative is always more than a chronological series of events" (p. 148).

Each woman's story was interspersed throughout 18 hours of transcript and 1-2 hours of follow-up comments and/or notes. Each had initially told her story in one or one and a half sessions. These stories were of their experience of menopause in the context of their lives at that time. As such, the stories covered a wide and diverse range.

Those aspects of each woman's story which referenced her experience of menopause was then extracted by the researcher from the transcript. Attention was paid to the role of context and sequence. Date and page number of the original transcript were noted in order, primarily, that the sequence or temporal position of the comment could be noted should a question of meaning arise. Each extracted story was then read and re-read by the researcher, recalling in the "mind's eye" each woman's voice, emotion, and life story and checking the "fit" to her entire story as presented.

Common Threads of Experience, Perception or Reflection

The term, "themes," as traditionally used by phenomenologists, has not been used in this study. Instead, the terms, "common threads" and "commonalities" were used interchangeably to convey not only experiences shared by the coresearchers which related to their experiences of menopause, but also to their perceptions, reflections, actions and opinions which arose as a function of their construction of meaning.

The Random House Dictionary of the English Language, (2nd Edition, Unabridged) , defined "commonality" as "a sharing of features or characteristics in common; possession or manifestation of common attributes; a feature or characteristic held in common." "Threads" and "common threads" are terms which are used with regularity in women's writings. They convey a sense of tapestry, webs and interconnectedness--metaphors which are appearing with increasing regularity to describe women, their ways of being and their development. Daly (1978), for example, wrote of women as "spinners of cosmic tapestries" spinning "threads of connectedness" (pp. 386-392).

After the last narration (at the end of session seven), the group was asked to reflect on their past experience of menopause, those of the other group members, and on their reflective/exploration process--toward identifying common threads of experience, action, opinion, perception--whatever stood out for them as common to the group. Fourteen of the 20 common threads were identified by the group during the last two sessions. For example: "There was anger." "A stereotype definitely. Negative." "Isolation for sure." "Unfairness." These were noted and verified later by the researcher from the transcripts as applying to each of the coresearchers, based on their narrations and comments throughout.

Similar threads were then grouped, but no attempt was made to narrow those which were not amenable to narrowing. For example, experiences of confusion, vulnerability, disorientation and uncertainty were grouped as one common thread and simply named, "Confusion/Vulnerability/ Disorientation/ Uncertainty."

Only lack of time prevented the group's identification and discussion of further commonalities. The most clearly visible of these were identified during the researcher's transcription and reading processes. For example, that their experiences of menopause had an impact on their close relationships was not *identified* by the group as a common thread. There is no doubt that it would have, given more discussion time, as it was a clear, prominent and consistent element throughout their narrations.

One of the common threads did not appear during the group sessions, but arose during the individual follow-up meetings, and thus could only be identified by the researcher. This related to changing perceptions. Two commonalities may not have been identified by the coresearchers, regardless of the amount of time available. They stood out for the researcher as a function of the time spent with the women's words and voices, and of my reading in the area of women and their relationships to their bodies and bodily processes. One related to language and the second to evidence of a menstrual taboo and its relationship to menopause.

In noting these common threads, whether explicitly discussed by the coresearchers or noted later by the researcher, every effort was made, as noted by Belenky et al (1986), to honour each woman's story in context, and to honour her point of view and method of explanation. The women's metaphors and symbols for their experiences, whether explicit or indirect, were also noted.

Each woman's story generated considerable detail on her physiological experience. It was response *to* the physical experience, rather than the physical experience itself, which was the central focus of this study.

CHAPTER IV - RESULTS

The intent of this chapter, in addition to conveying research results, is to allow the words of the coresearchers to paint a portrait of menopause as they experienced it. While their experiences differed in many ways, there were a surprising number of similarities in *how* they experienced menopause--in what menopause meant to them. These similarities constitute the common threads which are the focus of this chapter.

For Rebecca, Ludmila and Lucy, menopause was on time and expected, while for Nickii and Sharon it was not. Rebecca's experience, as noted in the "Summaries of Coresearcher's Experiences" below, suggested future research possibilities relating to diet. Physically, Ludmila and Lucy had uneventful menopauses, while those of Nickii and Sharon were profoundly distressing. As a group, their last-menstruation ages ranged from Nickii's 35 to Sharon's 57, a span of 22 years. While the literature on menopause has been generally unanimous in suggesting that the experiences of menopause cannot be separated from those of midlife, Nickii's experience, which spanned ages 33-35, was far more similar than dissimilar to that of the other, older women.

Initially, several significant aspects of the research process will be discussed, followed by an overview of the process of the group. The coresearcher's experiences are then summarized. Each of the women had a metaphor and/or symbol which she felt captured the essence of what her experience of menopause meant to her. These were included within the summaries. Commonalities arising from the narratives and the group process followed, with liberal use made of quotations from the women so as to allow their words to speak for themselves. The coresearchers'

perspectives on their experiences, as reported in the follow-up meetings several months later, were detailed separately. They were considered to have added significance as they occurred in isolation from the group and following considerable reflective time and the reading of the transcript.

Significant Aspects of the Research Process

Experience of Locating Coresearchers

The process of bringing up the subject of menopause in various circles for the purposes of discussing the topic, learning the opinions or experiences of others and locating coresearchers, was overwhelmingly met with "Don't paint me with that brush, I'm not there yet!" It was clearly either shameful or insulting to "younger" women to question whether they were in menopause.

Networking, notices, and a newspaper advertisement run twice in one week yielded in the vicinity of 50 telephone calls. The advertisement did not specify the natural-menopause criterion and the great majority of the women calling had had hysterectomies. Without exception they expressed an urgent need for information and research which applied to them, and were disappointed that they could not be included in the research. In the conversations which ensued from explanation of the rationale for natural-menopause coresearchers, stories of isolation, pain, anger, invalidation, lack of information, understanding and knowledge emerged. I was profoundly moved by these stories--and by the difficulty in locating women who had not had surgery on their reproductive systems.

Time Frame

As expected, the process of meeting once a week over 9 weeks allowed the coresearchers considerable time for reflection on both their experiences and those of the other group members. Each week the women returned with thoughts, questions and memories which had risen in the interim. Such an extended process allowed for a considerable depth of exploration and reflection. The individual follow-up meetings several months later allowed for further clarification of meaning and significance of experience.

Transcription

Audio recordings were transcribed by the researcher. This process, while very time-consuming, proved invaluable in that it linked each woman's voice to the printed word. Individual moods, tones, and nuances were thus retained and embedded, for the researcher, in the typed word.

As so much clarification and determination-of-meaning occurred during the dialogue process, it proved difficult, from the original transcript, to clearly gain a sense of each woman's individual story. Thus, it became necessary to extract each woman's story from the complexity of the group transcript. This task had not been anticipated in the research design and proved to be a lengthy process. Ideally it would have been these condensations, rather than the entire transcript, which were presented to each coresearcher for validation as they clearly illustrated the process of the construction of meaning.

Group Process

By the middle of the second session the group had reached a surprising degree of openness, trust and intimacy. This high level of interaction and responsiveness continued throughout the remaining sessions and was exemplified by the group's suggestion to gather two months later for a pot-luck dinner. This rapid movement to a sense of security and intimacy was considered to have been facilitated by the trust-building and communication exercises, by the leader's nondirectiveness and by her modelling of openness and trust. Group exclusivity was enhanced in that the women had all shared a uniquely female experience about which little was known. It nonetheless took a particular courage on the part of the coresearchers to personally explore, in a group setting, experiences which, as will be discussed later, came laden with unflattering stereotypes, and for which there was little common knowledge of what constituted a "normal" experience.

Belenky et al (1986) discussed the characteristics of "didactic talk" versus "real talk." Their comments reflected the climate of the group as well as the experience of "real talk:"

> In didactic talk, each participant may report experience, but there is no attempt among particpants to join together to arrive at some new understanding. "Really talking" requires careful listening; it implies a mutually shared agreement that together you are creating the optimum setting so that half-baked or emergent ideas can grow. "Real talk" reaches deep into the experience of each participant; it also draws on the analytical abilities of each. Conversation. . .includes discourse and exploration,

talking and listening, questions, argument, speculation and sharing. (Belenky et al, 1986, p. 144)

On a number of occasions the group experience was a highly emotional one. We heard and felt pain, distress, humour, strength, laughter, ruefulness, anger, grief and sadness as the women recounted and sought to understand their experiences. This exploration of their *felt* experience, coupled with the reflective process, led to the discovery of their "way of knowing," of a greater personal understanding of *their* menopause. This was facilitated by exploration of their experience within the context of their lives, by the perspectives offered by the passage of time, and by the experience of the group interaction.

Lack of information and a resultant sense of isolation characterized each woman's story to varying degrees. Consequently, the process of hearing the in-depth and contextual stories of other women often resulted in reexamination of experiences and the development of new perspectives. These will be expanded on as common threads later in this chapter. As suggested by Mishler (1986), meanings did, in fact, emerge and develop through the discourse process.

The group reached Corey's (1985) working stage by the middle of the second session. From that point on, until the termination stage of the last two sessions, the researcher's role as leader was lessened considerably. The group, at that point, had a life of it's own in that members shared and were committed to the research goal. They established a high level of trust and openness with each other. They felt free to bring up and discuss group process and to offer differing points of view.

Coresearchers' Experience of Being in the Research Group and/or of Narrating Story

The experience of completing a time line of their lives proved to be a valuable experience for the coresearchers in that it greatly facilitated the reflective process and the location of their menopause experience within the context of their lives.

Lucy: "I thought, Oh my gosh! Look at what was going on in my life at that time!. . .The most significant aspect was starting to think about context.. . The experience of being in the group was profound for me. It gave me perspective and served as a marker for the end of a period of my life."

Nickii: "This is the first time I've ever talked about menopause with people who've been through menopause. I'm absolutely amazed at some of the similarities and the trends." For Nickii there was an "immediate and enduring healing power, sense of completion, closure" which came from telling her story "in full, in context and, most importantly, being heard. . .I was heard, versus only telling the story. That's where the completion and peaceful feeling came from. . .I felt like [my menopause] was a pretty weird period, bizarre almost. But after being here, I feel like those years, for me, were as normal as apple pie. And I can hardly wait to go home and tell my family, Hey, listen! It's not just *moi* ! Honest to God, it was real good. I didn't know. There was nobody when I was going through menopause."

Rebecca: "Some things are hurting me about my past, because I think they're not totally resolved. Some of the things [the group] raised touched things in me, [and] I noticed some of the things are not quite

finished. They've still got to come to the surface. Hearing the stories has helped me with this."

Sharon: "I got more of a feeling of validation here than I've had before, and I think it is from hearing the other stories. Like, from Nickii, and the others sharing. I'm in the menopause [support] group, and I feel really validated in there, but it's not the same. It's more in the present. This is looking back, hindsight. And they're more in the present. They're dealing with their issues and have a lot of them, like some of the things we're talking about."

Ludmila: "Being in the group gave me the support, validation of my experience and understanding that I lacked when I was actually experiencing menopause. . .Though I still resent the isolation I felt throughout my menopause, being in the group has done much to ease that resentment."

Summary of Coresearchers' Experiences

The coresearchers were each physically and socially active, healthy and articulate women. They demonstrated a desire and willingness to explore their experiences and to understand those of others.

For each the experiences of pregnancy and childbirth were generally positive. Lucy had had a tubal ligation at age 35 Ludmila had had one ovary removed and a tubal ligation at 47. Rebecca had had a miscarriage at 22, two children in her 20s, cervical cancer at 30, and a third child at 37. None reported any difficulties with PMS. Nickii was on hormone replacement therapy, which she had begun after she was post-menopausal.

Each summary following is preceded by the coresearcher's memory of her mother's experience of menopause.

Ludmila

"My mother's menopause went on in dribs and drabs, way on. . .She was in really poor health and I think menstruating was just a physical nuisance for her."

Ludmila was 59 at the time of the research. She was retired from teaching, had been divorced for 12 years, and had three adult children. As a result of her interest in women's health issues, Ludmila had done considerable reading on menopause and had become involved in leading workshops on menopause.

Ludmila had had her last menstruation 8 years prior to the research. She did not remember when she began menstruating, but felt she had probably menstruated for 37-40 years. In retrospect, Ludmila felt that her response to menopause was more emotional than physical. As a result of reflecting on her experience, she felt that her menopause process probably began earlier than she had originally thought--during the dissolution of her marriage in her mid-40s. Her last menstruation was at age 51. Ludmila considered her menopause to have been on time and expected.

"I really didn't think too much about menopause [at that time], you know?. . . I didn't really deal with it very much. Maybe I ignored it. . .I'm still feeling sadness and anger and betrayal around not knowing what was happening, not having any awareness [of the possibility of being in menopause]. . .I had very few outward signs of menopause. But certainly the emotional ones."

Ludmila's symbol for her experience was that of an infinity sign above the symbol for female. "It's a symbol of coming full circle and being sort of childlike again, and feeling free, that freedom. But underneath it is this base of. . .the cross that we bore. But it is a base. The infinity symbol [relates to] cycles going into cycles, going into cycles."

Sharon

"My mother had a terrible menopause. She was late starting also, and my grandmother was too. Yet I was never sure with my mom if it was [menopause] or if it was other pressures. . .And, so, I had no dread [of menopause] and it was a real shock to me."

Prior to her menopause, Sharon was an exceptionally healthy, active, easy-going woman. By her description, during the five-year period of her menopause she became someone she "did not like" and did not understand. Today she feels she is herself again, and more, and considers that she had a "bad menopause" gene. "The menopause, for me was *horrible*. . . hell." She had a wide array of distressing and disrupting physical experiences which had no discernable cause. She became irritable, easy to anger and cried for no apparent reason. Her life came to a standstill as she experienced a great many "throw-away" days.

She had been married, has adult children, and was divorced. She was a retired teacher, was currently living with Al, and was 59 at the time of the research. She had menstruated for a total of 45 years, beginning at age 12, and ending at age 57. Her menopause began when she was 54. This is generally considered, as it was by Sharon, to be a late menopause. She had her last menstruation 1 1/2 years prior to the research. Although her mother had also entered menopause late and had had a difficult

menopause, Sharon had not anticipated any difficulties. Her experience came as a profound shock to her. She was told that hormone replacement therapy was not appropriate in her case as she was still menstruating during the time of greatest difficulty. In order to make sense of what was happening to her, Sharon conducted extensive personal research on menopause, eventually forming a menopause support group which she was participating in at the time of the research.

Sharon had several metaphors for her experience, each of which arose at different times during the research period. Her experience of menopause was "as if somebody else was in charge of me and they were just shaking me out like a dog. I don't know if you've ever seen a big dog pick up a little dog and shake it and shake it and shake it. And the little dog bleeds all over but he still goes on shaking it. That, in a way, is what I feel menopause [did to me]. . . .My metaphor [for my menopause] was an albatross from The Rime of the Ancient Mariner, where you couldn't get rid of it. It was. . .[a] physical chain around the neck. . .He couldn't go forward, he couldn't go back, he was just stuck with it. Menopause was an albatross for me. . . Actually, it saved me too (laughing), because I have come through to the other side." Sharon felt that she was now back to being someone she likes again, with energy and enthusiasm for life.

Lucy

Lucy had a graduate degree and was a writer. She and her husband had two children, both of whom were in their late teens and early 20s at the time of her menopause. "For some reason I thought most women went into a menopausal time around 40! So, it seemed quite normal to me [to begin my menopause at 38]. . . .I had been afraid it would be

uncomfortable physically." Lucy had menstruated for 31 years, beginning at age 14 and ending at age 45. She had a tubal ligation at 35, and began the menopause process at age 38. When her periods became irregular she was, by her description, "overweight and drinking fairly heavily." At 41 she quit drinking and lost 60 pounds. That same year her daughter became anorexic.

Her menopause lasted for 7 years. At 45 she had her last menstruation 4 years prior to the research. On reflection and exploration of her experience, Lucy felt that while she had no particular physical response to her menopause, she had considerable emotional responses. "It [menopause] was relatively a nonevent. . .I have to admit, [before hearing the group's stories], I used to feel that the reason that women experienced difficulty with their menopause was because they *expected* to, and if they just took a very casual attitude towards it nothing happened."

Lucy experienced her menopause as being on time. "I knew I was going through menopause. I didn't care what the doctor said. And I still thought it was the right time (laughing). I still can't get over finding out I was about 10 years early!"

"One of the metaphors I walked around with during that time [of menopause] was of a chrysalis. A real sense of changing and emerging, and, not being sure what I was (laughing). It was like there had been a period of latency in my life, in which nothing much happened. Except other people grew up. But now it was my turn. And, that was the sense that I was starting to come out, and I was not sure I wanted to, and I was not sure what I was going to be. I, I think that it would be a very upsetting time, for a moth, or a butterfly, to have to come out!. . .It was a change

that was forced. It wasn't one that I chose. But it was one that I was involved in. An inevitable process."

Nickii

Nickii experienced an early menopause, beginning at age 33, with her last menstruation at 35. "I was *devastated.* I was absolutely devastated. . . .I was so confused. . .I didn't know what was going on. . .I still bothers me to think about it." At age 37 she was advised that she was post-menopausal. She had menstruated for only 22 years. During the five-year span from ages 33 to 38, when she began hormone replacement therapy, she experienced intense and frequent hot flashes and night sweats. "I was having hot flashes like crazy. Just roasting. Absolutely soaked in sweat. I hated it. I really hated it. . .I got so I couldn't cuddle with my husband at night. It was just too hot." She also experienced confusion, bewilderment, embarrassment, and was unusually quick to anger, and easily irritated. "I was *hysterical* so much of the time. . .it was a *really* painful experience for me. It was really painful for the whole family." The decision to begin HRT was initially a difficult one for Nickii. "I don't take aspirins, or any of that kind of stuff. It was like, *Hormones!* Seventy-year old women in Florida take hormones so they can keep on looking like they're 20." At 38 she began HRT, which she continues today. She was 41 at the time of the research. The group experience was "the first time I've ever talked about menopause with people who've been through menopause."

Nickii reported no prior memories or anticipations of menopause. However, in the process of reflecting on her experience, she realized that earlier behavior by her mother, which she had previously attributed to her mother "going crazy," occurred at a time when her mother may have been

experiencing menopause. This experience has been included under the common thread, Fear.

Nickii is a landscaper, has a Bachelor's degree, and is married with two teenage children. As with Sharon, prior to menopause she was an active, healthy, relatively easy-going woman. Nickii's metaphor for her experience was that of a "war zone."

Rebecca

"I didn't know when it [menopause] was going to come. I hadn't really thought a lot about it, but my sisters had just told me that they hadn't had their period for about a year or two, so I thought it would start fairly soon."

Rebecca is a physiotherapist, married, with three children, two of whom live at home. She had menstruated for 39 years, beginning at age 12 and ending at 51, which was also her age at the time of the research. "There may be another couple [of periods], but it feels over. My sisters all had their last period when they were 50, so it seems about right that I should end fairly soon." Chronologically, Rebecca was the least removed from menopause. As a result she may not have had the perspective afforded by the two, four, six and eight years of the others. On the other hand, her memory may have been fresher.

Rebecca was the last to tell her story in the group. A previous sense that an earlier experience of hypoglycemia was, in fact, the beginning of her menopause was confirmed for her as a result of hearing the experiences of the other women in the group and recognizing commonalties. "I associate menopause with that time when I first started

feeling hypoglycemic. That's when it starts for me, and I can't separate it too much. To me it's all interwoven."

Her experience of hypoglycemia began around age 44, although it was not diagnosed for another year. That year was an extremely difficult time for Rebecca as her life came to a virtual standstill. During that year, she experienced hot flashes, sleeplessness, weight loss, inability to concentrate, irritability, and intense emotional sensitivity. Her symptoms were eventually brought under control by a diet which eliminated coffee, tea, white sugar, alcohol and chocolate, while increasing complex carbohydrates and eating every 2-3 hours. During the group sessions the similarity between Rebecca's diet and that of Lucy, who was on a Weight Watcher's diet, was noted. Lucy did not have noticeable physical experiences with her menopause, thus raising, in the group's eyes, the possibility that diet may have been a factor in her experience. This possibility coincides with some anecdotal evidence of the significance of blood sugar levels in menopausal women.

As a connection between hypoglycemia and menopause has not been established, a decision was made to differentiate between Rebecca's experience of hypoglycemia, from ages 44 and 45, and the span of time from the beginning of her irregular periods at age 47 to her final menstruation at age 51. This differentiation is not meant to suggest that Rebecca's experience of hypoglycemia was not the beginning of her menopause. As so little is known about menopause, this remains a very real possibility. However, for the purposes of this research, and given its focus, only Rebecca's menopause experiences between the ages of 47 and 51 were considered within this study.

For Rebecca, menopause was a "catalyst for making changes." She drew a symbol for menopause which was a red circle divided by a white bar. On top of the circle was a tilted cross from which tears dropped into a pool below. The cross was meant to symbolize both women and spirituality. It was "also like a stop sign," which related to menstruation stopping. The colour red related to blood, and the tears to "the two strongest emotions which were fear and grief."

Common Threads

The majority of the common threads, both of experience and those arising from the group process were articulated by the women in the last two sessions. The remainder were noted by the researcher in the process of transcription and analysis. The descriptive phrases of the women were grouped in clusters, as in the common thread, Invalidation/Minimization/ Devaluation/Condescension. Other commonalities were more clear-cut and easily named, such as, Lack of Information.

No one common thread stood alone as each was related to, and intertwined with the others. For example, those relating to a negative stereotype and to a lack of information acted as catalysts, giving rise to those relating to isolation, invalidation, anger, embarrassment, fear and confusion. For purposes of clarity and for an understanding of the complexity of the menopause process, these latter threads were considered individually. However, when they were considered as a whole, a story of cause and effect, interrelatedness and interconnection emerged. This "bigger picture" and its implications will be discussed in the following chapter.

Several factors should be kept in mind while reading the following commonalities First, much of the power and impact of the coresearchers' stories has been lost in the process of extracting common threads. This decontexuatualizing process can have a tendency to promote "psychologizing" or analyzing of the experiences of others--itself a process which gave rise to one of the commonalities: the experience of invalidation. These women had already experienced having had their menopause named, labeled, described and analyzed by others. Consequently, as their words are clear and powerful in themselves, they are left alone to illustrate the common threads of this chapter. Thus, an attempt has been made to let the data speak for themselves. Secondly, the realizations these women have had about their experiences came primarily from an extensive reflective and exploration process. They were unanimous in saying that while *in* the process of menopause they did not have many of these realizations. Thirdly, each of the threads reflected the experience of each of the women, although the number of quotations used may not be distributed equally among the coresearchers. The quotations chosen were those which most accurately reflected the common thread. Fourthly, the quotations, excluding the follow-up interviews, spanned a nine-week period. They were products of both conversation and narrative monologues.

The following twenty common threads were located and will be discussed in the following order:

1. Naming: "The Change" or "The Change of Life" versus "Menopause"
2. First Menstruation: Entrance to Womanhood/Introduction to a Taboo
3. Premenopausal Associations to "Menopause": Entrance to Old Age
4. Experience of Loss of Fertility

5. Changes in "Femininity"/Being a Woman/Sexuality
6. Aging
7. Lack of Information and Understanding
8. Experience of a Negative Stereotype
9. Experience of Invalidation/Minimization/ Devaluation/ Condescension
10. Shame/Embarrassment
11. Isolation/Silence/Loneliness/Estrangement/Invisibility
12. Fear
13. Confusion/Vulnerability/Disorientation/Uncertainty
14. Clarification of Needs
15. Impact on Relationships
16. Grief/Sadness/Loss
17. Anger
18. Language of Separation of Menopause from the Self
19. After Menopause: Change and A Sense of having Emerged from a Process
20. Follow-up Reflections: Changing Perceptions

Numbers 2, 3, 10, 12, 15 and 18, while aptly illustrated by the coresearchers' words, were not specifically identified, named and discussed *as such* by them. Rather, these common threads were identified by the researcher as a function of the analytic process described in the previous chapter. Numbers 2 and 18 were identified through recognition of characteristics similar to those of other women--characteristics which had been discussed within literature on women and their bodily processes.

1. Naming: "The Change" or "The Change of Life" versus "Menopause"

One of the first commonalities to arise in the group was response to the word "menopause." Significant were its lack of historical meaning for the women and the extent to which it did not reflect their experiences.

Ludmila: "My mother always referred to it as a 'change of life.' I don't think I ever heard her use the word 'menopause.'"

Nickii: "I never heard the word 'menopause,' you know. It's like 'voiding' or something. My physician asked me if I'd *voided.* Pardon me! I don't think I ever heard 'menopause' until I was old enough to know a bit of biology. . .I *hate* the word *menopause* ! Nobody would use it in a poem. . . whereas when I think of 'The Change' or 'change of life,' I think of older women sitting around drinking tea, drinking sherry, and having a whale of a time."

Lucy: "Change is a long process, and that's where 'menopause' doesn't do it because it just means your periods stop. . .It sounds like a simple door you walk through, and instead of that, there's this long, convoluted process that involves all sorts of aspects."

Rebecca concurred with Lucy.

Sharon: "With a change you get the idea of time through it, whereas with 'the menopause,' you know, the way the medicals define it, you don't. And that's actually what I went through. And the other thing I realized was that it is a *process.* And being a natural process it takes time. . . that's something that was unexpected for me. . . .The menopause word itself is too limiting and too confusing. . .It's more accurate saying it's a change of life, because it really is a change. My grandmother, my mother talks about her, she stopped nurturing at menopause. And, my mother had to take over in that family. And I said to my mother, What happened to her? And

she said, She went through The Change. Isn't that interesting? More of a change than what we thought!"

2. First Menstruation: Entrance to Womanhood/Introduction to a Taboo

As menopause completed a considerable history of menstruation, the women's experiences and meaning they attached to menstruation were discussed. Along with secrecy, shame and embarrassment, menstruation meant achieving normalcy and becoming a woman.

Lucy: "I was really pleased [to begin to menstruate because] it meant to me that I was normal. . .'Cause I wasn't sure. . .When I was growing up they were still selling Kotex in boxes covered in brown paper. . . It was just something you didn't talk about very much. . .The impression I was given was this was kind of secret and not so very nice."

Ludmila: "It was almost a nonevent in a family of sisters where rags soaking in cold water were part of the household. . .It was a *very* great inconvenience having to wear a folded *rag*. I mean, it was bulky. . .I didn't want anybody to know [when I was menstruating]."

Sharon: "I didn't experience much trouble with my periods. . .My mother told me, You're going to have this thing happen to you. I looked at her, and she said, And then you're going to become a woman. . .She was very embarrassed doing it, and I picked up on that. I felt uncomfortable. . . .I *needed* privacy during that time, [to] not let people know."

Nickii: "The party line was that when you menstruated you became a woman, but I knew being a woman meant more than that."

Rebecca: "I had associated it with internal bleeding 'cause nobody had ever explained. . .I didn't like it very much because it was an uncomfortable thing. . . .It was kept deadly secret. . .I was afraid of odor.

. . .I remember a sense of shame. . . We had to sneak down before my father was up and put our used Kotex in this thing behind the boiler."

3. Associations to "Menopause" Prior to Entering Menopause

This common thread related to that of the women's experience and awareness of a negative stereotype of menopause. However, the women did not seem to have had focused or complete awareness of this stereotype until they were actually *in* the process of menopause, until they were in a position to feel the effects of a stereotype. This common thread, despite a lack of descriptive volume, suggested a certain innocence and, as will be demonstrated by the After Menopause thread, some misconceptions as to the actual lives of older women.

Nickii: "Older women."

Lucy: "Matron. Dry. Now, dry I mean sort of like all the life's been sucked out. There's no vitality left. Sort of lifeless. Dry. Colourless and Drab."

Ludmila: "Aging. Getting old."

Rebecca: "Fat. Double chins. Getting old."

Sharon: "Aging."

4. Experience of Loss of Fertility

None of the women missed the actual, physical act of menstruating, *per se*. Nor was loss of fertility related to wanting more children--none wanted more children. These factors did, however, have associations, implications and meanings for the women which arose in the discussion/exploration/reflective process. The cessation of menstruation signaled loss of fertility. This loss was distinct from whether or not the

women had previously had a tubal ligation. Sharon's comments relating to loss of fertility have been included within the common threads of Grief and Femininity.

Ludmila: "There was sadness involved because I realized I was no longer ever going to be (pause), be fertile again, although I'd had my tubes tied."

Rebecca: [The following comments were written out by Rebecca following reading of the transcript.] "Infertility--the ceasing of the ability to be a mother for all time. This has had an incredible effect on me and tends to show itself not in the wish to have more children, but in the fear of losing my existing children. . .I feel I communicate to a deeper level with my children than I ever was able to with my mother or sisters and, in fact, even my husband. Men tend to withhold on an emotional level, which one's children do not, and therefore I feel the letting go of my children when they reach adulthood extremely difficult and very threatening. . .I do not know what will fill its place--or *if* anything will. My role as a mother was by far the most successful thing I have ever done in human interrelationships."

Lucy: "Every once in a while I find myself thinking that, oh, but I can't have another child. And, I mean, it really *surprises* me, even though it's *4* years since I've even *had* a period and, um, 14 years since I had the tubal! I mean, you'd think I would have (pause), it's very, very strange. . . A tubal is just like using a very effective birth control--it's still possible to get pregnant. . . .Now, the idea of having a child at my age is just *horrible* to me! Sometimes I think, yeah, I could if I really wanted to! (laughing). . . .There was just this tremendous fear that *without* that ability, that reproductive ability, I was nothing. You know? *That's* what was

terrifying, that I was *losing* something awfully important, and I might not have anything left, at the end. And I don't feel that now."

Nickii: "[The bond between mother and child] is the strongest connection on earth. Period. And when I went to the doctor and she said that I was *post* -menopausal, *post* (pause), it hit me right here (touching chest). Immediately I realized what that meant. That means *I* can't have more children. And I don't want any more children. That didn't matter. It was, I can't have any more children. . .It was the biggest *sorrow* , you know. It was like a *weight* on my chest. I know it's *true* , but I don't really believe it (laughing). I still say to myself [deeply], *If I wanted a kid I'll bloody well have a kid!* . . .And the other thing that struck me as I was dragged on through menopause. . .it's almost become unfashionable to say how much those child-bearing years and raising children meant to us 'cause women are supposed to be able to stand on their own now, etc. (pause) So it gets difficult to express that whole, change."

5. Changes in "Femininity"/Being a Woman/Sexuality

This was a strong common thread, and the one which the women found the most difficult to articulate and to express clearly. It related to sexuality, and to a change in perception of themselves as women, and of being feminine. It was also strongly related to the common thread, Fertility, in some respects, yet distinct enough to be considered separately. This thread was also strongly interrelated with that of Grief/Sadness/Loss. As Ludmila noted, "It's kind of one big ball of wax."

All the women experienced, in varying degrees, having drier vaginas. For some, this was problematic to their sex life, for others it was

not. Their response to this experience seemed to relate most directly to this commonality and was thus included here.

Lucy: "Ugly. That's how I felt. . .Very sexless. Perhaps to say mannish is wrong. Just, sexless. Like I, I was no sex. [Nickii: Even though you were very slim, having lost 60 pounds?] Oh yeah, I mean, that did not make me feel feminine . . .I was waking up sweaty hot at night. . . .An image came to me of my uterus being ripped out. I mean, I know that sounds violent and bizarre, but I felt a sense of loss [then]. Now that a couple more years have gone by I no longer feel that loss. . . .Then I worried that I might become this strange amorphous creature. . . .I almost felt like I had become a man. I mean, I was afraid that I had lost all my feminine hormones and that I didn't look feminine any more. . . .I started feeling like I wasn't really a woman anymore. I really didn't know who I was!. . . .When I was around 12, before I started my periods, I felt like a very *powerful* person then. I wasn't a woman. And I wasn't ever going to be, as far as I could figure out. I felt much more like I feel now, then. It just seemed like I was, I didn't have a lot of the encumbrances that I've had, as a woman. Children, your kids, things like that. That I was free to be *anything*. You know? I can believe that again." For Lucy, association to a drier vagina meant "not very receptive, *inhospitable*. An inhospitable environment."

Ludmila: "Sexless (flat voice). Absolutely sexless, and *un* - feminine. . . one of the biggest reasons for my sadness, and why I felt like a *nil* . [Lafern: What does "unfeminine" mean to you?] Um, not attractive to the opposite sex, um (pause) (pause). Feeling like I was *used* as a woman, instead of having *worth* as a woman. You know? I was worthwhile for what I could produce and provide for my husband and my

family. I didn't feel my own *worth* as a woman was there." A drier vagina meant "getting old, or at least not able to cut it any more." [Nickii: Being accused of not being aroused.] "Yes! Right! Right! Less sexual. . . And the guys, I went with one of them, and I used KY jelly, and. . .to him it meant that *he* was not capable of arousing me to the point where I was producing juice, that it reflected *back* on him. So he didn't like the thought of me using KY jelly." Ludmila had experienced men asking her if she was sexually active. "They mean, am I dry? [The fact that they're asking] means that they've had dealings with women who are dry, and they don't want to have to go through that problem."

Nickii: "My sex life is really different, post-menopausally. I mean, we're talking *drop* here. . .It doesn't seem that long ago to me that I can remember being a young fox, and, it was like, *men* , God, they were so great! I mean, it was like I couldn't hardly stop myself from responding to men. . . and *now* . . .I gotta be in the right mood, have the right conversation, which is weird, because I'm young, you know? I'm young. . . .[Even with HRT] I'm still drier [in the vagina]. Using cremes, I find that really embarrassing [and] a real turn-off. And I take it personally. I feel lacking. . .I don't feel as feminine (pause), that way. . .Menopause *does* affect this man-woman dynamic because, for me it changed it because *post*-menopausally, I am not as able to *compete* (pause) in the, in some of the stereotypical ways that I was premenopausally. [Lafern: What's the difference?] I put on weight. And slimmer women are more attractive. . . I have hot flashes, which I found *the* most unattractive, physically unattractive of it all. . . Um, and then, I also wasn't calm, and gracious, and flirtatious. I wasn't as *capable* of that mode of behavior. So, the proximity of people to me far more often triggered my being upset than it

did my wanting an interplay with them of some sort. . .*I* don't think that I am *physically* as attractive as I was premenopausally." [In reference to a close male friend]: "I would *never* tell him I'm in menopause." [Lafern: What do you think would be his reaction if you told him?] "He wouldn't think I was an attractive young woman anymore, even though we're just friends. It would change his attitude." [Lafern: Even though he finds you attractive now?] "Yeah!" [Lafern: What is it about being in menopause that would make you appear unattractive if he knew that about you?] "(Pause) Well, because you can't have periods anymore and because you're dry and a little older when it happens to women and, it's just a whole different [thing]. . . . There's so much *female* energy on being desirable, and all that stuff." Nickii's response to what having a drier vagina meant to her: "Being accused of not being aroused. And the confusion and the fear and the sorrow and the grieving that goes with all of that, and [then] comes some anger."

Sharon: "My sex drive has always been steady all my life, until I got to the menopause. I couldn't *stand* to have any sex, you know, have anybody touch me or anything. My body just seemed to resent that. Then I would get very excited, like, you know, the other extreme. And at times I got quite worried because that time when I didn't want it, it lasted for quite a long time. I'm fine again now. I'm quite even. But, now, I'm more aware of my sexuality than I was before menopause. Before it kind of happened, it was just there. It was quite a shock to me to just not desire. And so much so that I couldn't even stand touch. . . .One thing that hit me at the beginning of the menopause is that I became an invisible woman, sexually. You know, that age had all of a sudden come to me. And I don't know why that was. I don't know why that happened at that time, that, that

sort of information came in. . .I think up to that time when I walked down the street I'd always get looks from men. . . . .There's an insidiousness that goes on by men that put you down so that you lose your self-esteem. . .in one way or another. . .I get the comeback on how big [my breasts are] all the time. I mean, how many women do you hear talk about men's testicles or penises?. . .I mean, the thing is, we could put *them* down in the same way but we don't, you see. . . We don't attack their vulnerability, but they attack *our* vulnerability that are brought about by our society, like we have a perfect mold of what woman should be. . .There is a perfect mold for the man, also, but we don't *tackle* the men, the men tackle us. . .And our self-esteem is really lowered by it. . . .For instance. . .men decline in their sexual ability after 40. And they can get into severe troubles. Some of them quit by the time they're 50. And yet, and yet, women take *that* on. They say, Well, he doesn't find me attractive anymore, I got wrinkles, let me go out and get [some anti-aging] creme."

Rebecca: "I became very aware of the masculine/feminine sides of myself. I didn't feel masculine, but I was very aware that there was a strong masculine side of me, but I saw it as the other side of my feminine side? I don't know how to say it right. I saw that there were two sides, a masculine and a feminine. . .I think menopause makes you look at certain things. Now, I don't know if it's because you're very vulnerable at that time, or that you come to have this feeling that you lost. . . .a lot of your attractiveness, so maybe you start looking at what you have *left*. I don't know exactly the process, but, it's something like that."

6. Aging

That menopause specifically signaled loss of youth was a strong common thread among the women--including Nickii who was post-menopausal at 35. It brought the undeniable reality of familiar cycles ending, periods no longer occurring and fertility, beyond any doubt, no longer possible. Menopause served as a clear and visible marker of the aging process. This thread is particularly intertwined with those of Fertility, Femininity, and Grief.

Sharon: As noted earlier, Sharon linked menopause to aging. "Age had all of a sudden come to me."

Lucy: "It's a real recognition that time moves on. . .I was now an older woman. I was never going to be a young woman again. . . . Menopause was a signal that I was getting older. . .It is not okay to get old. It isn't. It's okay to be 50 if you look like Joan Collins, but, if you don't, it's not alright. What kind of a message is that?"

Ludmila: "I was dealing with my aging. At least, I *wasn't* dealing with it. I was trying to delay it as long as possible. . .I wasn't thinking in terms of menopause at that time, I was thinking more in terms of aging, getting older, 'cause nobody around me was talking menopause. . . Menopause means aging. Getting old. . .Definitely aging was a problem for me."

Nickii: "I'm not scared about aging, and I don't think about getting old and dying. . .Yet somehow when, when I *knew* I'd gone through menopause I knew that I *was* aging, that time was marching on. And somehow I just knew the kids would leave too. And that was the first time it hit me, that it really occurred to me that they would go."

Rebecca: Rebecca also linked menopause to aging, adding, "getting old bothers me, a lot. . .During the last year [of my menopause], I noticed a *lot* of difference in my body. It felt like a lack of elasticity, or something. My muscles all seemed to be going to, just goo!. . .I thought, My God, I really am getting to be an old person!"

7. Lack of Information and Understanding

Lack of information about what one is experiencing is, in itself, isolating, confusing and fearful. In this sense, this common thread, as with that of a negative stereotype, often operated as a catalyst, giving rise to other threads.

Rebecca: "[My doctor] gave me a pap smear and it was really sore. [I asked], Why is it so painful? She never said anything! And it wasn't until months later that somebody said that this happened to menopausal women that I realized that that was why it was so darn sore."

Lucy: "I. . .needed to know some of the information that's been exchanged in this group, and that some women have a very difficult time, and some of the ways that they can recognize when these things are happening, and more information of what symptoms might be associated with menopause, more articles in magazines that [don't] gloss over and immediately say [it's nothing]. 'Cause I've read too many of those, and that's why I came up with my pat response to you that. . .if you're having this, take that. [We need to know] that sometimes there isn't anything you can do. Sometimes you just need to know that this is a normal thing you're going through and that it will end. . . .I was denying my body."

Nickii: Nickii went for 2-3 years without knowing what was happening to her. She was told several times by various physicians that she

was too young to be in menopause. "It was night and day when I finally found out [what it was that was happening to me]. It was easier to take. I still had the sorrow, the loss, the confusion. I was still *vulnerable* all the time. But I *knew* something was happening with my hormones. . .so I knew I wasn't crazy. . . It made a big difference to know. . . .If I had known that you guys were going through the same thing, it would have made a big difference to me. . .It was night and day when I found out what it was. It made a *huge* difference to me. . . .The stuff in the pamphlets in doctor's offices, the 'Chin up, Dearie' is irrelevant. It assumes you're making your own self miserable. It doesn't address the real issues. Women need hard-core questions answered, such as, How long will this last? A hug is not enough. I'm grieving and confused. Let's talk about what's happening. . . Physicians so often end up saying to a woman, Don't be ridiculous. They're so far off. At worst it's condescending, at best it doesn't address the real issues. A pep talk about exercise or positive thinking, etc., is not what's needed."

Ludmila: "Menopause *never* entered my head at that stage of the game, never. . .I didn't know myself anything about menopause at that time. . . .We never talked about it. There was nothing in the magazines 'cause I used to read Chatelaine and a lot of women's magazines and stuff. . . .I never had the chance to think about the fact that I *might* be in menopause, [that what I was experiencing might be related]. . .I was so healthy all my life. The only time I went to a doctor was when I was having children . . .I don't think I felt it *then*, but now, thinking about it, I really feel I was betrayed."

Sharon: "[If I'd known about the range of possible menopause experiences], I'm sure that having that knowledge, I would have handled

things a bit better, or differently, or something. . .And nobody, I had *no knowledge*. . .If I could have had some knowledge that it's *okay* , it's okay for your nerves to be bad. That's part of it. . . .When you dig down into it, it's all there, it's all understandable. But nobody could give me that. One doctor did say, go to a counsellor and at least you can talk it through. And that helped."

8. Experience of a Negative Stereotype

This common thread was thoroughly interrelated with most of the others and, in particular, played a significant, if not a source role, in the following common threads: (a) Invalidation/Minimization/Devaluation/ Condescension, (b) Isolation/ Silence/Loneliness/Estrangement/Invisibility, (c) Shame and Embarrassment, and (d) Anger. The quotations presented here are those in which the women specifically addressed their experience of a stereotype. The remaining common threads will provide numerous further examples which expand on this theme. As noted by Ludmila and Nickii, at times some aspects of the stereotype were accurate.

Sharon: "Crazy. . .And that's an excuse to ignore you so that you're just blocked. There's a wall that comes up and you're ignored. 'She's menopausal. I just can't handle her.'"

Lucy: "Unpredictable. [That menopausal women] get *strange*. I mean, I think that's the biggest one. She's *menopausal*. . . .Don't pay any attention to her. They're going to stay this way forever. And when they get out of it, they're going to be these strange, grey, dried-up creatures."

Nickii: "Irrational. . [Lucy: Don't pay any attention to her, she's menopausal.] *Exactly! Or, Geez, Fred, they're pretty irrational, aren't they? Hah, hah.* . . .The stereotype was true for me, about the irrational

part. Fair enough. But what's offensive about it is the condescending nature of it. . .You know, the *not* listening, and really knowing how it is for the woman from the inside out. . .Those stereotypes, they made it harder for me. They still make it harder for me. "Cause, like I say, I don't tell people."

Ludmila: Sour old bags. . . .At some time or another we probably all contributed to the stereotype ourselves."

Rebecca: "A negative picture. . .I didn't want people to know I was in menopause. I think it was sort of protective."

9. Experience of Invalidation/Minimization/Devaluation/Condescension

Throughout each woman's story-in-context were experiences of invalidation and devaluation, both directly and indirectly connected to menopause. Only those relating specifically to menopause were included here. A feeling of being devalued also appeared, as noted above, in the common threads of Femininity and Aging. The experience of not feeling *heard* was also central to this experience.

Ludmila's experience of devaluation and condescension centered on her experiences related to the common thread, Femininity, and are described within that section.

Rebecca: "[When I was 45] I went to a doctor [for heavy bleeding and erratic periods], and she said it was too early for menopause. I really felt that was odd. . . . I have *not* been given validation for my opinions [and that] goes back to when I was a little girl."

Nickii: "I went to my doctor and I said, I *may* be going through menopause. And she said to me, Don't be ridiculous, you're too young. . . You *look* too young." This experience was repeated twice for Nickii.

"When Russ said to me, You're going through menopause, I just thought he'd insulted me and that how I was feeling or how I was behaving wasn't valid and that I was some hysterical woman or whatever. . .If I'm upset about something and I'm screaming and yelling, and he looks at the calendar, or he says, Are you taking your hormones right now, then I could *really* kill him. It's like, what's bothering me is not valid. I mean, there's something *really* bothering me. . .If people stay calm and listen to me, in the beginning, then I'm okay! I won't fly off the handle. But. . .if someone cracks a joke or pretends that it isn't really happening it's like, Whit! I'm gone. That's it! I'm gone. . .Once I get going I don't stop, until I've said everything I have to say. And I don't know how to not do that. . . .My husband says, *Why are you shouting?* And I said, *Do you hear me?* And he said, *Well, you said it five times!* And I said, *Well, you still haven't answered me!* "

Sharon: "[Al] gave me what I call pseudo-sympathy, in that he sympathized with me. But I often-times felt that he was sort of looking at me with a jaundiced eye wondering why I just couldn't, you know, be stoic and just get up out of bed and do, and so on. . .A lot of doctors said, Go home and just meditate, you know? Just relax! It's all up; here [pointing to head]. It isn't. . .[A woman doctor said], Never mind, dearie, my mother was finished in a year and you will be too. . .Everybody that I talked to either hadn't had these experiences or they kind of looked at you as if you were a little bit tiched up here, you know. Or else, Well, what are you complaining about?. . .People would look at me [and] say, Gosh you look well! And there I was, dying! Or ready to die. . .You're supposed to look green to get sympathy. . .One of the things I felt most strongly through menopause was that. . .I had those symptoms!. . .and my

behavior was a result of being in that stage. And it annoys me to no end that I don't get that validation. I don't get it from doctors, I didn't get it from my family and I don't get it from most women. . .I was told, Just think positively."

Lucy: "I said to my doctor, I'm starting to notice my periods being even more irregular. Do you think that could be menopause? He said, Don't be silly. And of course it was. It was right when I expected it. . . What women experience [at that time] are dismissed as, *She's menopausal. Don't worry about that.* . . .I had put my energies into being a mother, and being, you know, housewife, and all that sort of stuff. And the start of my menopause to me was a signal that part of my life was over. And the *unfairness* I felt was that, when I was finished, and ready to move on. . .I did *not* get support from my family in doing this. . .Everybody was very comfortable with me being there. And I knew my job there was finished. But nobody was willing to let me go. . .What I wanted was some attention to me, the person, who hadn't been there for a long time. Who had, sort of, been pushed aside [because] I had been a role for a long time. . .And now I was going to be an individual and *these* people [my husband and children] were not ready to think of me that way."

10. Shame/Embarrassment

Ludmila: Ludmila's experience of embarrassment occurred in relation to her sense of femininity/sexuality--at feeling "unfeminine" and "sexless," at not having worth as a woman, and with respect to aging, of not meeting a standard of femininity.

Rebecca: "To me it was the age thing. . .I felt *old,* and if I told people they would *know* I was *old.* So, I didn't want to talk to people about it."

Nickii: "The only thing I hear from any of my girl friends [is] Oh, no, not me yet. . .There's a taboo somewhere. . .When you're having problems with your little kids you tell everybody in the world, and so do all your girl friends. Do you know what I mean? So it's a different type of a problem. . . There's *shame* associated with it. And we think of it as *that* type rather than, um, a *human* kind of problem. . . . It is weird. . . There's some kind of pride in there for not telling anybody too." Nickii found the experience of hot flashes and night sweats extremely embarrassing. "And feeling that I *looked* weird. I mean, I was *dripping."* Nickii eventually went on HRT. "I didn't tell anybody. I mean, I was some embarrassed. . .The whole thing felt so covert, you know?" With respect to changes in her sexual responses: "I don't tell anybody about that either." Making reference to a very close male friend: "I would *never* tell him I'm in menopause. I would be *very* embarrassed. I don't tell people." With reference to having a drier vagina and subject of using a lubricant: "Getting cremes or using, I find that really embarrassing."

Sharon: "[It] embarrassed me terribly that I had an *awful* odor. Terrible, terrible odor. I went to doctors and they just shrugged their shoulders. I used to be very, very self-conscious about that. . .[I'd] get weepy. I mean, I got so embarrassed. I'd go to a movie and there I'd be, tears coming down. And I couldn't control it. . . . I can tell you that during that time I became a person I did *not* like. I didn't like me at all." Sharon also experienced embarrassment when her mind would go "blank" and she couldn't continue speaking. "Often times I'd just stand there and

look at people and have nothing come. And this is from a very articulate woman."

Lucy: "I would have trouble telling people [about being in or past menopause]. . .Like, I'm not *embarrassed* about it, but I would think about what other people might think. . .Just like I had some preconceptions about what 'menopausal' meant, and it meant getting old. And so, if I tell somebody, I'm post-menopausal, they're going to think, she's old. So, why would I tell somebody? It doesn't make sense. . . .We're ashamed of it [menopause]! We're *ashamed* to admit that we are following the common fate of womankind by going through menopause. . . .I remember in women's groups where it was discussed, and it was, 'I'm *dreading* it.' But mostly we act like it's not *happening!* We are able to talk about a friend's menopausal problems, but nobody in the group would say, You know, *I'm having problems too."*

11. Isolation/Silence/Loneliness/Estrangement/Invisibility

As Nickii's menopause was so early, her sense of isolation from her peers was profound. This experience was, however, common to all the women in varying degrees. It was closely related to the common threads, Experience of a Negative Stereotype, Fear, and Lack of Information.

Nickii: "I knew *nobody* who'd been through menopause. I didn't know a soul. . . .I was really *alone* , 'cause I didn't have anybody to talk to, you know?" With respect to changes felt in her sexuality: "It was *alienating* to me to have that happen to a woman in her 30s. . . .It's very clear to me that menopause is a lonely experience. . . .I've mentioned that I take hormones to 2 or 3 women, max. And all women about my age, contemporaries. And every one of them has offered to give me herbal tea,

or tell me how to get off them, or whatever. So, I don't tell anybody anymore. And I am very attached to these hormones. I'm very attached to them. They calm me down. . . .As teenagers, *my God,* we talked over very *detail* [of menstruation], and the same with childbirth. . .What happened? I mean, how come we didn't share this experience with each other?"

Rebecca's experience of isolation related to her experience of a negative stereotype--of not wanting to let others know she was in menopause, the need to protect herself from the responses of others.

Ludmila: "Nobody around me was talking menopause, you know?. . The subject didn't come up, and that's why I didn't really realize that was what it was for me. Why did we *clam* up!. . .I *wish* my mother were alive. I would *love* to be able to talk to her more about these issues."

Lucy: "I have realized in this group that I do not know whether my sister, who's two years older than me, has been through menopause. And, my good friend, I realize she must be, because of her age, be going through menopause. It's something that never came up. And we're good friends."

Sharon: "There's 25% [of women at menopause] who have a really bad time. And I fall into that latter category, and I can assure you, there's no sympathy out there. . .when you're bad and you really, really need help, there is no sympathy out there. . . .Nobody could. . .steady me and say, Look, you know, it's okay and, yeah, it's just nature and it's doing it's thing. . .I had a great deal of loneliness. . . There was no (pause), sort of support group or someone to hold my hand or anything. . .Al is still a man, and men don't experience these physiological changes. They don't have a monthly period. They don't have babies. And to try to gain an

understanding there, it's pretty hard. . .they still go on with their own lives. . . [Everyone] was sympathetic, but that's not understanding. . .[and] didn't take away from that experience of being alone. . .People distanced themselves. Or they look at you and they say, suggest that you're crazy or something. There's that underlying theme. . . Menopause is so long lasting. I mean, if you're sick for 3 weeks people are willing to give to you, but they're not for 5 years. And that's what we're dealing with.

12. Fear

Fear related to not knowing what was happening to them and/or fear of losing their mind, of "going crazy." This theme related to lack of information and understanding, fear of the unknown, shame and embarrassment, and loss of fertility.

Rebecca: "[When I was around 45] I really started bleeding extremely heavily, almost, frighteningly to me. Because I would be afraid to go out sometimes on the second day of my periods because there would be floods of stuff. . .Being infertile meant fear of losing my existing children."

Lucy: "It was just sort of this tremendous fear that *without* that ability, that reproductive ability, I was nothing. You know? *That's* what was terrifying. . . .It's the process you're afraid of, because you don't know what happens next, hence, a lot of fear for me, in not being sure what it was going to be like being on the other side."

Nickii: At home, it was frightening how fast I could get upset. And I mean *really* upset. . .my body would be trembling. Everything inside me would be kind of like dancing around. . . .When I say I know I'm not crazy, I didn't know. I didn't know. I was really afraid, because my

mother *is* crazy. What I would call crazy. . .I think my mother is a schizophrenic, and an alcoholic. I left around 16. (pause) Never to return. And she had been wonderful. She'd been very loving, playful, and I adored her. There was just her and I. And then she got really *strange*. . . .and [would] just scream at me. . .I guess for years I had a nagging fear that I would go that way. And it scared me, like, for my kids, because I really love them (crying). And I thought, What if I started doing that to my kids? You know, like she did it to me?" [Sharon: How old was she at that time?] "I've been thinking about that for the first time. . .She was 36. . . .She turned into a monster to me it felt like overnight. . .It just really breaks my heart (crying) to think that it might have been the menopause with her and she didn't know and I didn't know."

Sharon: I worried all the time. I was *sure* I had a tumor, cancer. . . It was a scary time too. I can remember truly thinking, wondering, questioning whether I was going out of my mind. That's because I didn't know I was in menopause. I hadn't even thought about it. And it's very, very frightening to have those tremendous ups and downs. . .I really thought I was going crazy. I didn't recognize this person. I became this ugly slob (crying) who had no control."

13. Confusion/Vulnerability/Disorientation/Uncertainty

This common thread related to lack of information and to feelings of loss of control with respect to body changes which were not understood--for example, weight gain which appeared unrelated to changes in eating habits or amount of physical activity, hot flashes, night sweats, and drier vaginas. It related to experiences of emotional upheaval which threw them into a "validity dilemma," a struggle to sort out what was "hormonally

related" and what were "valid issues or feelings." It related to the common threads of Femininity and Fertility, as will be discussed in the following chapter.

Ludmila: "I had periods of depression and weepiness and irritability. . . I have so few memories of those years. . .I want to find out what was going on for me then. . .I don't know what was happening to me. . . .[My menopause] was emotional --depression, mood swings, crying jags, instead of physical."

Lucy: "I was going through so much *emotional* distress during that time, that I might have been totally unaware of any physical symptoms I was having. [Referring to her metaphor, menopause as a chrysalis]: I remember I went through years wondering whether I was going to come out as a butterfly or a moth. But, the creature that comes out doesn't fit anywhere. I mean, what is a woman? Someone who bears children? Someone who is attractive to men? You know? Someone who cares for people? And, the woman who comes out of menopause doesn't necessarily want to be any of those things. I mean, she may still *want* to be attractive, but perhaps she no longer is [by society's standards]. She *can't* have children, *and* , she no longer has this great wish to care for everybody. So, who is she/me?. . .It's not that it's not exciting, but it's scary too, because there's no anchors. . . Extremely vulnerable. . .There was a real sense of changing and emerging, and, not being sure what I was. . .It was like there had been a period of latency in my life in which nothing happened. Except other people grew up. But now it was my turn. And, that was the sense that I was starting to come out, and I was not sure I wanted to, and I was not sure what I was going to be. I think that it would be a very upsetting

time, for a moth, or a butterfly to have to come out. . .It was a change that was forced. It wasn't one that I chose. But it was an inevitable process."

Nickii: "My doctor said, I'm very sorry, but you have *completed* menopause. . . I was devastated. I was absolutely *devastated* (crying). What happened? I was so confused. I felt very vulnerable and confused. . . .It was like everything was signed, sealed and delivered. And I didn't even know anything about it! What was going on?. . .[I had terrible] mood fluctuations. . . .I was upset a lot. . .During that time I *couldn't sort out* what was really bothering me. What was hormone poisoning [or not]. . .I would be so frustrated and angry! And I'd never know if it was valid or not. I found it very confusing, because when I calmed down, and I thought about what had happened, I could always see Russ' side of the story. But at the time, I was *crazed.* I mean, you only have to get that upset two or three times a week to colour your life. It was horrible. It was really hard. . . .It's very stressful for *me* , to be upset, to be feeling these things. . .The huge dilemma that I lived with for about 5 years [was] what's a valid complaint and what isn't? Because when I look at the men's point of view too, it's very easy for them to say, Oh, a hysterical woman. But, on the other hand, in all fairness, there *were* times when I was hysterical, and I would just as well prefer that he didn't take it all that seriously. You know?. . .It's certainly annoying to be very upset and have it brushed off as hormonal. It's *terrible.* It's a tough one. . .I think one of the *hardest* parts of menopause for me was making the distinctions. You know, am I really upset or am I under the influence of hormones?"

Sharon: "When I started into my menopause I found that all of what had been familiar to me, that I could check into, disappeared. I had no cycle anymore, yet I was still menstruating. . .I could find no organization

in it. And I couldn't count from one day to the next what was going to happen to me. . .I got terribly annoyed very quickly. And I've *never* been like that. Never, never been like that. . .My emotionality, it was just not under control. Like, I feel now [post-menopausally] under fairly good control. . .I just kept saying to Al, this person that you're looking at now isn't me. It isn't me. I really disliked me, who I became. . .Here I was, a very active, energetic, going woman, up to my eyeballs in doing things, involved. And all of a sudden I became this debilitated person. And *nobody* could give me any answers. I went from doctor to doctor. . .Yes, you're in menopause, and, yes, one thing I can tell you, it's going to end. . . and you just keep on mucking through. And that was his answer. . .What bothered me was that I never knew when I was going to be better. We're talking years here. . .If somebody had come around to me and said, You know, you're crazy, I probably would have believed them! Because there was nothing to hold on to. . .It's so hard for me to separate, like, [is it] a problem between us, or menopausal? In a sense, it inhibited our resolving our differences and brought extra tensions because that frustrated me [that the validity of my feelings was doubted], yet, what could I say? I knew I wasn't a very likeable person then. I *wasn't.* I had no barriers to saying anything. I'd just roar it out anyway. . .I felt so many frustrations, like, is this really fair, being blamed in this way?. . .My *patience* ran out! . . .I became this person I didn't know, and behaved in ways that I didn't understand. . .I just wasn't used to this person. . .Feelings of sadness became torrents of sadness. . .It's not [that I was sickly] but as if the interior's not what it was supposed to be."

14. Clarification of Needs

During the early weeks of the group, the women sought to express a feeling which related to unmet needs. The words were difficult to find until Sharon, in an outpouring of frustration and anger, was able to articulate the collective experience. Sharon and Nickii clarified the need and the feelings which accompanied those needs not being met. The following dialogue demonstrated the essence of this strong common thread, and, while it originated with Sharon, it was shared by all the women.

Sharon: "Instead of us getting *treated* in a way that accommodates *us* for going through this *hellish* period, we go through an apologetic period. You see what I mean? And it almost makes me want to cry even now. I mean, why should I *apologize* for something that's going on in *my* body that I *can't* control in that way?. . .I needed *care* . But I didn't get care. Now how do you give someone care? You say, Look, what would you like me to do? Do you want me to sit with you for a while? Yes, I do. I need company right now. You come and sit with me. *That* would be *care* . . . Would you like me to do supper? Yes, I'd like you to do supper. Do you need time alone? Yes! I need time alone! All that cotton-pickin' understanding that isn't there! Even with the doctors it isn't there.

In *puberty*. . .with the kids we say, Oh, well, you know, he's going through, give him a bit of time, give him a bit of space. . .But we don't have that. . .Women are made to feel *guilty* about being in the menopause because they get into these situations that are triggered. . .and you're made to feel guilty when people trigger you. . .You should be given *space* during that time, and you're not. . .I heard a doctor say that with PMS the family needs to know that during that time, those days, that they lay off. Leave you be." Nickii: "That's right!" Sharon: "I think that during

menopause they should lay off." Nickii: "*That's right!* That's the *closest anybody* [has come to expressing how I feel. It's] *back off!* " Sharon: "That's right. And you should have time out." Nickii: "*Let me be!* " Sharon: "Like, Look it, I may need five years, but you guys back off because I'm. . .out of *order!* Back off!

There's a great need for *education* , like, if you need time out, or you're out of order, or however you put it, you need that time. And it's really important." . . .Nickii: "I was *very crowded* for those years, and it pissed me off. So if people had *backed off* more, the way you are in a professional environment, more so than in your own home, I would have had a lot more peace of mind. . .But I had no idea at the time. I had no idea until Sharon said it. That's all I needed. Just to let, leave me be. Leave me be." Sharon: "There was sympathy, but there wasn't action. . . Because you're upset within yourself, because of the hormonal change, the problems that are going on in your life, you can't deal with them."

15. Impact on Relationships

For each of the women, relationships with their children, husbands, and friends were affected by their experience.

Ludmila: "Because I *was* by myself [for much of my menopause] . . .I was lucky because, whatever came up for me, I dealt with, and, if I didn't feel like cooking a meal or something, I didn't have to. . .That's why my menopause was reasonably sane."

Nickii: Nickii's husband, Russ, also experienced isolation in that, "he was all alone too, 'cause there was nobody he could talk to. What's he going to do, tell his buddy his wife is picking on him all the time? That's not very loyal. Not very manly. He didn't say much. My heart goes out

to him, all of us. . .It took me (pause) another year, after taking hormones, to recover my marriage. To even discover that I still wanted my marriage. I think there was a *lot* of damage done. When I calmed down, and I think about how those years were from Russ' point of view, it really breaks my heart. . .I picked on him something terrible. . I discovered he really *does* love me. I figured he didn't all those years. I figured he was *deliberately* trying to bug me. I had no doubt about that. . .I think it was because I was so easily *annoyed* that I kept drifting further and further away from him.

Sharon: I think it would have been worse going through it with [my ex-husband instead of Al]. I think I would have murdered him. . . The problems Al and I had, he blames on the menopause. He calls it the chemical changes. And, I know that my buttons don't get pushed like they were before.

Rebecca: "[My husband] *had* to go through a lot, because I was not the woman he married. . .He had to deal with my changes."

Lucy: "I never related the physiological changes I was going through to [what I was feeling, and now I think] about when I'd want to get up from the table [when sitting with my family]. I did not want to be with those people. I wanted to be away from them." For Lucy, these feelings related to the long-term implications of loss of fertility, which are discussed in the following chapter.

16. Grief/Sadness/Loss

This was a strong common thread in the group and has already been illustrated in many of the above themes. It was thoroughly intertwined with, and generally arose from other commonalities relating to femininity/sexuality, loss of fertility and aging. Occasionally, more

generalized expressions of sadness and loss relating to menopause were expressed, as in the following quotations:

Lucy: "I was coming to terms with some feelings I had about being a mother, that went back to when I was a child, because my own mother died when I was five, and, I had wanted to be (pause) a better mother than anybody else in the world"

Nickii: On learning she was post-menopausal: "I can remember every step of that walk home. I passed a rose bush, and I took a cutting, which I rooted, and this rose is growing in the back of my house right now. But I, I just, I really don't have the words for it. I know how I felt. Really *sad* . I just felt really *sad* (crying).

Ludmila: "[Speaking sadly] I realized I never was nurtured."

Sharon: I think there's sadness on all our parts. I think there's always sadness when you close off parts of your life. I grieve for some of the things I did when I was young. And I grieve for when my kids were little, because I did have really good times with them. . .I didn't get the basic *care* that I needed [during menopause]. I needed caring! Really deep caring. And he never gave it to me. My daughter never gave it to me. And my mother, I told her once about it, and she immediately took the old English stoic trip, *Oh, you can't be like that!* Well, Hey, Ma, I am like that."

17. Anger

Anger ran through many of the above common threads, and was thus a thread in itself. The experience of feeling invalidated, condescension, of not feeling understood or heard in the fullest sense, of feeling isolated, of

not having needs met, and of lacking information all acted as catalysts to anger.

18. Language of Separation of Menopause from Self

There was a tendency for the women to speak of their menopause as if it was separate from the self. Their language was more often that of dissociation of self from body--"it" or "the," versus "my" menopause. "It wouldn't let me go;" "I wasn't free;" "What's real and what's menopause?" "Each day I didn't know what was going to happen to me." This separation will be linked to the other common threads in the following chapter.

19. After Menopause: Change and A Sense of having Emerged from a Process

Nickii: "I've always liked kids and pets. Now I really like them. I mean, to get up in the morning and to go home and pick up my cat, it's just so soothing. And I really appreciate moments of calm. . .I'm getting more and more energy. . .When all was said and done, I felt like a heroine, that I had survived, and my marriage survived! . . . .The grieving process is important. I'll have a better post-childrearing time *because* I grieved not being fertile any longer."

Ludmila: I really enjoy being the age I am. . .I think women in menopause, especially in post-menopause, become more *eccentric* about [being a woman, feeling pressure to be attractive to men]. I mean, I think we decide, Well, to *hell!* Who needs a man!. . .I think you become your own person. Like, you are no longer pussy-footing around and trying to decide, now, is this going to be okay with my husband, etc. You're free. . .

to think the way you want to think. . .I don't *need* a man to make me whole. I am whole by myself. . .Invisible is more what I feel *now* , after I *am* post-menopausal. I was walking down the street. . .feeling *very in* - visible because [men would] never be looking at me. And that's okay. I don't have to worry whether I'm dressed right, or whether my bust is big enough. I'm in my own world. It's a freedom. . .to be eccentric, to express yourself in the way you want."

Sharon: "I'm back to me! I really like me now (laughing). . .I've owned my own life again. And that's called for a renegotiation [with my family]. . .There *is* a life after menopause. And it isn't the dry, grey area. Actually, I find it a real freedom. It's *marvelous* not menstruating. Really marvelous. My energy stays like this, like a man's (laughing). I mean, it has little burps, but very little, 'cause before. . . .with the monthly you'd get tired, and so on, just before. . .I find that I have what I call an 'I don't care' attitude that's almost frightening. Like, I challenge professors in front of mobs of people. I mean, I never did before. . .I go back to that period just before I graduated from high school. I have that same kind of feeling now, like the world belongs to me. I can remember doing silly things and getting away with it. Because after I became a woman I couldn't. And now I can again. Now I can again. And I don't have that, Now you mustn't say this because you'll offend him. You mustn't say that or else you'll upset the kids. Now I don't have to worry about all that because I *don't care* anymore. That's like I was when I was a teenager. . . I've made it through. I think I should get a medal made of gold."

Rebecca: "I found that my nurturing changed. I wanted to pull away a bit from this looking-after I was doing. . .I really feel like I started being myself. . .I've not had that freedom before. [It's] something to do with this

whole procedure [that] has now given me permission, or something, to be me. I don't know why I didn't have it before, but maybe it needs something critical to happen to make you realize that these things are important to you. . .Even though I feel I haven't become completely *me* , yet I feel so much stronger than I was before I went through menopause."

Lucy: "Now I no longer feel the sense of loss I felt then. I mean, right now I feel like someone. And I don't worry that I might become this strange amorphous creature. . .Feeling attractive did come back gradually. . . .I *trust* myself a lot more than I did back then. . .and I *don't* expect authorities to be able to fix things for me. And I don't expect that I'm capable to fixing everything. . .By the time I was told I was post-menopausal, I was starting to feel feminine again. . .[and] in a much more cheerful frame of mind. . .The further I get away from that turning point, the more I realize that it *wasn't* the finish that I thought it was. . .I thought I was going to feel old forever, and I don't. I *forget* that I'm my age. . . I'm actually very pleased to have that behind me. . .It's almost like a birth again. It's like going through a *dark*, very difficult place. For me it was *emotionally* difficult, rather than physically difficult. . .I feel less vulnerable. . .Now I feel a lot stronger than I did when I was a young woman. I felt very vulnerable then, when I was reproductive, and much less vulnerable now."

20. Follow-up Reflections: Changing Perceptions

This common thread included comments and notes made by the coresearchers primarily during the individual follow-up meetings 2 1/2 to 3 months after the group sessions. The central purpose of those meetings was to have the women verify the accuracy of the transcript. They were

invited to make whatever comments came to their mind. There were no formats or predetermined questions. As a result, their comments and notes reflected what was of significance to them and/or areas they continued to struggle with. This thread, as with many of the others, reflected recognition of two change processes: that which occurred during their menopause, and that which occurred as a result of the exploration/reflection process generated by their group experience.

This commonality comprised several aspects, themselves interrelated. First, an awareness of the impact on their lives, at that time, of the largely unrecognized loss of fertility and/or youth, plus perceived changes in femininity and sexuality. Included was awareness of the impact of a negative stereotype, isolation and lack of information. Secondly, was an appreciation of the power and impact of hormonal changes. Thirdly, was an awareness of an interconnection between body, mind and emotion.

Sharon: "Before I could never understand middle-aged women committing suicide. I believe they [may] go into a bad menopause. . .or else they end up [in an institution]. . .Right now, I'm back to where I was before menopause. And the emotionality that I experienced was of a hormonal nature, with possibility some cultural stuff. . .Doctors have a vague idea about it, but they really don't have the essence of it. . .We really need to educate women about it, and the men about it, and families about it. Like, Hey, this is a tough period you go through, and you're not going to knock the women around who are going through it. . .In hindsight, I hated going through 'the change.' I felt betrayed by everyone and everything that I had taken for granted--my body, my partner, my family and my society. I was not prepared for the shock. . .I see menopause as a double bind. . .Society has preached the principle of being stoic, which often

works, but in this case, it only makes a woman feel guilty. . .The sad part is that the menopause lasts for years, testing everyone and causing me to feel that I was a failure. I had to let important others down. I did not (nor could I) act in a way that was expected. Because of this, others withdrew support, giving birth to the loneliness that haunted me. . .Now, this time is for me. It is a big relief. My nurturing days have passed!"

Lucy: "Because I wasn't getting any physical symptoms I never related any of the psychological changes I was going through to anything that was happening to me physiologically. . .I'm aware that physical symptoms can be much broader-ranging than the simple end of periods and hot flashes. . .It's fascinating to me that I was going through hormonal changes at a time that was emotionally upsetting for me. . .Having children is a deep human experience, a profound connection. The issue was not losing kids, but the connection. . .Menopause heralds an identity crisis. . . Issues arise again at menopause. . .Part of me didn't fully acknowledge that I was experiencing menopause. Menopause was a non-event, physically. If I'd had symptoms I would have connected with the fact that my body had changed. I was denying my body."

Ludmila: "I believe now that the ups and downs I experienced [before leaving my marriage] were related to my hormonal changes. . .I'm more convinced than *ever* that a lot of what I was feeling [just prior to leaving my marriage] related to menopause. I had *no* concept of that then. It never entered my head." Ludmila felt that her experience resembled Lucy's in that because she didn't have any major physical symptoms, she never related any of the emotional changes she was going through to anything that was happening to her body. Ludmila continues to wonder what would have happened in terms of her marriage had she had awareness

and information with respect to menopause] "Did my ex-husband mention the word 'menopause?' I have a faint recollection of it, but likely dismissed it. . .Nickii saying that she couldn't stand being touched reminded me that I couldn't either. That was one of the problems we were having."

Rebecca: "What I'm beginning to realize is that everything, the emotional, the different layers, it's all menopause. . .I think [during menopause] you're very aware of your needs. You're very aware that you can't *give* to other people just now. You need to be the one being given to. . . We need to change our language here. Instead of, I'm feeling whacky, or crazy, or whatever, we need to say, I need lots of love today, or, I need help today. . .I think maybe we should be the first ones to say it's a time when we need lots of love, and lots of support, and say the positive things. Because all you hear is crazy, and fat." Rebecca felt that, with menopause, both the young, sensual role and the fertile mother role go at once, and that menopause means saying good-bye to children. Her role as a mother was the one with the greatest human contact, the only role with a deep human connection. Menopause indicated the end of this most profound connection, without the promise or likelihood of anything else to take its place. Rebecca also felt strongly that her experience of hypoglycemia was connected to her menopause, and was disappointed that it was not considered as such within this thesis.

Nickii: "I think hormones are generating things, all on their own. . . But on the other hand, to be *that* thrown, to be that confused, to be that vulnerable, certainly gives an opportunity to express all those other feelings that would be there because of life. . .The connotations *are* different about post-menopausal women and pre/prior-menopausal women. . . .When my behavior was irrational, my husband's first thought was

menopause. He picked up on the stereotype of the hysterical woman at menopause. He didn't know that 33 was generally too soon for menopause. . . .We celebrate birthdays and wedding anniversaries which are small in comparison to the implications of either entering or leaving menopause. . . Regarding the femininity issue: The sorrow and confusion I felt also related to being a full-bodied woman, and losing some femininity in the transition [of menopause]. On a scale of one to 10, I went into menopause as a nine, and came out as a six or a seven as a Woman, capital W.

More than shame [with respect to menopause], there's a longing, grieving for loss, for the feeling of being a fox, a woman in her 20s." [Lafern: What did the 20-year-old have that you don't have now, in this area of femininity? What's different?] "Slim, healthy, feeling beautiful--to do with my body and men--ease of motion--the way men would react and I would to men--[tied in with] a great interest, willingness and ease of response. . . a light, easy, fun, playful way of being with men. That type of connection is not easy now. Everything now has to be right (regarding sex), whereas earlier it was easier. But the bonds are stronger now. That playfulness that can come with my body being up to standard, that requires an ease of being with self. We're at odds with a standard of femininity; the package, the wrappings have changed; but our physical standards haven't changed, the ideals are the same. We're out of synch, so we lose confidence, spontaneity."

CHAPTER V - DISCUSSION

Within this chapter limitations of the study are outlined, and a portrait of menopause is painted through first a brief summary, followed by a discussion of the common threads as they interrelate. This is followed by the theoretical implications of the study, its implications for counselling and suggestions for future research. A summary concludes the chapter.

The physical experiences of the coresearchers varied widely, ranging from the extremes of Sharon and Nickii to Lucy's "non-event." The reasons for such variation remain unknown. In addition to the 20 common threads, Sharon and Nickii experienced profoundly difficult physical disturbances related to fluctuating hormone levels. The extent to which the common threads were influenced by the hormones, or the hormones influenced by the common threads also remains unknown. The purpose of this research was examination of the meaning attached to the experience rather than of the cause of physical variations in experience.

Limitations of the Study

This study reflected the experiences of five white, middle class, educated, North American women who experienced the cessation of their menstruation naturally. Other women, and in particular those who have had a hysterectomy, or who have never had children may, or may not experience menopause differently. Some of the coresearchers had had tubal ligations which again may, or may not have influenced their experience of loss of fertility. Women who have either never been fertile,

or who have never had children may also experience some aspects of menopause differently.

This research is restricted by its numbers, in that only five coresearchers took part in the study. On the other hand, such an in-depth exploration of the experiences of more than five was beyond the mandate of this research.

This study was restricted by its time-frame. Further aspects of the coresearchers' experiences would have no doubt been generated had more time been available. In addition, had time allowed, greater detail and/or clarification of the common threads may have been possible. The validity of the threads would have been enhanced by having had them available as a list for the coresearchers to verify specifically during the follow-up meeting. On the other hand, the extended amount of time the researcher spent with the coresearchers may have offset this factor.

Finally, since the data were comprised of self reports, they were limited to what the coresearchers were able to report. In addition, as with any group, there was always the possibility that the coresearchers' perceptions may have been affected by their group experience. The benefits of the methodology employed were considered, however, to greatly out-weigh their possible disadvantages. It is this researcher's conviction that "group think" was not a factor during the group process. This is attributed to both the time spent on trust building in the initial sessions, and on the coresearchers' strong sense of self.

An Emerging Portrait of Menopause

The common threads which emerged from these women's stories were the product of both their personal and their group reflective and exploration process. As a result of this process they were left wondering what their menopause experience would have been like had they and their families had a fuller understanding of what was happening to them at the time.

Prior to full awareness of being in menopause, the coresearchers sensed that their "change of life" was approaching. As menopause had been defined medically they sought medical confirmation of this sense. With the exception of Sharon, who experienced a late menopause, they had, at this early stage, suggested to their physicians that they were in menopause. They were told, however, that they either were too young, or that they looked too young. This experience of not being heard and of having their experiences invalidated would be repeated throughout their menopause.

While the coresearchers were strongly influenced by the medical definition of menopause, they resisted a disease definition of their experience. This was perhaps most clearly demonstrated by their response to the term "menopause" and by their preference for their mothers' more descriptive terms, "The Change," or "The Change of Life."

Their menopauses can best be described as a continuum of experiences differing in degree rather than in kind. They experienced the themes with varying intensity over the span of their menopausal years. For one, sadness seemed dominant, for another it was confusion. A portrait emerged of an experience which was profoundly influenced by an original menstrual taboo and a negative stereotype of menopause. Silence, secrecy,

shame and embarrassment were central to this taboo and stereotype. Silence and shame breed lack of information and misinformation. These dynamics resulted in experiences of isolation, invalidation, condescension, confusion and vulnerability. These experiences were, in turn, central to the coresearchers' feelings of sadness, anger and fear.

This portrait also included a three-fold process which emerged from the 20 common threads: (a) loss, (b) redefinition/readjustment, and (c) emergence. With respect to the first stage of this process, loss, the women experienced loss of cycles, fertility, youth, visibility, roles, credibility and of previously-defined sexuality, femininity, and attractiveness. They lost a position of value and worthiness as a fertile being, which was inexorably linked to a cultural identification of femininity, sexuality and desirability. These losses were generally not recognized at the time and were therefore not accredited, by themselves or by others, with the validation of genuine losses for which grief and sadness would be appropriate responses. The relationship of the common threads to the stages of grief will be discussed later in this chapter.

These losses were coupled with the isolation engendered by the lack-of-information-taboo-negative-stereotype syndrome. It was a time of felt vulnerability and of a heightening or escalation of emotions in general. Irritation became anger, sadness became "torrents of sadness." The vulnerability which was a product of this process heightened their awareness of a need for the nurturing and "deep caring" they had given to their families over the years. This deep caring was rarely forthcoming and added to their feelings of sadness and/or anger.

The second stage of this three-fold process, readjustment, grew out of their responses to these losses. They were aware, sometimes in the

moment, sometimes not until later, that "something was happening to them," that they were "out of step" with who they had been, but did not understand why. They struggled with self-doubt with respect to the validity of their emotions. If they were physically feeling their menopause they felt devalued and insulted when their experiences were considered by others to be solely hormonally driven or, conversely, as solely the function of cultural influences. While they did not fully understand what was happening to them, they appeared to intuitively reject black and white, either-or explanations for their experiences.

Their physiological changes, regardless of how overtly they manifested, marked a tangible, concrete end of two central functions/roles which were profoundly intertwined with their conceptions of themselves as women at that time in their lives. The losses inherent in these changes appeared to act as catalysts in precipitating the process of redefining some essential element of themselves in relation to their femininity--a redefinition of self, femininity-womanhood, and role-position-value in society. A redefinition of their relationships with those closest to them, in particular to their spouses, was a consequence of this process.

Menopause was a time when they more strongly felt the need for "space." The enormity of the task of redefinition of self appeared congruent with the need for processing/reflective time, which could be interpreted as a need for space--particularly when this process was infused with embarrassment, shame, isolation, devaluation and a profound lack of information. They were going through considerable changes, on physiological and emotional levels, and required time to assimilate, reflect, adjust, and process what was happening to them. As mentioned earlier, they were not usually able to articulate these needs at that time. Nor were

they aware at that time of just what it was that needed so much processing, and why they needed space. They did become aware of anger toward their loved ones when these needs were not met. Ludmila considered that one of the reasons she did not have a difficult time with menopause was that she had the space she needed. She was not married and did not feel, as is common to women, the pressure to put the needs of others before her own.

During menopause the women ceased long-term familiar cycles and ceased to be fertile. They also experienced loss of value as a sexual being at that time. As a result, they were forced to alter their concept of femininity--and they had to do so in the face of powerful cultural messages which defined femininity, value and desirability in terms of fertility and youth. They were faced with the task of redefining an aspect of their feminine selves, to determine who they were beyond their sexual and fertile roles.

Menopause marked the point after which they could no longer call themselves young women, or fertile women, and as such served as a marker, as an introduction to the aging process. This had different meanings for the women. Aging equalled a perception of loss of femininity/sexuality and/or loss of children. When the threads of interrelatedness were untangled, both became the potential for loss of connection. With respect to loss of children, which was the case for Lucy, Nickii and Rebecca, the most profound connection they had ever experienced would soon be ending, bringing with it grief, sadness, and sorrow.

Their ideals or expectations of how they *should* experience menopause were clear. Menopause should be a non-event. If a woman experienced difficulty with menopause she should endure it silently, keep

busy, get in shape, and cultivate a positive attitude and a sense of humour. She certainly should not inflict her emotional state on others.

Not surprisingly, this was a period of high stress and confusion for each of the coresearchers, although at the time the source was not necessarily attributed to either their physiological changes or to the meaning or implication of those changes. In their follow-up interviews both Ludmila and Lucy, who had had relatively uneventful physical experiences, had come to feel that much of what they experienced at that time in their lives was, in fact, related to their menopause--to a combination of the effects of fluctuating hormone levels, physiological changes, and the meaning and implication of those changes.

The third stage of the three-fold process, emergence, was illustrated by the coreserchers' sense of having come through a process and of having changed. Within this common thread, the coresearchers spoke of resolution of loss, acceptance of self and development of perspective on their experience. This acceptance of self was achieved at the price of sexual "invisibility" and perceived loss of value by society. With the exception of Nickii, who experienced an early menopause, being post-menopausal involved gain rather than loss. The women felt a sense of having emerged from a process, of having "come through." They had a clearer sense of self as separate from and beyond their roles. They felt a strength and freedom from the vulnerability of fertility and sexual objectivity. In a sense, this was the freedom of invisibility. They were released from confusing emotions. In most cases the fears or anticipations felt during menopause were not realized. They had gained strength, sense of self, and with it a certain freedom. They had not lost their sexuality, and had gained the freedom of being "over the hill," and therefore no

longer visible, "on the market" or "in the running." They were in some ways released from the restraints of the "Madison Avenue" conception of femininity. No longer being fertile served as a rehearsal and/or a marker for no longer being defined in terms of their roles as mothers. They felt considerable freedom to finally explore who they might be beyond these roles.

Theoretical Implications

Change was not singled out as a common thread in itself as it was obvious, central and inherent to the coresearchers' experiences. Consequently, it was the nature of the change which was of interest. The terms, "The Change" and/or "The Change of Life" seemed to allow for personal ownership of the process. They were terms which conveyed a sense of normalcy, of a developmental process, of the passage of time, and of change. They were grounded in history, connected to the past, and to their mothers and grandmothers. On the other hand, "menopause" was embedded with negativity and depersonalization. It had clear illness or disease connotations and was considered to be "owned" by the medical profession, not by the women. As Nickii said, nobody would use "menopause" in a poem--it is not life affirming and honouring of women, nor is it invested with possibilities, hope or enthusiasm. "The Change" and/or "The Change of Life," however, seemed to have this potential.

The coresearchers' first menstruation set the stage for its ending. It introduced them to the menstrual taboo, which they felt in greater or lesser degrees. As documented by Weideger (1976), "the sense of shame about menstruation is instilled as soon as menstruation begins. . .This shame

continues throughout her life and is experienced into menopause. Any sign that menopause exists, for example, is as much a source of shame for a mature woman as the signs of menstruation are for a younger woman." (p. 9).

A taboo is maintained by silence. Silence reinforces shame. Silence limits self-knowledge and knowledge of others in that experiences are not shared. Silence creates and enforces isolation. Silence and isolation allow others to define experience.

The coresearchers' language of separation of self from body and of menopause from self supported Weideger's (1976) conclusion that women "have inherited the beliefs that menstruation and menopause are not really a part of a woman's life and that the feelings stemming from either state are not as 'real' as our other feelings. The denial of menstrual and menopausal realities, whether by women or by men, is part of the taboo of menstruation" (p. 10). Nagy (1987) noted that women are accustomed to "not being themselves," and of experiencing an intensification of their emotional life around the time of their monthly menstruation. She added that women sometimes do not notice their periods because society expects them not to notice. The experiences of the coresearchers suggested the possibility that these factors may, for some women, extend to menopause.

Martin (1987) also found a tendency for women to speak as if their menopause were separate from the self. Sennett and Cobb (in Martin) noted that "dividing the self defends against the pain a person would otherwise feel, if he had to submit the whole of himself to a society which makes his position a vulnerable and anxiety-laden one" (p. 19). Frank (in Martin) added that "many elements of modern medical science have been held to contribute to a fragmentation of the unity of the person. When

science treats the person as a machine and assumes the body can be fixed by mechanical manipulations, it ignores, and it encourages us to ignore, other aspects of ourselves, such as our emotions or our relations with other people" (pp. 19-20). Martin further argued that women "suffer the alienation of parts of the self much more acutely than men. For one thing, becoming sexually female entails inner fragmentation of the self. A woman must become only a physical body in order to be sexual" (p. 21).

Rubin (1983) noted that we are more likely to see stereotypes than the human actors who suffer conflict and confusion about their socially prescribed roles, and who struggle with the stress of trying to play their parts according to the script. Taboos and negative stereotypes both give rise to and result in lack of information, misinformation, "myths" and misdirected research and "treatment." Lack of information and understanding, coupled with a taboo and negative stereotype gave rise to experiences of confusion, invalidation, fear, anger, minimization, isolation, etc.

Minimization, invalidation, devaluation and condescension were experienced by all the coresearchers with respect to menopause. This theme is corroborated by Cobb (1987) who noted that one of the popular views of menopause is that it is trivial, and that the "pangs of female physiology" are imagined. Without exception, each coresearcher spoke of being invalidated and/or not having her needs met by the medical profession. Another aspect of this commonality, intertwined with and arising from the common thread of silence, was a general nonrecognition by others of the fact that everyone has varying degrees of sensitivity and awareness of their bodily processes.

Not feeling heard was also central to the coresearchers' experience of invalidation and minimization, as well as to their experience of anger. Belenky et al (1986) found that it is not uncommon for women to feel that they haven't been heard. "Even among women who feel they have found their voice, problems with voice abound. Some women told us, in anger and frustration, how frequently they felt unheard and unheeded--both at home and at work" (p. 146). This experience appeared to have been heightened amidst the complex dynamics of menopause.

Posner (1979) and Stimpson (1982) have suggested that the women's movement literature has tended to minimize menopause by dismissing its physiological component and by adhering almost solely to a social-psychological-cultural model of menopause. Posner suggested that while "[medical] texts suggest that adjusted, nonneurotic women who are in control of their lives will exhibit little problem with menopause, feminists, in their enthusiasm for negating women's low status based on the menstrual cycle, have tended to make some of the same assumptions, although accompanied by a different explanatory theory" (p. 182).

Menopause was also felt to be minimized in much of the popular literature. There was a tendency to focus on suggestions for improved life-styles, exercise and nutrition, coupled with admonitions to develop a positive outlook on oneself and life. These may insure a more comfortable experience of menopause and health in general, but, as expressed by Nickii, "At worst its condescending, at best it doesn't address the real issues."

It is perhaps not surprising that even if a woman did have a strong physiological response to menopause, she may choose to remain silent about it. Openness would appear to be an invitation to negativity and devaluation. Sharon concluded that "it's a no-win situation for women."

Martin (1987) has suggested that women's hesitancy or shyness in discussing menstruation or menopause may not be a consequence of a negative stereotype. Rather, choosing silence may be women's way of intuitively protecting themselves from the labelling and categorizing which are inherent both in a stereotype and in a disease definition of their experience.

The coresearchers experienced varying degrees of feelings of confusion, vulnerability, disorientation and/or uncertainty during their menopause. Aside from all the factors previously mentioned, including lack of information, this confusion appeared to stem in part from escalation or magnification of their emotions. For example, sadness became "torrents of sadness" and previously felt frustration became anger. Miller (1986) has noted that "we have a long tradition of trying to dispense with, or at least to control or neutralize emotionality, rather than valuing, embracing, and cultivating its contributing strengths" (p. 38).

This study supported Berkun's (1986) findings with respect to confusion and anxiety about physical deterioration during menopause. There was a similarity between the theme of shame/embarrassment and Berkun's feelings of guilt related to the inability to control and hide signs of bodily changes.

The fear experienced by the coresearchers during their menopause related in part to the fear of not knowing what was happening to them at the time, as well as fear of what lay ahead for them. Lack of information was central. There was another aspect of fear which was more difficult to name. It appeared to be related to the potential for loss of connection, for loss of their ties of connectedness which existed, at least in part, as a

function of their roles as sexual and fertile beings, mothers and sexual partners.

During their menopause the coresearchers struggled to make sense of their experiences in what could be described as a vacuum--an absence of information and understanding on all fronts. During the research process a growing awareness of the experiences of other women, of the range of possible experiences at menopause, and of what menopause meant to them made a considerable impression on each of the coresearchers. They felt a heightened sense of connection with other women and normalcy with respect to their experiences. Each spoke of the profound difference such information would have made on her experience of menopause.

For the coresearchers anger was a theme on two levels: (a) anger which occurred *during* menopause, and (b) *generated* anger which occurred during the group process. This generated anger was that which emerges from the development of a broader or wiser perspective--when one knows one has something to be angry about. It related to the extent to which much of what was painful in their experience was a function of the position of women in this society and to the negative impact of a taboo and stereotype.

Martin (1987) has noted that, with respect to PMS, anger is often listed as a symptom in a syndrome. Anger (or frustration, irritability or hysteria) is also a component of the stereotype of menopause. Martin's comments with respect to anger and PMS offer a perspective on the anger the coresearchers recalled experiencing during their menopause:

> In fuller accounts we find that the reason anger expressed by women is problematic in our society is that anger (and allied feelings such as irritability) makes it hard for a woman to carry

> out her expected role of maintaining harmonious relationships within the family. . .Her own anger, however substantial the basis for it, must not be allowed to make life hard on those around her. If she has an anger she cannot control, she is considered hormonally unbalanced and should seek medical treatment for her malfunction. If she goes on subjecting her family to such feelings, disastrous consequences--construed as a woman's *fault* in the PMS literature--may follow. (p. 130)

Again, the centrality of connection was indicated by the coresearchers' concern and sometimes even fear over their anger. This anger, in the moment, often appeared to relate to their need for space and to the difficulty, if not impossibility of meeting that need. Anger also related to not feeling heard, feelings of invalidation, minimization, devaluation and condescension, and to lack of information and understanding.

Miller (1986) has noted that women often have difficulty recognizing and clarifying their own needs, either to themselves or to others, and that, if highly charged with emotion, these needs may be difficult to discern. The identification of needs may also be hampered by fear, the source of which is kept obscure by taboo, negative stereotype and lack of knowledge. In addition, Belenky et al (1986), Gilligan (1982) and Miller (1986) found a central theme in the voice of women to be that they should devote themselves to the care and empowerment of others while remaining "selfless." Even during the research process the coresearchers did not find that the clarification of their needs came easily. These needs amounted to a need for nurturing and "deep caring," as well as for space.

Not surprisingly, the coresearchers' experience of menopause had an impact on their relationships with their loved ones. They struggled to

determine what was valid concerning what they were feeling, what was fair, whether they were expecting too much and what their responsibilities were. As the Belenky et al (1986) study indicated, "Even when the women held strongly to their own way of doing things, they remained concerned about not hurting the feelings of their opponents by openly expressing dissent. . . Once again we saw that sustaining connections with others prevail in the stories of women" (p. 84).

The subject of connection--whether desire for or fear of loss of--has appeared a number of times in the above discussions and warrants further examination. Miller (1986), among others, has written at length on the importance of connection to women (and to men as well, although generally more easily identifiable in women). "Women stay with, build on, and develop in a context of connections with others. Indeed, women's sense of self becomes very much organized around being able to make and then to maintain affiliations and relationships" (p. 83). She added that depression, which is related to one's sense of the loss of connection with another(s), is much more common in women, than in men. For women, "affiliation is valued as highly as, or more highly than, self-enhancement" (p. 84). Miller has pointed out that women learn very young that they are "related to other human beings [and] in their hands as well as one's own" (p. 87). According to Miller, this strength on the part of women has not been cherished or even recognized. On the contrary, when women act on the basis of this underlying psychological motive they may be considered to be suffering from emotional problems.

Miller (1986) and others have linked the need and desire for connection to women's development. With respect to research on women's development, Belenky (1986) summarized that many more women than

men define themselves in terms of their relationships and connections to others, that women are rooted in a sense of connection, and that this concept is central to an understanding of gender differences in human development. For a woman, to take a stand against others, as in anger or confrontation, means isolating herself socially and thus jeopardizing her connections to others.

Belenky et al (1986), Gilligan (1982), Miller (1986), and others have noted that separation and individuation, the keystones of traditional developmental theory, can leave women feeling vulnerable and unconnected. Belenky et al concluded that:

> If and when scientists turn to the study of women, they typically look for ways in which women conform to or diverge from patterns found in the study of men. . .We have learned a great deal about the development of autonomy and independence. . .We have learned less about the development of interdependence, intimacy, nurturance, and contextual thought (Bakan 1966; Chodorow 1978; Gilligan 1977, 1979, 1982; McMillan 1982). Developmental theory has established men's experience and competence as a base-line against which both men's and women's development is then judged, often to the detriment or misreading of women. (pp. 6-7)

The coresearchers experienced varying degrees of sadness over the loss of fertility. This sadness was not associated with the desire to have more children. It was also felt by those who had had a tubal ligation. It may be that the association of menstruation with fertility is too ingrained in women's psyches to be removed by the historically recent advent of tubal

ligations. It seems probable that as long as a woman continued to menstruate, on some deep level she would continue to perceive of herself as fertile. As Lucy said, a tubal ligation was simply effective birth control, not nonfertility. Menstruation meant fertility. Fertility meant value, desirability and an essence of womanhood. Loss of fertility meant loss of value, desirability and an aspect of femininity. Weideger (1976) noted that:

> The menopausal woman has had her social education. Within its framework her soul is now of little importance because fertility and "dangerous" menstruation no longer form part of her being. Her body is no longer unclean, but it no longer serves its most "important" function--that of giving form to fertility. (p. 200)

With the exception of Sharon who experienced a late menopause, loss of fertility signified eventual loss of children--even for Nickii, whose children were young at the time. This was related to loss of role as a mother. The clearest and strongest loss associated with loss of fertility was not loss of the motherhood role per se, but eventual loss of *connection* and of value. Motherhood was, or had been, a deep and profound connection. They knew, long before their families did, that this role, their value, and the role's potential for connection were coming to an end. At this time they appeared to feel, perhaps more profoundly than ever before, the need for recognition and valuing of themselves, for themselves, beyond and separate from their roles.

The coresearchers felt some degree of loss of what was termed "femininity." A significant aspect of this femininity appeared to be related to sexuality. Sexuality was related to societal definitions of attractiveness, which were, in turn, related to youth. Menopause unequivocally signified

the loss of youth, and the onset of aging. Some of the women experienced what they felt to be a hormonally induced loss of sexual interest. Four of the five experienced drier vaginas which were unrelated to degree of sexual arousal. Having a drier vagina was associated with some degree of loss of sexuality, and thus some loss of femininity.

As noted in many writings from the women's movement, for example, Jaggar (1983), the women felt evaluated in terms of their bodies and their sexuality, both of which were linked to their concept of femininity. This theme coincided with Japanese women's "loss of sacred function as a woman" and of their "value as a women decreasing" (Lock, 1986). Weideger (1976) wrote, "Most women become sexually invisible after menopause, not because of any mysterious or well-known physical upheaval but because the culture expects them to" (p. 212). She also added, "What could more easily drive a woman to the point of breakdown than to find herself at an arbitrary, biologically defined point in her life stripped of her identity as a sexual being" (p. 214).

Anticipation of losses related to their mother role, and losses related to femininity (brought into focus with menopause) appeared to have set up a struggle within the women. As the culture provides few visible role models for life after menopause, they seemed to be faced with incorporating these losses into their conception of themselves--to answering the question of who they were beyond these aspects of themselves. Part of the confusion and fear experienced at that time, in addition to the general lack of information available, appeared to have derived from this redefinition of self.

As demonstrated by the coresearchers' experiences after menopause, they had been freed from the restrictions of their sexuality and fertility

roles. For Nickii, having had such an early menopause, this remained an imposition and loss rather than a gain. For the others, once they were post-menopausal they were free to learn who they were beyond these roles. Feelings of loss, confusion and vulnerability passed and were replaced by self-confidence and feelings of strength. They experienced a return to feeling attractive. Sexuality had not been lost. There was a sense of having "come through," of having experienced change, and of having come full circle--back to reconnecting with, or picking up on where they left off before their sexual and fertile roles.

Although it would appear to be self-evident that any physiological change, particularly in women in this culture, would be accompanied by some degree of emotional experience, this component of menopause has been largely ignored in the literature. What women experience around the time of their menopause process has been attributed to everything but menopause: to an "empty nest syndrome" (Parlee, 1976), negative attitudes towards aging, role changes (Flint, 1975), perceived loss of femininity (Deutsch, 1945) and a general negative attitude towards menopause and aging in Western cultures. Yet, when menopause was explored in depth, with attention paid to the meaning attached to the experience, a far more complex picture emerged.

It was not loss of fertility, as such, which was of significance to the women--i.e., none wanted more children. Rather, when the "big picture" was examined it was what loss of fertility ultimately meant to them which was central. Loss of fertility meant loss of a major component of the concept of "femininity." It meant loss of youth, visibility and attractiveness, and therefore of value. It meant loss of role: as a woman, as a valued fertile being, and as a sexual being. With the exception of

Sharon, it meant loss of the mother role--whether this loss was upcoming, on-going or past. A component of these losses appeared to be a fear of loss of connection. As noted by Rubin (1983) and others, "some part of what we have traditionally called a woman's dependency is, in fact, a deep and primary need for attachment" (p. 149). Rubin added that connection may feel as necessary as the air a woman breathes. "This is the need that underlies her ability for deep and abiding connections with others, while it also consigns her to a painful struggle to maintain the boundaries of self" (p. 151).

This research suggests a developmental component to menopause. The meaning behind the physiological changes which form the basis of menopause may precipitate the developmental task of redefinition of self. It may be that when a woman is no longer fertile, in the final sense of the word, her self as separate from her roles as childbearer, mother and sexual being can emerge.

Within the literature the concept of menopause has been essentially reduced to a consideration of the physiological process alone. This virtually exclusive focus on women's physiological experience has contributed to an ignoring and/or devaluing of what the experience may mean to women. As with all experiences, it has meaning. Being a significant physiological change in cycle and function, both of which have been historically and intrinsically linked to women's value and definition, it would seem likely that the question of meaning would be significant, and worthy of consideration by both researchers and by women themselves.

There appears to be a tendency, both by women and within the literature, to suggest that menopause has no special meaning because most women do not want more children and do not miss no longer menstruating.

However, as suggested by this research, there are implications and meanings attached to the cessation of menstruation and the loss of fertility which may not be readily available to our awareness. Given the dynamics surrounding menopause--silence, isolation, negativity, detachment and confusion--a lack of awareness does not seem surprising. Cultural ideals and stereotypes are powerful forces, "shaping not only our ways of thinking and doing but our ways of being as well, giving form to both the conscious and unconscious content of our inner lives" (Rubin, 1983, pp. 2-3). In this case, it becomes especially important, therefore, "to be able to hear not only what is said but what is not--to listen for the latent meanings, to decode the metaphors. . . [and] to read the symbolic content of communication that usually tells more than the words they speak" (Rubin, p. 140).

There has also been a tendency within the research on menopause to attempt to isolate it from the context of women's lives. For the corsearchers, context was central to their construction of the meaning of their experience. It was consideration of context which facilitated a deeper understanding of and perspective on their experience. They, in fact, came to consider many of their experiences at midlife as having their *origin* in their response to menopause. That they did not have this awareness during their menopause is understandable given their experiences of confusion, lack of information, etc.

Women who have physical difficulty with menopause are devalued by the tendency to consider that the experiences of women at midlife (physical or otherwise) relate primarily to what is happening to them in terms of their children (or lack of), their husbands (or lack of), careers (or lack of), and to their response to the aging process. From this perspective

woman's experience of menopause is generally seen to follow from, and/or be determined by how she is faring in these areas. Or it is felt to determined by cultural attitudes. Her physical experiences are subordinated and de-emphasized. This research suggests that perhaps it is this subordination and de-emphasis which is problematic for women. Sharon's and Nickii's distress and discomfort were a function of what was happening to them physiologically. Their experiences were part of a continuum of menopausal experiences. They experienced the common threads *in addition to* profound physiological distress.

This research supports the concept of menopause as a transition. Levinson (1986) referred to transitions as "structure-changing" periods in which:

> The primary tasks. . .are to reappraise the existing structure, to explore possibilities for change in the self and the world, and to move toward commitment to the crucial choices that form the basis for a new life structure in the ensuing period. . .As a transition comes to an end, one starts making crucial choices, giving them meaning and commitment, and building a life structure around them. (p. 7)

With menopause the women experienced a biologically enforced series of reappraisals and readjustments. They entered the transition with the security of existing roles and knowledge of their place in the scheme of things (femininity, sexuality, fertility). They entered a period of profound physiological change and varying degrees of emotional upheaval. This was a period of questioning of self (of validity of emotions and roles), confusion, loss, vulnerability, isolation. They emerged feeling greater security in themselves, a sense of at least the possibility of self as separate

from roles of mother and sex object. They experienced the freedom of invisibility, a freedom from sexual expectations.

Schlossberg's (1987) discussion of transitions, while not mentioning menopause, provides a useful perspective from which to examine this transition. She has noted that it is not the transition per se that is critical, but how much it alters one's roles, relationships, routines and assumptions, and how able one feels to cope with the situation. She delineated four categories to consider in attempting to predict how someone in a transition will cope. In the first category, "Situation," it is significant whether or not the transition is seen as positive, negative, expected, unexpected, desired or dreaded, voluntary or imposed. In the second, "Self," whether or not the person has previously experienced a similar transition, and whether they believe they have options is significant. With the third, "Supports," the presence or absence of support from family, close friends and coworkers is pivotal. The fourth, "Strategies," related to knowledge of the meaning of the transition and the ability to creatively cope with the situation.

By these predictors women could be *expected* to have a difficult time with menopause. The transition is generally seen as negative, if not dreaded, and it is imposed versus voluntary. Not only have women not had previous experience with it but it has been shrouded in silence and/or misinformation. As a function of the taboo and negative stereotype surrounding menopause, women tend to be isolated by silence, embarrassment and/or shame. As a result they do not generally have the support of accurate and complete information, or of understanding by others or themselves. Finally, the meaning of the experience is often not readily accessible to women as it is culturally obscured.

This research suggests that menopause also has characteristics suggestive of a rite of passage--at least when experienced as being on time. Turner (1987) regarded a transition as a "process, a becoming, and, in the case of *rites de passage* , even a transformation" (p. 4). He used as an analogy a pupa changing from grub to moth which is reminiscent of Lucy's metaphor of a chrysalis. Van Gennep (in Turner) defined "rites de passage" as "rites which accompany every change of place, state, social position and age" (p. 4). As noted by Turner, Van Gennep demonstrated that all rites of transition are marked by three phases. With respect to the coresearchers' experience of menopause, the first, separation, is demonstrated by their experience of isolation, silence and loneliness. The individual enters a status at variance with the one previously held. In the second, the individual or group "passes through a realm that has few or none of the attributes of the past or coming state. This phase is characterized by the women's experience of confusion, loss, invalidation, and fear. In the third phase the passage is consummated and the individual is stable once more. This sense of having "come through," and of heightened sense of self, of security and stability was demonstrated by the common thread, "After Menopause."

It is interesting to note the similarities between the common threads and the literature on grief. Worden's (1982) list of normal grief reactions bears close resemblance to the coresearchers' experiences when their accumulated perceived losses are substituted for references to "the deceased": (a) somatic or bodily distress of some sort, (b) preoccupation with the image of the deceased (for example, a youthful body, value), (c) guilt relating to the deceased or circumstances of the death (for example, feelings related to having a drier vagina), (d) hostile reactions, and (e) the

inability to function as one had before the loss. Worden's list of feelings associated with the grief process also have a close fit to the coresearchers' experiences: sadness, anger (that nothing could be done to prevent the death, and at the feeling of helplessness), guilt and self-reproach, anxiety, loneliness, fatigue, shock, numbness, yearning, emancipation (freedom from the tyranny of the deceased), and relief (especially if a long illness was involved). A number of physical sensations, cognitions and behaviors have been documented as commonly experienced in connection with grief. Among them are a number common to women during menopause: tightness in chest and throat, oversensitivity to noise, breathlessness, weakness in the muscles, lack of energy, dry mouth, confusion, preoccupation, sleep disturbances, absent-minded behavior, and crying.

This research supports Lennon's (1982) findings with respect to the significance of timing in the menopause experience. Of the five coresearchers, the experiences of Nickii and Sharon were the most similar, despite the 20 year difference in their ages. While other unknown factors may have accounted for this similarity, they did have in common that each of their menopauses occurred "out of synch."

Also supported are Davis' (1986) findings in general, although her population was distinctly different from that of this study. Agreement was specific with respect to the women's lack of identification with the word "menopause," preference for "the change," concept of menopause as a potentially difficult life stage with certain developmental tasks inherent in it, and the concept that meaning can only be determined in context.

This study supports the literature which addresses cultural influences on women's experience. Weideger's (1979) findings with respect to the taboo/negative stereotype component of menopause are particularly

verified. Also supported were Posner's (1979) and Stimpson's (1982) criticisms of the women's movement for its tendency to discount the physiological. At the same time, it is important to recognize the dangers, for women, in attention to the physiological. Hopefully, the concept of "equal yet different" will prevail.

This study further validated the following concepts as discussed in the Literature Review:

- the value of research which seeks to empower both its coresearchers and its audience--as demonstrated by the positive impact the research process had on the coresearchers,

- the value of a group process for research in areas in which, as Miller (1986) has noted, do not "make sense" to women, or in which it is difficult for women to gain access to their voice,

-the importance of ascertaining meaning as an initial step in the understanding of any process with developmental and/or cultural components--and in determining research directions,

- menopause as a developmental transition,

- the medical community's recognition of the power and potential impact of hormones and of women's physiological processes,

- the value of HRT for women experiencing profound difficulty with menopause,

- the need for increased research on hormones, and on the underlying causes of the many physiological experiences of menopausal women,

- the need for new words of description for women's experiences, which originate with women.

In many ways, the historical, mythological and narrative literature more accurately approximated the coresearchers' experience with respect to feelings, transition and change. These women did, indeed, seem to possess "the wisdom of evolution in every cell of their bodies" and possess the "power to lose as well as gain" (Starhawk, 1989, p. 93). Having transcended their fertile and sexual roles, they know Hecate's secrets of deep emotion and passion, being authorities in these areas. Freedom from these roles allowed spiritual seeking for Nobel's (1983) "feminine source of life." The value of ritual to mark and honour beginnings and endings was also clear.

Implications for Counselling

It is important for counsellors of women at midlife to be aware of the dynamics of the menopause process, and of the implications of a negative stereotype and the cultural influences operating on women at this time of their lives. Essential would be recognition by the counsellor of the impact of experiences of invalidation and minimization associated with menopause.

Counsellors can promote a developmental perspective with a woman in or approaching menopause. A critical consciousness can be developed through reflecting on the meaning she attaches to menopause and by promoting problem-posing versus a "foregone conclusion" perspective. Her *voice* can be developed by demystifying through knowledge and awareness, and by sharing her experiences with others.

The personal meaning of menopause for a woman cannot be known until she recognizes what she feels she is losing and gaining by the

experience. This can be determined by exploring her attitudes toward being female, being a woman in our culture, sexuality, her feelings surrounding loss of fertility, and attitudes and meaning attached to menstruation--all of which are influenced by the definition she has of that experience.

A client may be struggling with the question of the validity of her feelings, with what is "real" versus what is "hormonally induced." An appropriate counsellor role would be to facilitate exploration and clarification of the issues.

Clearly, aspects of grief counselling would be appropriate. These could encompass acceptance of the reality of the loss, assistance in articulating and experiencing the losses and the grief, and in readjustment. Validating the reality of her losses and the normalcy of her grief would be central to the therapeutic process.

Also helpful would be development of the awareness of the extent to which current losses may reawaken past experiences of loss, and, in particular, those losses which have not been fully resolved. Memories and feelings associated with past experiences of sexual abuse may be reawakened by possible menopausal feelings of being out of control, and/or of physical experiences or changes which are not understood. The loss of youth which menopause marks may also be more profoundly felt by women who, because of the ramifications of any form of abuse, had never experienced the innocence or freedom from responsibility traditionally characteristic of childhood.

Facilitation of awareness of the role of transitions in psychological development, and of the role of the menopause transition in a client's life would, in particular, assist her in "seeing the light at the end of the tunnel."

Exploration of what she is moving from and to would promote development of perspective. What is she leaving behind? What are her anticipations of the future?

The same dynamics of menopause which prompted the use of a group approach for this study suggest the appropriateness of the use of small groups when working with women in a therapeutic setting. When stories were shared, when they were heard and understood by others, the coresearchers' experiences were normalized. As they became aware of the forces acting upon them at that time of their lives, they viewed themselves more kindly. The client-counsellor dyad, while initially useful, may prove to promote rather than break the isolation component of menopause. Within a small group, however, the power of a taboo and negative stereotype can be overcome.

Suggestions for Further Research

Whether menopause is conceived of as a medical condition or as a natural developmental process determines the nature of the questions asked and thus of the research directions we follow with respect to menopause. Consideration of menopause as a transition and/or as a rite of passage would lead naturally to research which focused on the psychological meaning and cultural function of the menopause transition. An understanding of the process would necessitate an examination of *what* changes--a consideration not of whether or not they had changed but *how* they had changed.

Choice of methodology is central to determining the meaning of menopause. Asking direct questions of women in, or even past, menopause

with respect to the meaning of their experience is akin to asking for a response to, "Who are you?" or "Who are you becoming?" Each may be considerably difficult for women to answer without a period of exploration and reflection--such as that provided by this study's methodology. What women express in response to survey or interview questions regarding their menopause may not necessarily be what they experience. The power of stereotypes, admonitions to have positive experiences, the expectations of others as portrayed in women's magazines, and/or a tendency to protect inner experience from the devaluation of labelling may all hinder recognition of experience and response to questions.

Maccoby & Jacklin and Rosenberg (in Belenky, 1986), among others, have suggested the need to also examine how women differ from men with respect to their development:

> From the moment women gained a foot in the academic world, they sought to examine and dispel beliefs suggesting sexual polarities in intelligence and personality characteristics. However, research studies and critical essays on the topic have focused on the demonstration of women's intellectual competence, minimizing any differences that were found between the sexes (Maccoby & Jacklin; Rosenberg, in Belenky, 1986, p. 7).

Several repetitions of variations on this study would be valuable in terms of further verifying the findings and/or expanding on the information. Locating coresearchers who were between 1 1/2 and 3 years beyond their last menstruation would be more likely to achieve a balance between retention of memory of the menopause experience while allowing enough time to have elapsed to allow for perspective on the experience.

A number of possible areas of inquiry would serve to enhance the findings of this study and to further develop a more complete picture of the menopause process. Among them are explorations of the menopause experiences of women who have had a hysterectomy, an oophorectomy, have never been fertile, were fertile but never had children, lesbians, single women, women from different socioeconomic backgrounds, those who were post-menopausal by ages 40-45, and those who did not begin menopause until ages 55-60.

In addition, further research on the physiology of menopause is needed. The relationship of genetics, diet and environment to the menopause experience needs to be examined. Rebecca's experience suggested that blood sugar levels may be an area of inquiry. Continued and expanded research on the endocrine system will go far toward answering the myriad of questions women have regarding the intricacies of the menopause process.

Summary

This study suggests that perhaps we have "thrown the baby out with the bath water" with the current tendency to discount, devalue or ignore the experiences of women who have had a difficult time with menopause. Menopause experiences range over a continuum varying in degree rather than in kind. As such, the midrange is comprised of elements of both extremes. Given the silence/taboo/stereotype dynamics of menopause, it may be that by paying attention to the experiences of the women at the "bad menopause" extreme we can gain a clearer picture of the remainder of the menopause-experience continuum. Feelings or events which are difficult to

name are often given expression by those who experience a magnification of those feelings or events. Clarity and identification are possible in the "larger than life" quality of their experience. These others, having been propelled by either the power of their emotion or the severity of their situation, are often able to put words to what they, and we, to a lesser degree, are feeling.

Women have struggled not to be *defined* by their fertility and by their reproductive processes. Such definitions and categorizations have previously, and often currently, meant pathologizing of these deeply personal processes. A focus on the minimization of any differences between the sexes may have lead women to discount biological differences in the press for equality. In the rush to overcome the disease definition of menopause, and to counteract the resultant power of the medical profession with respect to women's reproductive processes, women may have been encouraged to minimize their bodily experiences. Educated women at midlife, and in the age of feminism, may feel that they *should not* be influenced or affected by menopause--that to do so would be akin to denying sexual equality, to succumbing to a "biology is destiny" philosophy. However, as at adolescence, the physiological changes experienced at menopause bring with them emotional changes and influence the way women see themselves and walk through the world. Again, the concept "equal but different" is apt.

Maintenance of silence around menopause has contributed to the ongoing power of a narrowly-defined concept of femininity and sexuality. The pressures on women with respect to their bodies are real. Their bodies (their size and image) continue to define their credibility in the culture at large. Perhaps if women weren't so culturally identified with

their bodies the focus on menopause may not be so thoroughly on physical symptoms.

Women's female bodily *processes* , on the other hand, are culturally dictated to be kept hidden as they are touched with shame. This study suggests that nonrecognition and/or devaluation of women's female bodily processes and their influence, implications and meanings, regardless of the source, will serve to perpetuate experiences of distress with menopause. On the other hand, the tendency to view women at midlife as controlled by their endocrine system is substituting one extreme for another. Neither extreme is helpful for women and their needs are no doubt best met somewhere in the middle. The coresearchers' experiences of minimization and invalidation demonstrated their desire for recognition and validation of *both* their physiological changes and the implications and meanings of those changes.

This research does more to suggest future research directions than it does to support the current literature. It suggests directions which originate with the experiences and words of women, as opposed to those which derive from the theoretical frameworks, definitions and labels of others. It suggests the need to reexamine research frameworks and methodology with attention to the influence of taboo, stereotype and labels. The language, definitions and descriptions currently available are inadequate and problematic. They misrepresent and leave unsaid what women actually experience. There is a clear need for an accurate, descriptive and complete naming of the experience of menopause. Such naming can only originate with women.

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APPENDIX A

Definition of Terms

Unless otherwise indicated, the following definitions in quotes have been taken from Cobb's (1988b) *Understanding Menopause* , pp. 216-227):

Artificial Menopause - A term which "may be applied to (a) those women who have had their ovaries removed (usually in conjunction with a hysterectomy); (b) those whose ovaries fail following radiation therapy; (c) those who experience a premature menopause as a result of a hysterectomy, even when some or all of the ovaries are untouched. The women in categories (a) and (b) experience a very sudden menopause. . .Unless there are strong reasons for artificially menopausal women *not* to have it, estrogen replacement therapy is started almost immediately and may continue for some years" (Cobb, 1988b, p. 10).

Climacteric - "Generally used to refer to the middle years in both males and females, loosely the years from about forty to sixty."

ERT - Estrogen Replacement Therapy

Estrogen - "Hormone classified as 'female sex hormone' although it is produced by both men and women. There are three different kinds of hormones, the major one produced in the ovaries."

Exogenous estrogen - That derived from external sources; from the urine of pregnant mares.
Hormone - "Substance produced by a gland and circulating through the bloodstream.

Hot flash - "The subjective sensation of heat, often through the chest and over the head but felt, by some women, to the ends of their fingertips and to the soles of the feet. There may be an accompanying rise in temperature. The most common menopausal complaint, its cause is unknown."

HRT - Hormone Replacement Therapy - "Usually understood to comprise estrogen replacement therapy (ERT) with the addition of a progestational agent (progesteren or progestogen) taken for a least ten days with the estrogen for an optimum of thirteen days before both drugs are withdrawn and "withdrawal bleed" follows."

Hypoglycemia - "An abnormally low level of glucose in the blood" (*Webster's II New Riverside Dictionary*).

Hysterectomy - "Surgical removal of the uterus. A complete hysterectomy involves removal of uterus and cervix. A partial hysterectomy involves removal of the uterus only. A radical hysterectomy involves removal of uterus, cervix, lymph nodes, and sometimes part of the vagina."

Menarche - "The beginning of menstruation" (*Webster's II New Riverside Dictionary)*

Oophorectomy - "Excision of one or both ovaries."

Osteoporosis - "Abnormal thinning out of bone; porous bones."
Peri-menopause - "Period of time surrounding menopause when menstruation is irregular."

Post-menopause - "Period of time when menstruation has definitely ceased. Post-menopause is usually understood to begin when a woman has not had a menstrual period for twelve months."

PMS - Premenstrual syndrome - "A wide range of physical and emotional symptoms which occur usually seven to ten days before the menstrual period."

Premenopause - "Period of time when some menopausal symptoms occur but before menstrual periods become irregular."

Progesterone - "Hormone produced by the corpus luteum (yellow body) that is left after a follicle bursts from the ovary. This hormone paves the way for menstruation."

Tubal Ligation - "Surgical technique of sterilization. The fallopian tubes are cut and bound, or plugged. Rarely reversible."

Physiological and emotional experiences variously reported as accompanying some menopausal experiences:

Changes in frequency, duration or flow of menstrual fluid, hot flashes, chills, night sweats, changes in bowel habits or stools, palpitations, thinning or drying out of vaginal and urethral tissue (increasing the possibility of infection and/or painful intercourse), headache, dizziness, back pain, abdominal bloating, breast tenderness, sleeplessness, gastrointestinal disturbances, changes in energy levels, numbness, joint pain, nervousness, insomnia, forgetfulness, irritability, anxiety, lack of sexual interest or gratification, changes in content of dreams, increased premenstrual distress.

APPENDIX B - GROUP EXERCISES

Exercise 1 - Session 1

Goal: building of trust, safety, inclusion. Time: 10-15 minutes. Leader divided group into one pair and one triad. Each group was asked to find a quiet spot nearby and introduce themselves to each other and to relate an area of personal interest--something unusual or unique about themselves (unrelated to menopause). They were asked to clarify with their partner what was okay to relate later to the group as a whole. After 10 minutes or so, the leader called each group back and asked each woman to introduce her partner(s) and to relate that partner's area of interest. Members were asked what they valued and/or disliked about the experience.

Exercise 2 - Session 1

Goal: building of trust, inclusion and active listening and paraphrasing skills.

Time: 10-15 minutes. Leader divided group again, creating different pairings. The women were asked to introduce themselves to their new partner(s) and to relate some place they would like to live and why. The listener was asked to listen with care, and to paraphrase back to her partner what it was she heard. The leader demonstrated paraphrasing to the group. Again they were asked to clarify what was okay to repeat later to the larger group. When the women returned to the larger group each women introduced her partner and conveyed what her partner had said. Members were asked what they valued or disliked about the experience.

Exercise 3 - Time Line - Session 1

Goal: the development of a personal perspective regarding the events and sequence of their experience, to assist in jogging their memories. Time: 40-60 minutes. The concept of a time line was introduced to the group. The leader showed a time line she had constructed of her life, which included highs and lows of emotional experience and the reasons for them, significant points, as well as details of menstrual, reproductive, and general body history, including menopause. The concept of context was introduced, and an example given by the leader: that two events may be experienced very differently by the same person depending on the context of her life at the time. Each woman was given a six-foot length of paper and a set of felt pens. They were asked to find a quiet spot on their own to work on their time line. They were also encouraged to take them home at the end of the session to complete them, and to add to them in the future.

Exercise 4 - Session 2

Goal: self-awareness of their own emotions and their expression of those emotions, further development of the communication skills of attending, active listening and paraphrasing. Time: 20 minutes. The leader conveyed that we each express emotions differently depending on whether or not we're familiar with the person. The leader divided the group again into one pair and one triad, placing women together who had not yet been partners. Each small group was given a card with four emotions listed: anger, boredom, affection, shyness. They were asked to take 15 minutes and to discuss two or three of these emotions--specifically to tell and

demonstrate to each other how they expressed each emotion both in words and nonverbally, both to someone they were familiar with and unfamiliar with. Again, each partner was asked to clarify if there was anything her partner did not want related to the larger group. The women returned to the larger group and each partner paraphrased what she had seen and been told by her partner. The group was asked how they experienced the exercise, what they valued and/or disliked about it, what (if anything) they learned about themselves.

of menopause to the group. Final sessions will be devoted to discussion of issues or concerns related to menopause which the group feels are significant to a greater understanding of the process of menopause. Each meeting will be audiotaped.

After nine weeks the group will disband and the investigator will transcribe the results, deleting all identifying information. First names will be changed, should the members wish, in order to ensure confidentiality. Upon completion of the transcript the investigator will approach each group member individually, asking her to read the transcript and to indicate if, upon reflection, it accurately portrays her experience of menopause. If it does not, the disagreements will be noted.

The audiotapes will be erased upon acceptance of the thesis. At no time will any identifying material be made available to anyone other than the investigator, committee or group members.

If any aspect of the above-described process remains unclear or if you have any inquiries concerning these procedures, please do not hesitate to contact either the investigator herself or a committee chairperson. Each group member has the right to refuse to participate further in any weekly meeting or to withdraw from the study at any time during the nine weeks without any jeopardy whatsoever.

I, _____ , consent to participate in the above-described study under the conditions outlined and acknowledge receipt of this consent form.

SAMPLE OF SCREENING INTERVIEW QUESTIONS

1. What is your age?

2. Have you had a hysterectomy or an oophorectomy?

3. How long have you lived in Canada? What is your country of origin?

4. Have you ever participated in a group in which you had to express your feelings and experience of personal matters?

5. How do you feel about that experience? Did you find it relatively easy or difficult to express your feelings? - to find the words to say what you meant?

6. Have you ever had the experience of discussing your menopause in a group? If so, how did you feel about that experience?

7. What is your interest in participating in a study of menopause?