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University of Southampton

Faculty of Environmental & Life Sciences

Health Sciences

**The Volcano Within: A study of women's lived experience of the journey through
natural menopause**

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by

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Thesis for the degree of Doctor of Philosophy

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Abstract

Faculty of Environmental & Life Sciences

Health Sciences

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The Volcano Within: A study of women's lived experience of the journey through natural menopause

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Background: The Office of National Statistics 2011 census reported 8,585,600 women living in the United Kingdom (UK) between the ages of 45 and 59 years old. The natural menopause affects midlife women who have not experienced surgical or chemical interventions with the average age for menopause in the UK being 51 years. Menopause related changes are suggested to occur for some women before their final menstrual period and can continue for a significant time after the cessation of menses. The aim of this study was to explore women's lived experience of menopause, how they made sense of their experience and to what extent experiences and perspectives were shared.

Methodology and methods: Interpretative phenomenological analysis (IPA) was applied to explore the lived experiences of nine women aged 45-60 years old. Data were collected via semi-structured interviews and analysis guided by the idiographic, phenomenological and hermeneutic principles of IPA.

Findings: Data analysis generated eight super-ordinate themes: Physical losses, emotional losses, loss of traditional notions of feminine identity, liberation from biological restrictions, liberation from social expectations, "sisterhood": a shared female experience, making social comparisons with other women and women's knowledge. Three higher order concepts were developed encapsulating the super-ordinate themes and capturing the biopsychosocial experiences of the women who participated in this study: **Losses:** *"I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal"* (Kate:36), **Liberation:** *Freedom from "cultural baggage...to feel that you're becoming yourself finally"* (Kate:486) and **Women's Business:** *The "stuff of legend" that only can be experienced and shared by women* (Rose:278).

Conclusion: Findings challenge the dominant Western cultural narrative which explains menopause in terms of a transition. The language of menopause with its focus on 'symptoms', encouraged women to view and experience menopause in a negative way perpetuating Western cultural ideals situating youth as desirable and rendering older women invisible. This study offers an in-depth nuanced understanding of the complex, individualised nature of the natural menopause for a specific group of women and how their lived experience results in a new 'normal' and an **acceptance of the changing me:** *"You just get on with it"* (Rose:347).

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Research Thesis: Declaration of Authorship

Print name:	Yvonne Middlewick
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Title of thesis:	The Volcano Within: A study of women's lived experience of the journey through natural menopause
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I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature:		Date:	18 th November 2020
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Definitions and Abbreviations

CBT: Cognitive Behavioural Therapy

CIPD: Chartered Institute of Personnel and Development

CSD: Committee on the Safety of Drugs (UK)

CSM: Committee of the Safety of Medicines (UK)

DBAN: Darik's Boot and Nuke data removal system

DES: Diethylstilbestrol

FDA: Food and Drug Agency (USA)

FMP: Final Menstrual Period

FSH: Follicle Stimulating Hormone

GP: General Practitioner

HPO axis: Hypothalamic-Pituitary-Ovarian axis

HRT: Hormone Replacement Therapy

IPA: Interpretive Phenomenological Analysis

IVF: In vitro fertilisation

JBI: Joanna Briggs Institute

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer plus other sexual identities

LTC: Long Term Condition

MHT: Menopausal Hormone Therapy

NHS: National Health Service (UK)

NICE: The National Institute for Health and Care Excellence

OCP: Oral Contraceptive Pill

PIO format: Population, Exposure or Issue, Outcomes format

PRISMA: Preferred Reporting Items for Systematic reviews and Meta Analysis

Definitions and Abbreviations

QOL: Quality of Life

RCT: Randomised Control Trial

STRAW+10: Stages of Reproductive Ageing Workshop +10 years

SWAN: Study of Women's Health Across the Nation

UK: United Kingdom

UKCTOCS: UK Collaborative Trial of Ovarian Cancer Screening

UoS: University of Southampton

USA: United States of America

WHI: Women's Health Initiative

Chapter 1 Introduction

1.1 Introduction

This PhD thesis presents an exploration of the lived experience of women experiencing the menopause. The study methodology, Interpretative Phenomenological Analysis (Smith et al. 2009), has facilitated generation of a rich in-depth exploration of the experiences of nine women living in the United Kingdom (UK) who identified themselves as menopausal.

Chapter One situates the study and presents the research aims and objectives guiding the study followed by an overview of the thesis.

1.2 What is Menopause?

The menopause is a universal phenomenon experienced by human females who live beyond 50 years of age (Burger 2006; Derry 2006). The menopause is defined as the permanent cessation of menstruation which is determined to be one year after the final menstrual period (Soules et al. 2001).

The average age of a natural menopause in the UK is 51 years (National Collaborating Centre for Women's and Children's Health (NCC-WCH) 2015). However indicators of the menopause can appear as early as the 4th decade (Hunter and Rendall 2007; Moilanen et al. 2010) and can continue postmenopause for 10 years or more (Hunter et al. 2012; Avis et al. 2015). Various terms are used to describe this period, including 'menopause' or 'the menopause', 'menopausal transition', 'perimenopause' or 'climacteric'. In view of these varied terms the term menopause or the menopause will be used throughout this thesis to refer to the period both before and after the final menstrual period (FMP) when changes are purported to be related to the menopause.

1.3 Theoretical Perspectives on Menopause.

In setting the context for the study reported in this thesis this section will give an overview of the theoretical perspectives that appear to influence women's experience of menopause starting with the most dominant in Westernised culture, the biomedical perspective followed by feminist, psychosocial, and cultural. Consideration is also given to menopause as a transition.

1.3.1 Biomedical Perspectives on Menopause

Biomedical perspectives focus on the menopause as a biologically determined event with the marked decline in ovarian hormone levels leading to a reduction in reproductive function (Barth and de Lange 2020). The female reproductive system functions as a result of a finely tuned balance of hormones modulated by the hypothalamic-pituitary-ovarian (HPO) axis. It is the depletion of available oocytes in the ovaries that stimulates hormonal change leading to an imbalance in the HPO axis resulting in fluctuating levels of oestradiol and follicle stimulating hormone (FSH) (Brinton et al. 2015; Davis et al. 2015). The reduction in oestradiol eventually leads to the cessation of menstruation (Barth and de Lange 2020) and the potential for reproduction. Moreover, hormonal changes do not just affect the reproductive system but multiple systems (Barth and de Lange 2020). These include the neurological system indicative in for example thermoregulation and sleep (Brinton et al. 2015), the cardiovascular system (Davis et al. 2015) and potentially the immune system (Barth and de Lange 2020). Hormonal changes are suggested to last on average between four to eight years (Griffiths et al. 2010; Griffiths and Hunter 2015).

The main focus in establishing changes during the menopause as normal, rather than pathological, is medical diagnosis (Breidenbach 2009; Hyde et al. 2010; Lim and Mackey 2012). For women with suspected early menopause, aged 40-45 years it is suggested that assessment of FSH levels may be useful in informing a medical diagnosis unless combined oestrogen and progesterone contraception is being used (NCC-WCH 2015).

Currently medical confirmation of menopause in women over 45 years old is based on two observable biological indicators, vasomotor symptoms and an irregular menstrual cycle (NCC-WCH 2015). The Stages of Reproductive Ageing Workshop +10 years (STRAW+10) staging system (Figure 1.1) suggests that stage -3a has subtle changes to the menstrual cycle making it less likely women will recognise early indicators. Women who keep a record of their menstrual cycle may identify early menopausal changes but the longevity of the timeframe may mean that these are not linked to reproductive ageing and the eventual cessation of menstruation.

Figure 1.1 STRAW+10 Staging system for reproductive ageing¹

Stage	-5	-4	-3b	-3a	-2	-1	+1 a	+1b	+1c	+2
Terminology	REPRODUCTIVE				MENOPAUSAL TRANSITION		POSTMENOPAUSE			
	Early	Peak	Late		Early	Late	Early			Late
					Perimenopause					
Duration	variable				variable	1-3 years	2 years (1+1)	3-6 years	Remaining lifespan	
PRINCIPAL CRITERIA										
Menstrual Cycle	Variable to regular	Regular	Regular	Subtle changes in Flow/ Length	Variable Length Persistent ≥ 7 - day difference in length of consecutive cycles	Interval of amenorrhea of ≥ 60 days				
SUPPORTIVE CRITERIA										
Endocrine			Low	Variable*	↑ Variable*	↑ >25 IU/L**	↑ Variable	Stabilizes		
FSH			Low	Low	Low	Low	Low	Very Low		
AMH				Low	Low			Very Low		
Inhibin B								Very Low		
Antral Follicle Count			Low	Low	Low	Low	Very Low	Very Low		
DESCRIPTIVE CHARACTERISTICS										
Symptoms						Vasomotor symptoms Likely	Vasomotor symptoms Most Likely			Increasing symptoms of urogenital atrophy
* Blood draw on cycle days 2-5 ↑ = elevated										
**Approximate expected level based on assays using current international pituitary standard ⁶⁷⁻⁶⁹										

The menopause is often associated with a number of less desirable effects such as vasomotor symptoms, urogenital atrophy, reduced libido, dyspareunia, dysuria and musculoskeletal pain (Hunter and Rendall 2007; Moilanen et al. 2010; NCC-WCH 2015). The Study of Women's Health Across the Nation (SWAN) cohort study reported that 80% of women experienced vasomotor symptoms (El Khoudary et al. 2019). The results from the Penn Ovarian Ageing longitudinal study found that 79% of the cohort of 259 participants experienced hot flushes commencing before the age of 50, most commonly between 45 and 49 years of age (Freeman et al. 2011). A later report identified one third of women in the cohort (n=255) experienced moderate to severe hot flushes more than ten years after the cessation of menses (Freeman et al. 2014). Strezova et al. (2017), in their study of women aged 45 to 75 years (n=81) found that several women continued to experience hot flushes and other symptoms into their seventies. The National Institute for Health and Care Excellence (NICE) postulate that hot flushes and night sweats are the most commonly reported symptoms by peri and postmenopausal women in the UK (NCC-WCH 2015). Hunter and Ayers (2013) found vasomotor symptoms affected quality of life with a significant impact on social

¹ Reprinted from; Harlow SD, Gass M, Hall JE, Lobo R, Maki P, Rebar RW, Sherman S, Sluss PM and de Villiers TJ (2012) Executive summary of the Stages of Reproductive Aging Workshop +10: addressing the unfinished agenda of staging reproductive aging. *Fertility and Sterility* 97(4): 843-851 with permission from Elsevier.

Chapter 1

functioning, emotional functioning, mental health, energy levels and increased bodily pain for the sample of 140 UK menopausal women. As well as hot flushes, night sweats and disruption to the menstrual cycle, hormonal changes have been linked to a number of emotional and mental health issues such as stress, mood swings, anxiety and depression (Hunter and Rendall 2007; Marieb and Hoehn 2010; Parry 2010).

Depression in particular has been reported to occur in women with no previous history of mental health problems and become exacerbated for some women with a history of depression and bipolar disorder (Schmidt and Rubinow 2009; Parry 2010; Pinkerton et al. 2010). A systematic literature review of papers published between 1980 and 2015 Maki et al. (2019) considered the epidemiology of depression using cross sectional and longitudinal studies with sample sizes ≥ 200 . They concluded that while there is an increased risk of depressive symptoms during perimenopause most women who experience a major depressive episode have a previous history of depression. The risk of depressive symptoms and mood changes cannot be clearly linked to the biological changes as there are other sociodemographic factors that have been identified as potential midlife stressors such as career changes, bereavement, changing health status, caring for children and ageing parents (Hunter and Rendall 2007; Maki et al. 2019).

The literature suggests that there is confusion amongst women about the symptoms resulting in them seeking reassurance that there is not an underlying medical condition (Duffy et al. 2011; Lim and Mackey 2012; Morgan et al. 2012; Strezova et al. 2016). Arguably this lack of knowledge and clarity can leave women feeling frightened by changes in their body (Winterich 2003). The focus on the purely biological may be a useful diagnostic tool but it also draws this normal midlife experience into the medical arena.

1.3.2 Feminist Perspectives on Menopause

Feminists argue that the medicalisation of normal female life events, particularly the focus on the female reproductive system, are a means of controlling female behaviour (Caplan and Cosgrove 2004; Perz and Ussher 2008). Historically, non-medical and social problems have been defined as illnesses or disorders which require medical study, diagnosis and treatment representing control, including social control, over women's health and behaviour (Showalter 1987; Chesler 2005; Appignanesi 2008). In more recent years men's health has been subject to the 'medical gaze' but predominantly it is women's health that has been medically constructed focusing on menstruation, pregnancy, childbirth and the menopause (Cahill 2001; Kelly 2008; Wieczorkowska 2012).

Feminist discourse argues that the menopause is a complex and diverse experience that is influenced by biopsychosocial and cultural aspects of women's lives (Loppie and Keddy 2002; Murtagh and Hepworth 2005; Voicu 2018). Hunter and O'Dea (1997) used a feminist perspective and focus on the accounts of women aged 49 to 51 (n=37) participating in semi-structured interviews. They found women initially constructed their experiences of menopause from a biomedical perspective by articulating bodily changes and trying to avoid thinking about 'it'. They offer a critique of dominant gendered constructions of menopause and their findings suggest the impact of the menopause is complex and influenced by the contextual aspects of women's lives, for example, the working environment (62% of their study participants worked). Their conclusion was that the experience of change was socially constructed. The effect of the cultural context has been reported by other authors (see for example: Atwood et al. 2008; Breidenbach 2009; Jones et al. 2012; Ussher et al. 2015) as positioning of the menopause as diametrically opposed, with either positive or negative experiences that extend beyond a biologically determined event.

These complexities have been largely ignored within the dominant biomedical ideology that has presented the female body as essentially deviant, as opposed to the 'organised' male body with the menopausal body as a 'faulty machine' requiring intervention (Coupland and Williams 2002). Feminist discourse has been vocal about the potentially harmful effects of pharmacological interventions but was largely silenced until the media widely published the results of the Women's Health Initiative ((WHI) 2002) and the Million Women Study (Beral and Million Women Study Collaborators 2003) about the risks of hormone replacement therapy (HRT).

Kelly (2008) found in her mixed methods lesbian feminist analysis (n=116), exploring the demise of HRT, that participants felt the menopause was a natural process that was viewed negatively by society. They suggested that the medicalisation of the menopause and the promotion of HRT "provides artificial oestrogen to keep the body younger and sexually available to men" (Kelly 2008 p.303). This in turn maintains the heterosexual ideal of femininity as youthful, sexually attractive and fertile (Coupland and Williams 2002; Kelly 2008).

The biomedical stance arguing that female reproductive ageing is a universal biological experience is the view that feminist discourse aims to challenge, suggesting that a more holistic approach focusing on the impact of biopsychosocial and cultural aspects of women's lives would be more appropriate (Loppie and Keddy 2002; Hunter and Rendall 2007). This could have the potential to provide a more in-depth understanding of the menopause and the impact on women's lives.

1.3.3 Psychosocial and Cultural Perspectives on Menopause

Feminist perspectives position the menopause as a natural experience that has become medicalised and takes place within a wider context. Psychosocial and cultural perspectives articulate additional influences that add to the complexity of the menopause experience. Elliott et al. (2002 p.381) in her ethnography of Korean Canadian women's experiences of menopause suggests that "the influence of culture is insidious" as women in her study were unable to recognise its influence on menopause. Although the participants stated there were no cultural influences impacting on their experience, subsequent analysis showed culture had a strong influence on their stories.

Empirical studies demonstrate variation in the experience of menopause across cultural and sociodemographic groups. In cultures where women's status increases within the family, or community, as they grow older, women report menopause as being more positive and providing freedom and respect (Im et al. 2010; Hakimi et al. 2016; Hammoudeh et al. 2017). This was akin to being viewed as a 'wise woman' with liberation from reproductive burdens (Mahadeen et al. 2008; Jurgenson et al. 2014) and for some groups the opportunity to be involved in regular religious activity which menstruation had previously precluded their participation (Hakimi et al. 2016) .

Winterich and Umberson (1999) used grounded theory to explore the role of social context of women (10 non-Hispanic whites, 4 African Americans and 2 Mexican Americans) in the United States of America (USA) concluding that women who view menopause as a neutral or positive event usually define menopause as only cessation of menses and that for those who consider menopause inconsequential other life events as considered more important. Im et al. (2010) also found that midlife women (n=20) were managing other more important aspects of their lives which resulted in downplaying their menopause experience. The menopause often occurs at a point women when may experience personal and social change including relationships, children leaving the family home, the death of a parent, or women themselves facing physical changes or longer-term illness for the first time (Hunter and Rendall 2007; Vigod and Stewart 2009) thereby adding to the contextual complexity of the menopause experience.

Derry (2006 p.397) argues that stereotypes of women becoming "fuzzy headed, having poor memories, or in other ways having deteriorating brains" at menopause are unhelpful in gaining an understanding of this 'maturational' process. Gender stereotypes were found by Haines et al. (2016) to have remained stable over the last 30 years (1983-2014) despite changes in the representation and roles of women. They postulate that gender stereotypes are deeply embedded within society and can influence attitudes, behaviours and choices. The views of others

and attitudes of women towards themselves have been found to impact on the experience of the menopause. In Ayers et al. (2010) study a systematic review was undertaken of women's attitudes and the impact on menopausal symptom experience. Three databases were searched (Medline, Web of Knowledge and PubMed), dating from inception until 2009 with ten of the final 13 studies finding that women with negative attitudes towards menopause reported more symptoms.

Ohemeng (2008) argues that women are socialised to recognise the symptoms and appropriate behaviours of menopausal women which are reinforced through the media as requiring medical intervention. This is not a new concept as historically female behaviours have been constructed as being directly related to their reproductive system and used to legitimise ageist and sexist attitudes to women (Showalter 1987; Hunter and O'Dea 1997; Chesler 2005; Appignanesi 2008).

To challenge negative stereotypes the function of women needs to be more positively reframed and dominant views of the menopause as a unidimensional experience needs to be contested (Loppie and Keddy 2002; Murtagh and Hepworth 2005). Hunter and O'Dea (1997) argue that polarised approaches fail to recognise the varied experiences of midlife women and that 'menopause' is used as a blanket term but has multiple meanings. Hvas and Gannik (2008a) identified seven menopause discourses used by women (Table 1.1) with biomedical, forever young and health promotion discourses having the most in common and being dominant. Feminist discourse provided a challenge to biomedical views framing menopause as a natural, neutral and positive period rather than one requiring medical intervention. There appears to be a tension between the changing roles of contemporary women and entrenched cultural, social and biological views of the ageing female body.

Table 1.1 Hvas and Gannik (2008b) Seven different discourses for menopause²

Discourse	Explanation
Biomedical discourse	Menopause is seen as a deficiency syndrome caused by declining hormones: menstruation stops, various symptoms occur and the risk of future diseases (especially osteoporosis) rises. Such discourse constructs menopausal women as patients who need medication if they want to maintain body control
'Forever young' discourse	Youth and youthfulness are admired and longevity is promoted, while ageing and old people are belittled and made invisible. Menopause is seen as a negative symbol of the ongoing ageing process; a threat to be counteracted by cosmetic surgery, moisturizers, hair colouring remedies and hormones. Hormones are seen as an age-retarding commodity, or a 'life elixir'
Health-promoting discourse	Good health and physical fitness are increasingly valued and promoted, and menopausal symptoms and risk of osteoporosis are seen to be modifiable by lifestyle changes. Menopausal women are obliged to be fit, to stop smoking and follow dietary recommendations
Consumer discourse	The women should be provided with information in order to make an 'informed choice'. Menopausal women are seen as active, informed and educated, having consumer rights, but they are encouraged to make their choice together with a physician, and can choose often only among choices set up by doctors
Alternative discourse	Menopause is seen as a natural and often positive process, but also as a passing imbalance, eventually straining the body. Symptoms caused by the imbalance could be treated with natural substances such as plants and tofu
Feminist/critical discourse	Menopause is seen as a natural period in women's lives that has become medicalized by the medical profession and international drug companies. Menopause is a neutral or positive transition, but severe symptoms could arise due to stressful events in women's lives. Treatment is seldom necessary, but it is important that women are well informed about bodily changes
Existential discourse	Menopause is uplifted to a process of self-discovery, a catalyst for change and personal growth. It is a question of being able to accept life 'of good and evil', with symptoms not necessarily being something negative, but a part of life itself. Menopause and ageing include a lot of possibilities like becoming more experienced and competent and having the confidence to hold on to one's own opinions. It is also a period of more freedom, with time to spend on one's own interests, and the possibility of becoming a grandmother

² Reproduced from: Hvas L and Gannik DE (2008b) Discourses on menopause - Part II: How do women talk about menopause? *Health* 12(2): 177-192: with permission from SAGE Publishing

1.3.4 Menopause as a Transition

A transition can be defined as "the process or a period of changing from one state or condition to another" (English Oxford Living Dictionary 2020) suggesting it is something that is distinctive and recognisable. Arnold van Gennep (1873-1957) and Victor Turner (1920-1983) have been credited as the founders of transition theory (Turner 1969; Larson 2014). Van Gennep's early ethnographic work identified three component parts of sociocultural rituals that mark a 'rite of passage' enabling a person to move from one group to another (Kalmijn 2004; Teodorescu and Calin 2015). The second phase of the three phase framework 1) separation, 2) transition 3) aggregation or reintegration was further developed by van Gennep's student Turner who developed the notion of the transition phase as a period of liminality, being between positions both socially and culturally (Larson 2014; Kapferer 2019). A key component of the theoretical perspective was a shared sociocultural ritual that moved a person from one sociocultural position to another.

Hattar-Pollara (2010) postulates that human developmental transitions can be complex involving predictable biologically determined stages or unanticipated events that impact on health and wellbeing. The focus on a 'biologically determined' event and the suggested predictability aligns with biomedical perspectives rather than considering any contextual complexity outside of the biological. The menopause is considered a normal developmental process that is influenced by biopsychosocial and cultural perspectives (Walker and Hunter 2002; Hunter and Rendall 2007; Meleis et al. 2010; Im 2014) and with some women experiencing changes over ten years after the FMP (Freeman et al. 2014) it appears to lack predictability.

More contemporary interpretations, while including the elements of van Gennep and Turner's seminal theory, do not include the sociocultural ritual as defining the process of change but retains elements of the early theory. In a search of the literature between 1994 and 2004 Kralik et al. (2010) analysed the use of the word transition within healthcare literature. In the 23 empirical studies identified they concluded that transition involves: the passage between two points, a process of alteration including a challenge to self-identity, and reorientation as the person adapts, although Kralik et al. (2010) observed from their own research that transition was not a straight forward linear process.

Lindmark et al.'s (2019) reviews the literature from 2003-2013 using Whittemore and Knafelz (2005) integrative review method to identify how the concept of transition had been applied across the health and social care sector. The search retrieved 350 studies from nursing, occupational therapy and social work reporting four domains where the concept transition was applied: developmental, situational, health-illness and organisational or other. Within the review Lindmark et al. (2019) noted that transition tended to be used to refer to a transition between different contexts and

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that there is an assumption that a transition has a defined start and end point and this assumption has subsequently been reflected in theoretical models. Similarly, Bridges (2003) identified transitions as having three phases: an ending which includes feelings of loss and letting go of the old, the neutral zone where the old is gone but the new way of being has not yet been accepted and the final phase, the new beginning, which once reached leaves the person with a new energy and sense of purpose. Although Bridges (2004) argues change is not a straightforward trajectory it does require people to recognise that a change is taking place.

Meleis has been attributed the development of transition theory in nursing research (Im 2014; Lindmark et al. 2019) aiming to empower nurses to recognise a person's transition to plan the provision of appropriate nursing interventions to support a healthy transition. Meleis et al. (2010) acknowledged the complexity and multidimensional nature of transitions and identified properties considered essential to the transition experience:

- Awareness that a transition is taking place
- Engagement in the process which may include for example, seeking information and proactively changing behaviours.
- Identifying internal or external changes and differences resulting from a sense of movement.
- Time Span: For many transitions there may be an anticipated timeframe with a distinct beginning followed by a period of instability and an ending although Meleis et al. (2010) suggest that not all transition experiences have easily identifiable boundaries.
- Critical points and events that identify a transition. These may be linked with an awareness and engagement in the transition process.

In considering the menopause as a transition the starting point is recognition or an awareness that transition has commenced. This can be challenging for women as the cessation of menstruation for one year is considered the marker of menopause, although changes can occur a number of years preceding menopause. The research study reported in this thesis will explore the ideas of transition and how the differing concepts are applied to women's lived experience of the menopause.

1.4 Menopause: Changing Contexts

The context in which contemporary women experience the menopause is different culturally, socially and medically from previous generations of midlife women. This includes changes in the demographic of working women, the influence of the feminist and biomedical discourse on perceptions of the menopause and the historical development of sex hormones which have

fundamentally changed the experience of the menopause, resulting in a focus on diagnosis and treatment as opposed to a 'normal' life stage further medicalising female reproductive health.

One fundamental cultural and social change are the number of working women, with the number of women in employment since 1971 gradually increasing from 52.7% in 1971 to 72.4% in 2019 (ONS 2019). This means that more women are likely to be in employment both through the menopause and postmenopause. Other changes that have impacted on women are the possibility of more control over their fertility through the availability of contraceptives and HRT. Unlike their mothers, women who have experienced the the menopause since 2002 have also been exposed to the controversy surrounding HRT resulting from the Women's Health Initiative (2002) and the Million Women Study (Beral and Million Women Study Collaborators 2003). They may also be aware of the publication in 2015 of the first NICE guideline for menopause.

In her study of 13 daughters born in the 1950s and their mothers (n=12) born in the 1920s and 1930s Utz (2011) found generational differences in the women's experience of menopause. Mothers were more accepting of the experience while daughters expressed the need to be in control of their bodies seeking out more information about the menopause. Access to information has also changed dramatically over the generations of women in Utz's study and digital technologies including the Internet and social media have continued to develop. Digital technologies have changed the landscape giving twenty-four hour access to a wide range of information including other women's views of the menopause. This reflects the different contextual experience for the current generation compared to their mothers.

Information is instantly available about interventions that might relieve the 'symptoms' of menopause such as hot flushes. Interventions include, for example pharmaceutical interventions such as HRT and therapies considered part of conventional medicine such as cognitive behavioural therapy (NCC-WCH 2015). There is a range of information about complementary and alternative medicine practices affecting the body and mind, such as yoga, exercise and hypnosis, along with foods and dietary supplements such as plant phytoestrogens including soy and red clover (Moore et al. 2017; Tonob and Melby 2017). Information about diets, exercise and improving health and wellbeing for midlife women is also readily available. The plethora of information offers a wide range of advice but it can also be overwhelming and difficult to judge the quality (Short 2017).

It has been suggested that widening accessibility to media is not without challenge and has resulted in continued exposure to negative and stereotypical Western views of female ageing (Hunter and O'Dea 1997; Derry 2004; Edström 2018). Westernised culture portrays beauty as being youthful and sexually desirable whereas signs of ageing, often related to loss, are viewed as

undesirable and comical which in turn reinforces fear of the ageing body (Twigg 2004; Chonody and Teater 2016).

1.5 Medicalisation of the Female Body

Historically, women's sexuality, social issues and non-medical problems have been defined as illnesses or disorders requiring medical study, diagnosis and treatment (Showalter 1987; Chesler 2005; Appignanesi 2008). Natural events such as fertility and reproductive ageing have been drawn into the medical arena leading to a shift in defining what were perceived as 'normal' events to medically defined 'conditions' or 'disorders' (Kelly 2008). Pregnancy and childbirth are examples of normal life cycle events which have been subjected to the medical gaze. In the UK since the 1960s there has been a shift from childbirth taking place in the social sphere of the home under the care of a midwife, a predominantly female profession, to the male dominated medical sphere of hospitals and obstetricians (Johanson et al. 2002; Brubaker and Dillaway 2009). This suggests that childbirth is pathological, requiring medical intervention rather than as a natural process (Cahill 2001; Wieczorkowska 2012). For example, since the 1970s infertility has increasingly been seen as a medical condition rather than a natural or social issue (Bell 2010). The success of In Vitro Fertilisation (IVF) means that reproductive ageing, a natural event that leads to a gradual reduction in fertility until the menopause, can be 'cured' for those women who have postponed motherhood until later life (Shkedi-Rafid and Hashiloni-Dolev 2011). Therefore, every major female life stage from adolescence to old age has been placed under medical scrutiny with the identification of the role of female sex hormones being a key focus in women's reproductive health and wellbeing. The identification of female sex hormones was closely followed by the development of synthetic sex hormones increasing the medical focus on menopause as a pathological condition.

1.5.1 Synthetic Sex Hormones as a Control Mechanism

The past nine decades have seen significant developments in human endocrinology. The first human female sex hormone, oestrogen, was isolated by scientists during the 1920s closely followed by the isolation of progesterone in the early 1930s (Tata 2005; Piette 2018). These discoveries led to the development of the first synthetic oestrogen diethylstilbestrol (DES) in the late 1930s in the UK. DES was approved for use in the USA by the Food and Drug Agency (FDA) in 1941 after pharmaceutical companies joined forces to demonstrate the clinical use of DES rather than focusing on the potential side effects (Rothenberg 2005). The approval was limited to prescriptions for the menopause and menstrual disorders, but doctors could also prescribe DES 'off label' if in their professional judgement it might be of benefit in other situations, for example,

to prevent miscarriages or early delivery. Prior to the Medicines Act 1968 there was no legal requirement to demonstrate safety or efficacy of pharmaceutical products, although the Committee on Safety of Drugs (CSD), set up in 1963 following the disastrous impact of Thalidomide, reviewed data for new drugs, clinical trials and adverse events (Teff 1984). The CSD did not impose any mandatory controls resulting in the only incentive for manufacturers to comply being access to NHS prescribers (Teff 1984; MHRA 2008).

With a view to improving public safety the Medicines Act 1968 regulated by the Committee on Safety of Medicines (CSM) provided a legal framework for the control of medicines in the UK (Teff 1984; MHRA 2008). The result was a lack of regulation for hormone preparations before 1963 and this can be clearly seen with the lack of co-ordination of DES data.

DES continued to be used worldwide until the 1970s when an early evidenced link between higher incidences of female cancers in the offspring of animal model experiments (Rothenberg 2005; Reed and Fenton 2013). Later work connecting the use of DES to genital cancers in the daughters of women who received this treatment (Li et al. 2003; Tata 2005) led to its withdrawal in the late 1970s. Reed and Fenton (2013) suggest that the resulting impact of multi-generational carcinogenicity from DES on a third generation of women may not be known for over fifty years.

The 1960s saw approval of the combined oral contraceptive pill (OCP) for use by married women in both the USA and the UK (White Junod and Marks 2002; Dhont 2010), but it was not available to single women until the early 1970s (Dhont 2010). The OCP offered the opportunity for women to control their fertility through the use of sex hormones, but this did not come without risk.

In 1961 reports emerged that OCP use may be associated with venous thromboembolism and arterial thrombosis, with British researchers confirming the risk of thrombosis in 1962 (White Junod and Marks 2002). As safety concerns continued, detailed patient drug information leaflets were included in packets of the OCP to better inform women about the potential side effects of the drugs they were using (White Junod and Marks 2002; Utz 2011). 1969 saw the introduction of the progesterone only OCP to the UK (White Junod and Marks 2002; Family Planning Association 2010) which offered effective contraception for those women who experienced side effects using the combined OCP. By the 1980s lower dose OCPs were introduced to reduce the risk of side effects and as higher dose pills were superseded they were removed from the market (Family Planning Association 2010). Although there had been a number of health scares in relation to venous thromboembolism and arterial thrombosis (White Junod and Marks 2002), in the 1990s the FDA consumer report found that there was confidence from Government, the medical profession and the public in the effectiveness and safety of the OCP (Utz 2011).

1.5.2 Synthetic Sex Hormones as Replacement

Premarin (conjugated equine oestrogen), was the first branded HRT approved for the treatment of menopause symptoms, hot flushes, night sweats, vaginal dryness and atrophy (Rothenberg 2005). The use of HRT started to gain popularity during the 1950s and the publication 'Feminine Forever' (1966) encouraged the use of HRT. The author Robert A. Wilson, a New York gynaecologist, proposed that taking oestrogen would cure the totally preventable 'deficiency disease' the menopause (Krieger et al. 2005; Piette 2018). Studies around this time reported that HRT was beneficial in relieving menopause symptoms, providing protection from osteoporosis and reducing the risks of breast and genital cancers (Utz 2011). However by the mid-1970s studies were reporting an association with endometrial cancers for women using oestrogen only HRT (Krieger et al. 2005) and HRT use began to fall as a result of these findings. Rothenberg (2005) suggests that in the USA approximately 25 million prescriptions were written for oestrogen only HRT in the mid-1970s, within five years there was a 50% reduction in prescriptions. Krieger et al. (2005) argue that following the reduction in prescriptions HRT was reframed as osteoporosis prevention to give a rationale for continued long term use. Pharmaceutical companies appeared to downplay the fact that the study findings for osteoporosis prevention considered women who had surgical rather than natural menopause using these results to promote HRT use (Rothenberg 2005).

In the early 1980s a combined HRT became available containing oestrogen and progestogen (Piette 2018) that was associated with lower rates of endometrial cancer, cardiovascular disease and osteoporosis (Utz 2011; Simpson and Santen 2015) and despite associated safety concerns a significant number of women continued to take an oestrogen only form of HRT (Simpson and Santen 2015). HRT became popular during the 1960s and the first large scale randomised control trial (RCT) was over 30 years after HRT was first used. It appears that hormone manipulation for midlife women received far less scrutiny than hormones given to promote fertility or maintain pregnancies until the 1990s when the first large scale HRT clinical trials commenced (Women's Health Initiative 2002).

The Women's Health Initiative (2002) was an independently supported, clinical trial in the USA which began in 1993 investigating oestrogen only (n=10,739) and combined oestrogen and progestin (n=16,608) HRT. In the UK the Million Women Study (Beral and Million Women Study Collaborators 2003) commenced in 1996 (n=1 319 475) investigating the risks associated with HRT (Green et al. 2018). The studies made links to an increased risk of breast cancer, cardiovascular disease and cerebral vascular accidents, results which were widely reported in the media and led to a sharp decline in the use of HRT reported as an 80% reduction worldwide (Barbaglia et al.

2009; Tsai et al. 2011). Menon et al. (2007) reported a steady decline in the use of HRT from 2002 to 2005 for postmenopausal women (n=202,185) using data from the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS). The initial recruitment in 2001 identified similar HRT usage to the Million Women Study (1996-2001) for women aged 50 to 64, 35% (n=49,656) and 33% (n=359,629) respectively (Million Women Study Collaborators 2002; Menon et al. 2007) suggesting an ongoing popularity in the use of HRT. Menon et al. (2007) noted in the third quarter of 2005 a marked reduction in HRT usage, to 11% (n=22,240) of the total cohort (n=202,185). Highest usage was seen within the 50 to 54 year old age group (n=39,389) but again there was a reduction over the duration of the study (2001-2005) from 44.2% (n=17,410) to 16.3% (n=6,420) aligning with other studies reporting a decline the popularity of HRT (Barbaglia et al. 2009; Tsai et al. 2011).

In 2015 the first NICE guideline for menopause was published to provide guidance for healthcare professionals (NCC-WCH 2015). Following further studies Simpson and Santen (2015 p.T15) argue that “the pendulum is swinging back toward the use of hormone therapy” and that it is essential to assess women as individuals. Through individualised assessments the potential benefits versus harm of hormone therapy can be decided collaboratively between the clinician and the woman. The changing view of HRT from a universal treatment for menopause to an adjunct to support those who have severe symptoms has resulted in an ideological shift in some areas and a rebranding from hormone replacement therapy to menopausal hormone therapy (MHT) (Rothenberg 2005; Simpson and Santen 2015). The NICE guideline for menopause has however continued to use the term HRT in the 2015 publication.

The NICE guideline for menopause (NCC-WCH 2015) appears to have been pivotal in raising awareness of some of the needs of midlife women. There is a plethora of advice about HRT, perhaps unsurprisingly given the findings of the Women's Health Initiative (2002) and the Million Women Study (Beral and Million Women Study Collaborators 2003). The guideline provides some limited advice about alternatives to HRT including lifestyle changes, complementary therapies and cognitive behavioural therapy (CBT).

The isolation of female sex hormones has meant significant developments not only in oral preparations but in other modes of delivery including implants, transdermal patches, injections and pessaries (Family Planning Association 2010). The discovery and use of synthetic female sex hormones has been revolutionary in enabling women to gain more control over aspects their lives, particularly fertility (Tata 2005; Dhont 2010). In 1978 the knowledge and understanding of reproductive hormones enabled the first baby to be born using IVF in the UK (Tata 2005) and has arguably made a difference to couples who have not been able to conceive naturally. Tata (2005

p.495) argues that there remains a need for both “caution and more research when manipulating the human hormonal system for medical or lifestyle reasons”.

Equally women have had to contend with the often persuasive claims that HRT can help them remain young in a society that values youth. Initially this may have been viewed as empowering women but the subsequent controversy suggests that it may in fact have disempowered women by reducing the impetus to challenge gendered ageism (Brewis et al. 2017). Whilst the medical advancements have undoubtedly been life changing for some, these are examples of normal female life events have been drawn into the medical arena with suggestions of a universal experience while the complex nature of women's lived experiences particularly during midlife appear secondary to the dominant biomedical perspectives.

1.6 Dominant Paradigm of Inquiry

The dominance of biomedical voice in Western cultures is reflected by the plethora of empirical studies generated under the positivist paradigm using rational, reductionist research design. The main focus of positivist methods of inquiry is the biological experience of menopause and the impact on quality of life resulting from, for example, vasomotor symptoms and female sexual function (Bianchi et al. 2017; Kim et al. 2018; Nazarpour et al. 2018; La Rosa et al. 2019; Mirkin et al. 2019; Peixoto et al. 2019).

Positive inquiry also focuses on a range of interventions using RCTs to explore a variety of drug therapies both hormonal (Cortés-Bonilla et al. 2016; Diem et al. 2018; Mirkin et al. 2019) and non-hormonal (LaCroix et al. 2012; Meyer et al. 2016; Kulkarni et al. 2018) as well as alternatives such as isoflavones (Chen et al. 2016; Lee et al. 2017; Vitale et al. 2018) or black cohosh (Oktem et al. 2007; Jiang et al. 2015). Experimental designs also include therapeutic interventions: CBT (Ayers et al. 2012; Kauffman and McCurry 2016; Hardy et al. 2018a) and Mindfulness (Carmody et al. 2011; Enjezab et al. 2019) as well as alternative interventions such as acupuncture (Oktem et al. 2007; Nedeljkovic et al. 2014; Avis et al. 2017; Liu et al. 2018) and yoga (Reed et al. 2014; Jorge et al. 2016).

The main focus of menopause studies using quantitative designs tend to be the most frequently reported 'symptoms', hot flushes and night sweats, with the majority of studies reporting at least some success regardless of intervention. Some studies include a qualitative element to their research complementing the findings and presenting experiences of menopause (Hunter et al. 2009; Chou et al. 2013; Rubinstein and Foster 2013; Morrison et al. 2014; Wong et al. 2018). One study (Balabanovic et al. 2013) used interpretative phenomenological analysis (IPA) as a data analysis method to explore women's perspectives of using CBT to mediate their experience of hot

flushes and night sweats. The data analysis reported lacks the ideographic focus expected in an IPA study with Balabanovic et al. (2013) acknowledging that the findings were more akin to phenomenology. Individual interviews and data analysis focused on the intervention (CBT) and the process (what changed) as study outcomes aligning with a qualitative approach rather than aligning with the theoretical principles of IPA (discussed in Chapter Three section 3.2). These provided useful but limited perspectives of women's experiences of menopause.

Although menopause is postulated as multidimensional current methodologies that enable an exploration of complexity from the perspective of women themselves have been largely absent. Knowledge about the menopause is essentially biological and intervention focused, and while there is a need for this, it is equally important to understand what it is like for women living and experiencing the menopause. To fully understand women's lived experience studies using naturalist inquiry are essential.

1.7 Research Project

The aim of this research is to provide an in-depth exploration of the natural menopause as it is experienced by women themselves using naturalist inquiry. My interest in women's health stems from my first post as a Registered Nurse working in gynaecology and breast surgery in the early 1990s. I distinctly remember being told by one of the medical consultants that women should start taking the oral contraceptive pill when they started menstruating and move onto HRT once they reached menopause. I did not question this 'wisdom' at the time and gave many women the same advice until studies started to suggest that artificial hormones were not without long term risk.

Although my career has taken different directions since that time I have maintained an interest in the female body not least because I am female and curious about how the body functions and adapts throughout the life course. Like others in this study, the menopause was not something that had entered into my consciousness other than talking about HRT with women in my early career. However, as a midlife woman working with many other midlife women, this is something that I started to think about. I noticed women experiencing 'symptoms' of menopause, particularly hot flushes but not necessarily talking about them. One colleague had extremely heavy bleeding and came to work with several changes of clothing, determined to carry on as normal despite the obvious inconvenience.

Working in a profession that employs predominantly women many of whom will work well into their 60s, they will also be working through the menopause. In November 2017, 77% of all staff in the National Health Service (NHS) were women and of the 288,081 nurses and health visitors,

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89% were female (NHS Digital 2018). Although statistical data relating to the age range of female employees was not available in the data presented by NHS Digital, it is known that there is an increasing trend of employed midlife women (Brewis et al. 2017).

Following the publication of the first NICE Guideline relating to the menopause in 2015 (NCC-WCH 2015) there has been a renewed interest in the menopause resulting in an increase in publications and workplace related policy (Davis 2015; Royal College of Midwives 2016; Royal College of Nursing 2016; Brewis et al. 2017; University of Leicester 2017; Hardy et al. 2018b; Bridgewater Community Healthcare NHS Foundation Trust no date). Study recommendations highlight the importance of having a positive, open culture to empower women to speak up about any challenges they are experiencing during the menopause and postmenopause (Brewis et al. 2017; Hardy et al. 2018b; Faculty of Occupational Medicine of the Royal College of Physicians).

I felt that it was important to understand something about how this somewhat silent part of life impacts on women, how they manage any challenges and how they make sense of the experience. The experience of menopause by contemporary women has been suggested to be different from the menopause experienced by their mothers (Utz 2011). Women's roles have changed dramatically and women speaking to their mothers about their experiences are comparing different historical contexts. The menopause experience has been fundamentally changed due to the intervention of medicine and specifically through medicine's engagement with HRT.

The menopause can impact on women from a biopsychosocial and cultural perspective (Hunter and Rendall 2007). To date there has been a paucity of research exploring how women experience and make sense of the menopause in the context of their lives. This research aims to add to a growing range of knowledge by exploring how the menopause is understood and experienced by women within the contemporary context of their lived experience.

Research Question

What are women's lived experiences of the transition to natural menopause?

Research Objectives

- i. To explore how women make sense of their transition to menopause and the meaning they attribute to their experiences within the context of their lives.
- ii. To understand the shared perspectives of women as they transition to menopause.

1.8 Overview of the Thesis

Chapter One has situated the study phenomenon, the menopause, within a contemporary context for midlife women and the influence of theoretical perspectives. The chapter focuses on the discoveries of oestrogen and progesterone which fundamentally changed the experience of the menopause. The chapter proposes that the discovery of female sex hormones and the subsequent ability to synthetically replicate oestrogen and progesterone were key in the medicalisation of female reproductive health and particularly the menopause. Chapter One has also presented the research question and objectives.

Chapter Two presents a scoping review of the literature using the framework developed by Arksey and O'Malley (2005). The scoping review explores the extent to which the lived experience of the menopause has been studied in the literature since 2002 following the publication of results from the Women's Health Initiative (2002) and the Million Women Study (Beral and Million Women Study Collaborators 2003). The chapter concludes by identifying gaps in the current literature.

Chapter Three articulates the chosen methodology for this study, Interpretative Phenomenological Analysis and the research design. The chapter presents the decision-making process underpinning this choice and details ethical considerations, data collection, ensuring quality in the research process and an overview of data analysis.

Chapter Four presents an overview of the pilot study and data analysis of nine participant's data. The analytic process leading to the development of the super-ordinate theme, women's business is demonstrated via the data of one participant in phase one and phase two of study. The chapter concludes with the cross-case analysis and identification of the eight super-ordinate and 54 emergent themes that led to the development of three higher order concepts.

Chapter Five commences with the higher order concepts and cross-case super-ordinate themes presented with quotes demonstrating the idiographic perspectives of the participants. The interpretation of the findings represents the double hermeneutic of the researcher's interpretation of the participants making sense of their lived experiences of the natural menopause. The discussion focuses on abstraction and my interpretation of the findings.

Chapter Six concludes the thesis by demonstrating the contribution of this study to the existing knowledge base by making visible the lived experience of the nine women participants in this study, and identifying recommendations and future research. The study limitations are discussed and the chapter concludes with a discussion of reflexivity and my personal reflections on undertaking and completing this thesis.

Chapter 2 Literature Review

2.1 Introduction

Chapter Two provides an outline of the literature review methodology, a detailed record of the literature exploring what is known about the phenomenon, women's experiences of natural menopause and how this has been studied within contemporary literature. Bazeley (2013) suggests that a literature review is an important starting point in any thesis as it will clarify what is known about a topic and inform data collection and analysis. Smith et al. (2009) suggest that an understanding of current literature can help researchers learn something about participant views while Bazeley (2013) argues that critically reviewing the literature to seek alternative views is one technique for challenging the researcher's own worldview.

The literature review is a key step in identifying gaps in the body of knowledge related to the phenomenon under exploration. Having looked at the literature generated under the positivist paradigm, which is the dominant voice in the literature in Chapter One, the key findings articulated from a fundamentally positivist perspective were based on symptoms and interventions. Empirical studies predominantly used RCT and cross-sectional design with data collected using surveys, rating scales and outcome measures. The empirical focus on rational, reductionist methods results in a narrow, specific focus such as vasomotor symptoms, sexual issues and drug therapy, (Meyer et al. 2016; Andac and Aslan 2017; Worsley et al. 2017; Diem et al. 2018; Gozuyesil et al. 2018; Kim et al. 2018; Kulkarni et al. 2018; Dąbrowska-Galas et al. 2019). Therefore, Chapter Two aims to present the literature that goes beyond objectivist epistemology to explore the quieter voice of data collected under the naturalist paradigm. Empirical studies using naturalistic inquiry do not appear to have been fully represented within the literature and underpin my area of interest, the lived experience of women themselves.

2.2 Literature Review Methodology

Scoping reviews are increasingly being used in healthcare to inform current practice and identify future research questions (Pham et al. 2014). Colquhoun et al. (2014) reported that before 2009 there were less than ten scoping reviews published annually across a number of healthcare related journals, but by 2013 this had risen to 85. Colquhoun et al. (2014 pp.1292-1294) define a scoping review as "a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge".

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A structured systematic framework needs to be applied if they are to achieve the aim of identifying gaps in the literature and considering the need for future research (Daudt et al. 2013; Tricco et al. 2016). Scoping review methodologies are usually selected where the aim is to identify a breadth of evidence and to map the scope, nature and extent of research evidence related to the topic of interest.

A key component in obtaining high quality results is aligning the review methodology with the topic being studied (Pawson et al. 2005). Prior to selecting a scoping review methodology other review methodologies were considered but rejected, see Table 2.1.

Table 2.1 Other literature review methodologies considered³

Types of literature review	Key components	Rational for rejection
Systematic Literature Review	<ul style="list-style-type: none"> •Aims to answer in-depth a clearly formulated research question •Has a clearly stated set of objectives with pre-defined eligibility criteria for studies •Has an explicit, reproducible methodology •A systematic search that attempts to identify all studies that would meet the eligibility criteria •An assessment of the validity of the findings of the included studies, for example through the assessment of risk of bias •A systematic presentation, and synthesis, of the characteristics and findings of the included studies 	Systematic reviews use only empirical evidence to answer specific and narrowly defined research questions. This methodology was not suitable as the aim of the review in this thesis was to answer a broadly framed review question; What is currently known about the experiences of women during the menopause?
Systematic Review: Meta-analysis	<ul style="list-style-type: none"> •A form of systematic review •Takes findings from several studies on the same subject and analyses them using standardised statistical procedures •Tests a hypothesis using quantitative data •Integrates findings from a large body of quantitative findings to enhance understanding (study=unit of analysis) <p>Draws conclusions and detects patterns and relationships</p>	Meta-analysis is suitable for studies within the positivist paradigm. The study reported in this thesis is within the naturalist paradigm therefore the review methodology needed to facilitate exploring studies with qualitative content.
Rapid evidence reviews Also known as: Rapid systematic review Rapid evidence summary	<ul style="list-style-type: none"> •Used to summarise the available research quickly •Carried out within a given timetable, typically three months or less. •Differs from full systematic review as there are limitations on the extent of the searches and other review activities. 	This methodology aims to synthesise empirical research only and to provide provisional findings to underpin outcomes such as policy development. Therefore, this methodology was not suitable for the review in this thesis where the aim was to map literature exploring the experiences, views and perceptions of women for

³ Adapted from: Lau F and Kuziemsky C (2017) *Handbook of eHealth Evaluation: An Evidence-based Approach*. Victoria (BC): University of Victoria Available from: https://www.ncbi.nlm.nih.gov/books/NBK481590/pdf/Bookshelf_NBK481590.pdf Handbook of eHealth Evaluation: An Evidence-based Approach with permission from University of Victoria and Paré G, Trudel M-C, Jaana M and Kitsiou S (2015) Synthesizing information systems knowledge: A typology of literature reviews. *Information & Management* 52(2): 183-199 Synthesizing information systems knowledge: A typology of literature reviews with permission from Elsevier.

Types of literature review	Key components	Rational for rejection
	<ul style="list-style-type: none"> • Useful to policymakers who need to make decisions quickly • Should be viewed as provisional appraisals, rather than full systematic reviews 	discussion and has a broad review question.
Traditional or Narrative literature Review	<ul style="list-style-type: none"> • Critiques and summarizes a body of literature • Draws conclusions about a particular topic • Identifies gaps or inconsistencies in a body of knowledge • Search strategy is selective in nature. • Authors usually select studies that support their own view. 	Narrative reviews aim to retrieve studies that are focused on a specific topic, often those that support the authors view whereas the review in this thesis aimed to retrieve a wide remit of information (not limited to empirical research) providing a breadth of work including the lived experience.
Meta-synthesis Also known as: Meta-ethnography Meta-grounded theory	<ul style="list-style-type: none"> • Non-statistical technique • Integrates, evaluates and interprets findings of multiple qualitative research studies • Identifies common core elements and themes • May use findings from phenomenological, grounded theory or ethnographic studies • Involves analysing and synthesizing key elements • The aim is to transform individual findings into new conceptualizations and interpretations 	Meta-synthesis uses qualitative studies to generate new theory whereas the aim of the review in this thesis was to explore the experiences, views and perceptions of women rather than generating theory.
Realist Reviews	<ul style="list-style-type: none"> • Focuses on complex interventions applied in diverse contexts to inform policy decision-making • Draws on a range of methodologically diverse material • The protocol is iterative rather than pre-defined • The value of studies is established in synthesis • They are not standardized or replicable • Aims to provide a holistic interpretation of a phenomenon through theoretical saturation. • Aims to inform, enhance, extend, or supplement conventional systematic reviews • Results are explanatory rather than making judgements e.g. explain how complex programmes work or why they fail in a specific context. 	This methodology seeks literature relating to interventions only, this review methodology was not suitable. The aim of the literature review in this thesis was to identify information exploring the lived experiences, views and perceptions of women of menopause, rather than focusing on an intervention.

The use of a scoping review was the most appropriate methodology to answer the review question and meet the aims identified in Stage 1 of the Arksey and O'Malley (2005) framework and reported below (section 2.3). Scoping reviews are designed to answer broad questions while facilitating a comprehensive, iterative search of the literature (Lau and Kuziemsky 2017). There is utility to synthesise empirical research to map the evidence and this methodology can be successfully used to explore evidence related to a specific time or place (Peters et al. 2015). The temporality of menopause makes a scoping review methodology relevant to search for literature focusing on women's views during this time.

Although the aim in applying a scoping review methodology is breadth, it is essential to produce a transparent, reproducible scoping review with data extracted and presented in a structured way (Grant and Booth 2009; Peters et al. 2017; Munn et al. 2018) and there are now a range of protocols for undertaking scoping reviews have been developed including: Arksey and O'Malley (2005), Levac et al. (2010) and most recently the Joanna Briggs Institute (Peters et al. 2017). An overview of scoping review frameworks is presented in Table 2.2 for an overview of. Levac et al. (2010) added additional detail to each stage of the first protocol developed by Arksey and O'Malley (2005) but this did not substantially change the original framework.

For this thesis three literature reviews took place, the first review for the upgrade document in 2017, the second for the thesis and viva submitted in June 2019 and the final scoping review was completed in November 2019 for the post viva thesis submission in March 2020. The three reviews used the Arksey and O'Malley (2005) scoping review framework although as the thesis developed and having read more broadly about review methodologies I kept updated on the development of scoping reviews at the Joanna Briggs Institute. Scoping review protocols have continued to evolve (Table 2.2), but it is the Arksey and O'Malley (2005) protocol that remains the seminal work that underpins scoping review protocols that have been subsequently developed (Cacchione 2016; Peters et al. 2017).

Table 2.2 Scoping review frameworks⁴

	Arksey and O'Malley framework (2005 p.22-23)	Enhancements proposed by Levac et al. (2010 p.4-8)	Enhancements proposed by Peters et al. (2015); (Peters et al. 2017)
1.	Identifying the research question	Clarifying and linking the purpose and research question	Defining and aligning the objectives and question/s
2.	Identifying relevant studies	Balancing feasibility with breadth and comprehensiveness of the scoping process	Developing and aligning the inclusion criteria with the objective/s and question/s
3.	Study selection	Using an iterative team approach to selecting studies and extracting data	Describing the planned approach to evidence searching, selection, extradition, and charting
4.	Charting the data	Incorporating a numerical summary and qualitative thematic analysis	Searching for the evidence
5.	Collating, summarizing and reporting the results	Identifying the implications of the study findings for policy, practice or research	Selecting the evidence
6.	Consultation (optional)	Adopting consultation as a required component of scoping study methodology	Extracting the evidence
7.			Charting the evidence
8.			Summarizing the evidence in relation to the objective/s and question/s
9.			Consultation of information scientists, librarians, and/or experts throughout

The key challenge for researchers undertaking a scoping review is for the process to be systematic, robust, auditable and reproducible. This is achieved by applying a framework such as Arksey and O'Malley (2005), developing a review question and associated aims and objectives, the articulation and application of a rigorous analytic technique and illustrating a robust audit trail of

⁴ Reproduced with permission from: Aromataris E, Munn Z (Editors). *Joanna Briggs Institute Reviewer's Manual*. The Joanna Briggs Institute, 2017. Available from <https://reviewersmanual.joannabriggs.org/>

process and outcomes. The review questions should be informed by key elements for example: Population, Issue, Outcome ((PIO) Bettany-Saltikov 2016).

Tricco et al. (2018) published an extension of the former preferred reporting items for systematic reviews and meta analysis (PRISMA) endorsed by the Joanna Briggs Institute for use with scoping reviews. Although the scoping review framework remains fundamentally the same, in response to examiner feedback I have made the use of the three-step search strategy recommended by The Joanna Briggs Institute (2015) more explicitly in Stages 2 and 3 (identifying relevant studies and study selection) of the Arksey and O'Malley scoping review framework. This was advantageous in articulating the identification of key words and testing search terms demonstrating the iterative nature of a scoping review and improving rigour in identifying studies. Table 2.3 illustrates the scoping review framework and how it has been applied in this review.

The following sections illustrate the scoping review process undertaken as per Arksey and O'Malley's (2005) framework (Table 2.2).

Table 2.3: Arksey and O'Malley (2005) Scoping review framework

Stage:	Approach:	Detailed in:
Stage 1: Identifying the research question	<ul style="list-style-type: none"> Define a broad review question to generate a breadth of results; Define parameters after familiarisation with the scope and potential volume of literature. 	Section 2.3: Review question and review objectives
Stage 2: Identifying relevant studies	<ul style="list-style-type: none"> Decide search terms, sources, time span, and language; 3-step search strategy recommended by the Joanna Briggs Institute (JBI): <ol style="list-style-type: none"> A search of 2 databases to allow for analysis of text words contained in the title and abstracts and index terms used to describe the articles. A second search using all identified key words and index terms across all databases. Reference list search of all identified articles Search different sources to be as comprehensive as possible: electronic databases for studies, theses and conference papers. Clearly state factors that have the potential to limit the review. 	Section 2.4 JBI Steps 1 & 2 applied in stage 2 of the upgrade literature review Section 2.4.1 Section 2.4.2 JBI Step 3 was applied in Stage 3: Section 2.5: Study selection Table 2.7 Bibliographic databases Section 2.2: Literature review methodology
Stage 3: Study selection	Study selection: <ul style="list-style-type: none"> Define inclusion and exclusion criteria based on review question. Obtain full text articles for studies that represent the 'best fit'. Apply JBI Step 3: Reference list search of all identified full text articles. Set a deadline after which no further studies will be included: November 2019. 	Section 2.5 Table 2.10 Figure 2.1 6 additional records identified Figure 2.1 Table 2.10

Stage:	Approach:	Detailed in:
Stage 4: Charting the data	<ul style="list-style-type: none"> • Apply a descriptive analytical method to data charting; • Data charting included: <ul style="list-style-type: none"> ○ Author(s) ○ Year of publication ○ Country of origin ○ Study population/sample size/ participants ○ Aims of the study ○ Methodology ○ Key findings 	Section 2.6 Table 2.11 Charting the data
Stage 5: Collating, summarizing and reporting the results	<ul style="list-style-type: none"> • Use a narrative account to provide an overview of the breadth of literature but not a synthesis. • Present findings as: <ul style="list-style-type: none"> ○ A basic numerical analysis of the extent, nature and distribution of the studies included in the review. detailing author(s), year of publication, country of origin, study population/sample size/ participants, aims of the study, methodology and key findings. ○ A thematic analysis of the literature. 	Section 2.7 Addressing scoping review <i>Objective 1</i> Addressing scoping review <i>Objective 2</i>
Stage 6: Consultation (optional)	<ul style="list-style-type: none"> • Use research supervision to develop a 'team' approach to literature selection and gain additional insights, references and discussion to challenge thinking. • Consultation with the librarian as an expert in their field of practice. 	This was done consistently over the period of generating the thesis.

2.3 Stage 1: Identifying the Research Question

To refine development of the research question, the following review question was developed facilitated by use of the PIO format (Bettany-Saltikov 2016) (Table 2.4).

What is currently known about the experiences of women during the menopause?

Review objectives:

Objective 1: To map how researchers have explored the menopause from the perspective of women since the publication of the Women's Health Initiative (2002).

Objective 2: To identify the experiences, views and perceptions of women during the menopause reported in the current literature.

Table 2.4 PIO format

P	Population	Women who have experienced the transition to menopause
I	Issue	Transition to menopause
O	Outcomes	Experiences and views of the transition to menopause.

2.4 Stage 2: Identifying Relevant Studies

2.4.1 Developing Search Terms

The first review of the literature had been carried out as part of the upgrade to PhD process using Arksey and O'Malley's 2005 seminal framework over a five-year period, 2012 to 2017. The literature search for the thesis submission and viva reviewed the period from January 2002 until October 2018. Following the viva a final scoping review was completed covering the period from January 2002 until November 2019. The PIO format from the upgrade search remained unchanged but the search terms were refined as a result of the JBI three step search strategy.

Two databases, CINAHL and Medline, were searched to allow for an analysis of text contained in the title, abstracts and identify index terms used to describe the articles (JBI Step 1). This step

identified that the terms 'the change' and 'change of life' which were search terms used in the upgrade literature review (Table 2.5) were not used in the titles, abstracts or index terms, therefore they were removed. To reduce hits for studies examining conditions or procedures that may be associated with menopause; cardiac, fibroid and hysterectomy were added for use with the Boolean operator NOT (Table 2.6). Search terms added following JBI Step 1 were 'lesbian' and 'gay'; to reflect that women experiencing menopause may identify themselves in different ways (Table 2.5) and qualitative was added for the final scoping review to maximise the potential of retrieving papers that reported women's experiences which was the focus of this study

Table 2.5 PIO format and search terms

			Upgrade Scoping Review Search Terms	Thesis Submission and Viva Scoping Review	Final Scoping Review Search Terms
P	Population	Women who have experienced the transition to menopause	Women, woman, female	Women, woman, female, lesbian, gay	women, woman, female, lesbian, gay
I	Issue	Transition to menopause	Menopause transition, menopause transition, menopausal transition, perimenopause, climacteric, menopause, the change, change of life	Menopause transition, menopausal transition, perimenopause, climacteric, menopause	Menopause transition, menopausal transition, perimenopause, climacteric, menopause
O	Outcomes (identification of themes)	Experiences and views of the transition to menopause.	Experience, views, lived experience, daily living, quality of life, QOL of the menopausal transition.	Lived experience, quality of life, QOL, perception, views, attitudes	Lived experience, qualitative experience, quality of life, QOL, perception, views, attitudes

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The search strategy was developed with truncation (* in Table 2.6) and Boolean operators: AND, OR and NOT used to expand or reduce search parameters. The differing UK and USA spelling of words such as oestrogen and estrogen were compensated for by using both spellings to reduce the search parameters using NOT. The aim was to limit studies with a focus on medical conditions, symptoms or oestrogen therapy. There were a range of terms used interchangeably in the literature when referring to the menopause including menopause, menopausal, menopause transition, perimenopause and climacteric.

Table 2.6 Search terms and boolean operators

Search Terms and Boolean Operators		
Upgrade Scoping Review	Thesis submission and Viva Scoping Review	Final Scoping Review
woman OR women OR female AND "menopaus* transition*" OR menopaus* OR perimenopaus* OR "peri menopaus*" OR peri- menopaus* OR climacteric AND "quality of life" OR "QOL" OR "lived experienc*" OR perception* OR view* OR attitude* OR perceiv* NOT oosteopo* NOT cancer NOT incontinen* NOT oestrog* NOT estrog* NOT heart	woman OR women OR female OR lesbian OR gay AND "menopaus* transition*" OR menopaus* OR perimenopaus* OR "peri menopaus*" OR peri- menopaus* OR climacteric AND experienc* OR "quality of life" OR "QOL" OR "lived experienc*" OR perception* OR view* OR attitude* OR perceiv* NOT oosteopo* NOT cancer NOT incontinen* NOT oestrogen NOT estrogen NOT heart NOT cardi* NOT fibroi* NOT Hysterectom*	woman OR women OR female OR lesbian OR gay AND "menopaus* transition*" OR menopaus* OR perimenopaus* OR "peri menopaus*" OR peri- menopaus* OR climacteric AND experienc* OR "quality of life" OR "QOL" OR "lived experienc*" OR perception* OR view* OR attitude* OR perceiv* OR qualitative NOT oosteopo* NOT cancer NOT incontinen* NOT oestrogen NOT estrogen NOT heart NOT cardi* NOT fibroi* NOT Hysterectom*

2.4.2 Database Selection

The key aim of database selection was to gain literature from both a medical and non-medical perspectives and disciplines including health sciences, professions allied to medicine, social science, the arts and humanities. The upgrade scoping review used 5 databases but following the upgrade review this was extended to ten to ensure a comprehensive search across disciplines. Table 2.7 lists the 10 bibliographical databases searched in the final literature review using all key words and index terms (JBI Step 2) identified in Step 1 of the JBI three step search strategy.

Table 2.7 Bibliographic databases

Database	Selection criteria	Upgrade	Final
AMED 1995 to present	Covers complementary medicine and some journals from professions allied to medicine.	✓	✓
CINAHL plus with full text: 1937 to present	Provides comprehensive access to journals related to nursing and allied health.	✓	✓
Cochrane 1996 to present	Gives access to Cochrane systematic reviews and randomised control trials.		✓
Embase 1980 to 2019 week 41	A clinical medicine and biomedical database.		✓
International Bibliography of the Social Sciences (IBSS) 1951 to present	Provides access to article abstracts, books and book chapters in the social sciences with strengths in sociology and anthropology.		✓
Medline 1949 to present	This is a comprehensive database giving access to journal articles from the fields of medicine and the clinical sciences including psychology.	✓	✓
PsycINFO 1887 to present	The largest database for behavioural science and mental health.	✓	✓
Scopus 2004 to present	The largest abstract and citation database of peer reviewed literature in the fields of science, medicine, social science, arts and humanities.		✓
Sociological abstracts 1952 to present	Provides abstracts of books, book chapters, conference papers and dissertations as well as journal articles in the social and behavioural sciences.		✓
Web of Science 1975 to present (Arts and humanities) 1970 to present (everything else)	Provides access to articles from the sciences, social science, arts and humanities.	✓	✓

2.4.3 Search Procedure

The search terms (Table 2.6) were applied to the databases with the listed limiters. The limiters varied according to the database (for limiters applied see Table 2.8). CINAHL, Medline and PsycINFO had the option to set a limiter for 'middle age' which corresponded to the age range in which the majority of women experience the menopause. The search was not limited to research papers with the aim of retrieving conference papers and theses relevant to the review.

Table 2.8 Database searches

Database	Date of search	Number of articles	Limiters
CINAHL plus with full text:	6/10/2019	671 AB	Jan 2002 - Nov 2019 English language Middle aged- 45-64 Female
Medline	6/10/2019	1343 AB	Jan 2002 - Nov 2019 English language Middle aged- 45-64 Female
PsycINFO	6/10/2019	528 AB	Jan 2002 - Nov 2019 English language Middle aged- 40-64 Female
AMED	6/10/2019	43 AB	Jan 2002 - Nov 2019 English
Web of Science	7/10/2019	422 TI	2002 - 2019 English
Cochrane	7/10/2019	72 TI	2002-2019 NOT RCT NOT "randomised control trial" NOT randomized
Sociological Abstracts	9/10/2019	171 AB	Jan 2002- Nov 2019 English language
Scopus	7/10/2019	1268 TI	2002-2019 English NOT RCT NOT "randomised control trial" NOT randomized
IBSS	7/10/2019	104 AB	Jan 2002- Nov 2019 English language
Embase	7/10/2019	398 AB	2002-2019 English language 18-64 years Human Female

2.5 Stage 3: Study Selection

Arksey and O'Malley (2005) outline the importance of the scoping review being comprehensive and inclusive of a wide range of 'evidence' that can contribute to answering the review questions. Levac et al. (2010) argue that the identification of relevant studies is an iterative rather than a linear process involving searching the literature, reviewing abstracts then refining the search strategy. They suggest that this is a critical step in deciding which studies are appropriate for inclusion in or exclusion from the review.

2.5.1 Inclusion/Exclusion Criteria

The upgrade scoping review explored studies over a period of five years (2012-2017) from five databases. The inclusion and exclusion criteria had much less detail (Table 2.9) and did not articulate the rationale for each criterion. For the upgrade scoping review the number of hits were much smaller (Appendix A) and the lack of detail was less apparent in the application of the inclusion/exclusion criteria to the hits. However, as the parameters changed for the later scoping reviews the inclusion/exclusion criteria needed to be more detailed and incorporate a wider date range (2002 until November 2019). Peters et al. (2017) argues the application of inclusion/exclusion criteria provides clarity, transparency and focus on retrieving literature relevant to the review question.

Table 2.9 Upgrade scoping review inclusion/exclusion criteria

Inclusion:	Exclusion:
Studies in the last 5 years (1st January 2012 to 1st January 2017)	Studies over 5 years old (Before January 2012)
Related to the lived experience of the transition to menopause Women's views	Alternative therapies HRT, exercise Mental health/learning disability Surgically or chemically induced menopause Not related to the menopause transition Not related to the lived experience Healthcare professionals' views
Language: English	Other languages

For the final scoping review the inclusion and exclusion criteria were further developed to provide clarity and transparency about the process of study selection (Table 2.10). This allowed for the identification of more studies relevant to the review questions for the final thesis scoping review.

Table 2.10 Inclusion/exclusion criteria

Inclusion:	Exclusion:	Rationale
Literature using terminology related to the transition to menopause: Menopause, natural menopause, menopause transition, perimenopause or climacteric	Surgically or chemically induced menopause, premature ovarian insufficiency (POI). Studies with participants with a long-term condition (LTC) before the transition to menopause such as diabetes, HIV, depression and obesity.	Surgically and chemically induced menopause and POI have a different trajectory compared to a natural transition which is the focus for this study. The LTC or prescribed medication may impact on the experience of natural menopause.
Related to the lived experience of the transition to menopause	Literature focusing on specific conditions such as incontinence, cardiovascular disease or osteoporosis. Studies that focus on intervention such as HRT, alternative therapies and exercise. Studies that measure experiences quantitatively. Studies that focus on a specific aspect of menopause such as hot flushes or sexual contact.	Literature related to the qualitative experiences of women as the focus of this study is how women make sense of their lived experienced rather than focusing on a specific 'condition' or specific aspect of menopause.
The views of women about their experience of the transition to menopause	The views of other people.	The views of women who have experience of the transition to menopause are the focus for this study rather than the views of other people.
Language: English	Other languages	English is my first language and there was no access to translation services.
Time-line: Publications with data collection from April 2002 - November 2019.	Data collection before April 2002	This study is interested in contemporary views and experiences of women following the publication of the results WHI (2002) and the Million Women Study (2003). Participants in studies pre-2002 would not have been exposed to the media coverage and subsequent changes in health seeking behaviours for women experiencing the transition to menopause.

The retrieved studies needed to be written in English but as the menopause affects all women who reach mid-life (Hunter and Rendall 2007; Moilanen et al. 2010) the studies were not limited to the UK. It has been postulated that different cultural and social groups have differing experiences of the menopause (Kowalcek et al. 2005; Ayers et al. 2010; Delanoe et al. 2012); it was important to be able to consider not only the experiences of other cultural groups but how empirical studies had been conducted compared to the UK to situate this study within the national and international context.

The inclusion criteria included publications in which data collection had taken place between April 2002 and November 2019. This was to gain contemporary literature following the publication of the WHI study results in 2002⁵ and in response to Granville's (2000) commentary that up until that point menopause as a natural event had received minimal exploration and therefore alternative explanations of women's varied experiences were missing from the dominant biomedical model of the menopause. I, wanted, therefore to scope the literature from 2002 to explore the evidence after the findings of the Women's Health Initiative (2002) and the Million Women Study (Beral and Million Women Study Collaborators 2003) to establish if this had resulted in an increase in empirical studies using methodologies aligned with the naturalist paradigm focusing on women's lived experiences.

The inclusion/ exclusion criteria (section 2.5.1) were applied to hits gained after applying the search terms and Boolean operators (Table 2.6). The process for study selection is outlined in the PRISMA Moher et al. (2009) flowchart in Figure 2.1.

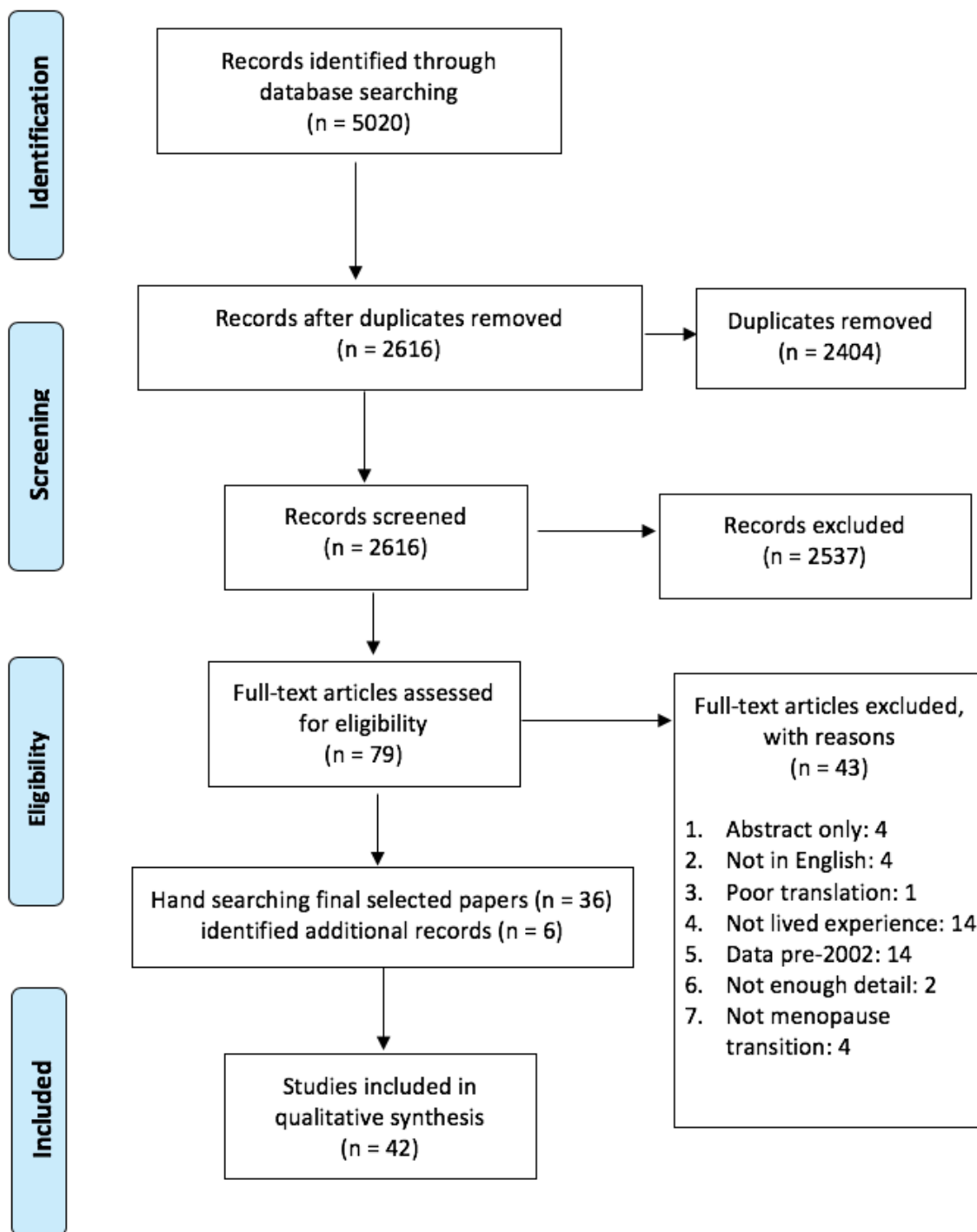
Database searches resulted in 5,020 references being imported to a reference management software package, Endnote X9. Following duplicate removal (2,404 papers), 2,616 papers underwent title and abstract review against the review objectives and the inclusion/exclusion criteria (Table 2.10). A further nine hundred and sixty-eight studies were excluded as the focus was the impact of menopause symptoms via positivist inquiry that were not the focus of the review.

The final study selection included 79 studies that underwent full paper review, with a further 43 papers excluded (Appendix B, PRISMA Figure 2.1). Step 3 of the JBI three step search strategy was applied at this point to the reference lists of the 36 remaining studies. Six further studies were identified from hand searches of the final selected papers. Forty-two studies were included in the

⁵ The WHI was the first larger scale RCT of midlife women taking HRT and resulted a reduction in the popularity of HRT for the management of menopause (see Chapter 1 section 1.5.2).

final review. Charting the data including six studies identified through the reference lists and reported on the PRISMA as identified from additional sources.

Figure 2.1 PRISMA



(Adapted from Moher et al. 2009)

2.6 Stage 4: Charting the Data

Charting the data is a key element in generating a robust scoping review (Levac et al. 2010; Fitzgerald et al. 2015). In response to the one of the aims of the scoping review identified by Arksey and O'Malley (2005): to examine the extent, range and nature of research activity within the area of interest, the following data were extracted with the outcomes of charting illustrated in Table 2.11:

- Author(s)
- Year of publication
- Country of origin
- Study population/sample size/ participants
- Aims of the study
- Methodology
- Key findings

(Arksey and O'Malley 2005; Peters et al. 2017)

The studies are presented alphabetically in the table below. Each article was allocated an identification number from 1 to 42 to provide ease of cross referencing between the information reported in the following sections and the table charting the data (Table 2.11).

Table 2.11 Charting the data

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
1.	Breidenbach (2009) Land dykes in the Ozarks: Lesbian feminists living menopause and beyond USA	To engage in the production of knowledge by privileging the voices of often marginalized lesbian women to present a fresh narrative of menopause	N = 12 11 postmenopausal 1 peri-menopausal Age: 49-75 Gender: Female Design: Feminist sociological Data collection: Interviews and participant observation Analysis: Narrative and thematic analysis	Positive views of the menopause: A metamorphosis; creating and embracing the new, naturally occurring process Women were in a position of agency in making decisions about their bodies and health. Women engaged in multiple discourses and practices Sharing intergenerational knowledge with a supportive community of women Menstrual blood viewed as a tool of resistance Other findings: Uncertain if physical changes are related to menopause because menopause can only be recognised retrospectively. Medical opinions sought when unsure about the changes in bleeding
2.	Christoforou (2018) Uncontrollable bodies: Greek Cypriot women talk about the transition to menopause Cyprus	To explore Greek Cypriot women's interpretations and experiences of menopause and the menopausal body.	N = 10 4 peri-menopausal 6 postmenopausal Age: 47-73 Gender: Female Design: Grounded theory. Data collection: Interviews	Positive views of the menopause: Considered the menopause as a normal life event No longer having to worry about pregnancy or menstruation Negative views of the menopause: A concern about Osteoporosis risk Looking old and having an identity as an older person Menopause articulated as a problem external from the body Changes related by participants to the menopause: Heavy bleeding

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			Analysis: Constant comparison method	Vaginal dryness and reduced libido Weight gain Physical, psychological and emotional changes felt uncontrolled and unpredictable
3.	Cifcili et al. (2009) "I should live and finish it": A qualitative inquiry into Turkish women's menopause experience Turkey	To explore the perceptions of Turkish women regarding menopause and Hormone Therapy	n=16 Age: 42-53 Gender: Female Design: Qualitative Data collection: Semi-structured interviews Analysis: Thematic analysis using Strauss' Constant Comparison method	Positive views of the menopause: No risk of pregnancy and the end of menstrual symptoms Defined as maturity and a natural period Not as bad as participants perceived it was going to be Negative views of the menopause: Related to getting old Changes related by participants to the menopause: Irritability that interfered with family relationships. Sexual dysfunction because of vaginal dryness and a loss of sexual interest Hot flushes Other findings: Attended more routine screening. Lack of family support was felt to worsen issues Attitudes to HRT were generally negative but non-pharmacological interventions such as diet, exercise and herbal products helped with hot flushes. Knowledge sources were mainly the media and friends
4.	Dare (2011) Transitions in midlife women's lives: contemporary experiences	To understand women's subjective experiences of midlife transitions	n=40 Age: 45-55 Gender: Female	Positive views of the menopause: Free from menstruation 'Symptoms' irritating rather than difficult

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	Australia		Design: Ethnography Data collection: Semi-structured interviews Analysis: Thematic analysis using NVivo 8	Changes related by participants to the menopause: Hot flushes and night sweats causing sleep disruption Other findings: Occurs at a time when other stressors are happening
42 5.	de Salis et al. (2018) Experiencing menopause in the UK: The interrelated narratives of normality, distress, and transformation UK	To investigate the experience and perspectives of the menopause	n= 48 16 pre- 21 peri- 11 post menopause Age: 49-56 Gender: Female Design: Qualitative Data collection: In-depth interviews Analysis: Thematic analysis using NVivo10	Positive views of the menopause: A normal process which is insignificant in the context of their lives Re-emerging sexuality New beginning, a merging with a new self-identity and narratives of transformation Negative views of the menopause: Didn't feel like themselves due to changes Feeling old and reduced attractiveness Ending of sex lives perceived to be due to a lack hormones Identity crisis when children left home Changes related by participants to the menopause: Uncontrolled emotions Hot flushes Poor sleep Vaginitis Joint stiffness Other findings: Compared their experiences to others and minimised their own experiences including normalising and downplaying unwanted symptoms.

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				Healthcare professionals dismissed experiences. Narratives of distress and normality can be simultaneously held.
6.	Duffy et al. (2011) The menopause 'It's somewhere between a taboo and a joke'. A focus group study UK	To explore the menopause from the perspective of women in the community	n=14 2 peri menopausal 4 menopausal 7 postmenopausal 1 not sure Age: 45-60 Gender: Female Design: Qualitative Data collection: Focus groups Analysis: Framework analysis	Positive views of the menopause: Discussions with other women allows the normalisation of symptoms and for the discussion of management options and support. Negative views of the menopause: Fear that they might be thought attention seeking by others Inability to seek support for fear of crying Changes related by participants to the menopause: Hot flushes and night sweats Mood swings, tearfulness and depression Tiredness Decreased libido Heavy bleeding Aches, pains and stiff joints Vaginal dryness, cystitis and frequent urination Migraine Memory loss Weight gain Other findings: Hot flushes are the only socially acceptable symptom to discuss. Confusion about what are symptoms of the menopause rather than something else.

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
44				<p>Women whose mothers were not troubled by the menopause assumed their experience would be the same.</p> <p>Among users of HRT half of women had to persuade their doctor to prescribe it.</p> <p>Symptoms managed by lifestyle changes including relaxation, exercise, diet and changes to clothing choices.</p> <p>The menopause is not openly discussed in society and women did not actively seek support due to it being seen as taboo and a joke.</p> <p>Reliable information should be available help women prepare for menopause.</p>
7.	Elton and Ballard-Reisch (2013) Dominant Cultural Discourses and Sense-making about Lived Menopausal Experiences USA	To examine whether and how dominant cultural discourses about menopause are reflected in women's framing of their lived experiences of menopause	n= 25 Age: 43-58 Gender: Female Design: Constructivist grounded theory Data collection: Semi-structured interviews Analysis: Thematic analysis	<p>Positive views of the menopause:</p> <p>Menopause had no significant impact- just annoying</p> <p>A natural process and new phase; an opportunity to learn about the changing body</p> <p>Freedom from parental responsibilities</p> <p>Cessation of menstruation</p> <p>Worry free sex due to no risk of unintended pregnancy</p> <p>Changes related by participants to the menopause:</p> <p>Hot flushes; for some anxiety attacks preceded hot flushes</p> <p>Irregular menstruation</p> <p>Memory loss</p> <p>Moodiness</p> <p>Headaches</p> <p>Depression</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				Weight gain which had a negative impact on self-image Reduced concentration Emotional, particularly crying Vaginal dryness and reduced sexual contact Other findings: Exercise and eating a healthy diet became important. Women understood their experience through their individual experiences, particularly their symptoms.
8.	Hammoudeh et al. (2017) Age of despair or age of hope? Palestinian women's perspectives on midlife health Occupied Palestinian Territories	To understand how women in the West Bank conceptualise, experience and manage their health in midlife	n= 35 Age: 40-55 Gender: Female Design: Qualitative Data collection: In-depth life history interviews Analysis: Thematic analysis	Positive views of the menopause: Not particularly significant with symptoms viewed as part of a natural process No risk of pregnancy No young children resulting in women being able to live life for themselves More power and control including becoming the head of the house Negative views of the menopause: Lost the chance to have children Other findings: Socio-cultural views of ageing were more important than biomedical views Knowledge gained from: Other women, magazines, television and educational sources
9.	Hakimi et al. (2016) Women's perspectives towards menopause: A phenomenological study in Iran	Explores the attitude and feelings towards menopause among Azeri menopausal women	n=18 Age: Over 40 Gender: Female	Positive views of the menopause: Association with cleanliness due to lack of menstruation A natural phenomenon considered to be God's will and a women's destiny. Free to conduct religious duties and feel closer to God after menopause

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	Iran		Design: Hermeneutic phenomenology. Data collection: Interviews Analysis: Thematic analysis using MaxQDA-10	Gain power and respect with age Negative views of the menopause: Unpleasant indicator of old age and the end of youth Loss of social freedom Accumulation of toxins within the body and a susceptibility of illness Bodily changes resulting in deterioration and ill health Other findings: Half of participants were indifferent toward menopause Women who were more religious tended to welcome the menopause more which allowed for an adaptive coping strategy and supportive networking. There was misinformation and lack of information due to information coming from family and friends.
10.	Hunter et al. (2009) Mid-Aged Health in Women from the Indian Subcontinent (MAHWIS): A further quantitative and qualitative investigation of experience of menopause in UK Asian women, compared to UK Caucasian women and women living in Delhi UK and India	To explain differences in the experience of menopausal symptoms using quantitative and qualitative methods	n= 153 Age: 45-55 Gender: Female Design: Mixed methods cross sectional Data collection: Interviews using questionnaires and open questions Analysis: Statistical analysis (SPSS) for	Positive views of the menopause: Cessation of menstruation No risk of pregnancy <u>Asian sample:</u> Feeling clean, less mess Being able to participate in religious practices Negative views of the menopause: <u>UK Caucasian sample:</u> Getting older Uncertainty/unpredictability Changes related by participants to the menopause: Hot flushes

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			quantitative data and thematic content analysis for qualitative data	<p><u>Asian sample:</u></p> <ul style="list-style-type: none"> Weight gain Visual problems Hypertension Aches and pains Anxiety and panic Palpitations Ending of menstruation = beginning of ill health <p><u>UK Caucasian sample:</u></p> <ul style="list-style-type: none"> Tiredness Reduced energy with night sweats Mood swings and irritability <p>Other findings:</p> <ul style="list-style-type: none"> Cultural differences were found with both symptoms and beliefs about menopause Embarrassment about not knowing about menopause or talking about it. Lack of control was associated with vasomotor symptoms <p><u>Shared meanings:</u></p> <ul style="list-style-type: none"> Menopause does not cause major changes Relief at the cessation of menstruation An associated with menopause and ageing
11.	Im et al. (2010) Black women in menopausal transition	To describe the menopausal symptom experiences of black	n=20 1 pre- 14 peri-	<p>Positive views of the menopause:</p> <ul style="list-style-type: none"> Natural ageing process Older women were usually respected and honoured.

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	USA	midlife women in the United States from their own experience in a 6-month online forum	4 post- 1 surgical menopause Age: 40-58 Gender: Female Design: Qualitative Data collection: Online forum Analysis: Thematic analysis	Menopause means 'maturing', 'increased wisdom' and 'more love for themselves' Felt fortunate to have lived long enough to experience menopause Motivation to keep moving forward and improving their lives Negative views of the menopause: Lack of information means that symptoms are related to major health problems Just another part of life to 'endure' Chose not to discuss symptoms because of embarrassment Other findings: More important things that required time and energy than menopause Did not learn from mothers or other family members how to manage symptoms Only other black women could understand what participants were experiencing.
12.	Im et al. (2008) An online forum on menopausal symptom experience of white women in the U.S USA	To explore the menopausal symptom experience of White midlife women within the context of their daily lives through a 6-month online forum	n=23 3 pre- 14 peri- 6 postmenopause Age: Midlife Gender: Female Design: Qualitative Data collection: Online forum	Positive views of the menopause: A time for reflection and becoming more comfortable with self Freedom from pressure of meeting others' expectations Cessation of menstruation and no risk of pregnancy Negative views of the menopause: Lost part of themselves/became a stranger to themselves/loss of youth An additional dimension in an already stressful life Changes related by participants to the menopause: Heavy bleeding and breast pain

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			Analysis: Thematic analysis	Other findings: Four themes: Redefining self; Laughing at suffering; Differences with sameness and talking to the wall. Not concerned about menopause until they experienced it. Laughing boosts inner strength Believed in a universal experience Generational differences = more open now Support from: family, friends and significant others Wanted healthcare professionals to start listening.
13.	Im et al. (2011) "Being Conditioned, yet Becoming Strong": Asian American Women in Menopausal Transition USA	To explore the menopausal symptom experiences of Asian American women within the context of their daily lives.	n=13 Age: Midlife 2 pre- 6 peri- 5 postmenopause Gender: Female Design: Qualitative Data collection: Online forum Analysis: Thematic analysis (Braun and Clarke 2006)	Positive views of the menopause: A natural, unavoidable event Cessation of menstruation = no more sanitary products, menstrual discomfort and no risk of pregnancy. Pleased to be able to live long enough to retire and see children grow Negative views of the menopause: Keep quiet and accept things "without making a fuss" Taboo to talk about menopause in public and at times in private Changes related by participants to the menopause: Mood swings, anxiety and depression Hot flushes Low back and Knee pain Unpredictable bleeding Other findings:

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Five themes: being conditioned; becoming strong; appreciating; without making a fuss and quiet support. Support from older female family members and close friends of the same age, gender and ethnic group was important. Cultural values passed through generations by mothers' influence views of the menopause. Symptoms are low priority Lifestyle modifications: exercise, diet, a hobby, keeping busy</p>
14.	Jurgenson et al. (2014) Exploring Australian aboriginal women's experiences of menopause: a descriptive study Australia	To understand Australian aboriginal women's understanding and experience of menopause and its impact on their lives	n=25 8 pre- 8 peri- 4 post- 5 surgical menopause Age: 20-67 Gender: Female Design: Qualitative Data collection: Interviews and focus group discussions Analysis: Thematic analysis associated with descriptive population statistics	<p>Positive views of the menopause: Largely viewed as relief and the next stage of life Supportive partners were valued A positive change of role with women having more time to themselves and gaining respect within the local community as a valued elder. A change of role going from learning to teaching cultural ways</p> <p>Negative views of the menopause: Loss of womanhood. Fear of symptoms An association of menopause with ageing Lack of knowledge about menopause meant some women interpreted symptoms as a sign of serious illness. Some preferred to avoid people and to seek social isolation Some reported hot flushes, night sweats or mood changes as embarrassing and/or distressing.</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Lack of understanding about menopause from men in their lives, resulting in a strain on relationships.</p> <p>Changes related by participants to the menopause: Loss of libido was common with implications for relationships including divorce Hot flushes and night Sweats</p> <p>Other findings: Although regarded as ‘women’s business’ many women felt they did not understand what they were experiencing or what to expect themselves. Many daughters believed their mothers would deny their symptoms and felt it appeared more appropriate to share experiences between sisters. Some women shared they were in denial or ignored it because they had higher priorities. Importance of women ‘sticking together’ was emphasised 20% of women were reluctant to take HRT for fear of health complications A small number of women reported they did not want more information Importance of communication and awareness in minimising relationship conflicts.</p>
15.	Lazar et al. (2019) Parting the Red Sea: Sociotechnical systems and lived experiences of menopause USA based social media site	To understand the experiences with menopause holistically and discover ways to improve women's health experiences as designers.	n= 617 authors contributing to 417 forum threads Age: Not stated Gender: Not stated	<p>Positive views of the menopause: No more menstrual pain, no risk of pregnancy and contraception no longer required No longer worrying what others think and more comfortable speaking their minds Better relationships with significant others</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
52			<p>Design: Feminist and hermeneutic interpretative</p> <p>Data collection: Forum posts</p> <p>Analysis: Thematic analysis and critical discourse analysis</p>	<p>Negative views of the menopause: Society values youth Negative experiences with healthcare professionals</p> <p>Changes related by participants to the menopause: Heavy bleeding Hot flushes and sweating Feeling possessed and mood swings Weight gain Skin changes and grey hair Vaginal dryness</p> <p>Other findings: Needed to convince healthcare professionals that an intervention was needed. Participants were knowledgeable about medical terms Journey was a metaphor used to describe the timescale Lack of information Supportive male partners are important Less about bodily experiences and more about how the experience becomes meaningful in the social context over time. "A virtual sisterhood": shared experiences = more support = normalises experiences</p>
16.	Lim and Mackey (2012) The Menopause Transition Experiences of a Chinese	Explores the menopause experiences of Chinese women in Singapore	n=14, 6 menopausal 8 postmenopausal	<p>Positive views of the menopause: Viewed as part of life Despite classic symptoms few described the menopause as problematic</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	Singaporean Women: An Exploratory Qualitative Study Singapore		Age: 40-60 Gender: Female Design: Descriptive qualitative Data collection: Descriptive qualitative interviews Analysis: Thematic analysis	Changes related by participants to the menopause: Abnormal, heavy bleeding. Hot flushes Sense of lethargy Diminished sexual interest Increased loss of temper Other findings: Most participants used HRT, some used traditional Chinese medicine Women sought medical advice for reassurance symptoms were normal Family support and empathy from husbands was important in managing symptoms Information sources: talking to others, internet, books, magazines and brochures. Most women were unsure when the menopause started
17.	Lindh-Åstrand et al. (2007) Women's conception of the menopause transition Sweden	To explore whether the conception of the menopause varies between women seeking medical advice because of climactic symptoms	n=20 Age: 44-59 Gender: Female Design: Phenomenology Data collection: Semi-structured interviews Analysis: Phenomenographic	Positive views of the menopause: Improved sex life Greater self confidence Negative views of the menopause: Sign of old age Changes related by participants to the menopause: Hot flushes/sweating Sleep disturbance Urogenital dryness Palpitations

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			procedure with QSR NUD*IST VIVO 1.3	Joint stiffness/general pain Less physical capacity Wrinkles and grey hair Rolls of fat Emotional instability Other findings: Menopause is viewed as a physical alteration A time of changing roles
18.	Mackey (2007) Women's experience of being well during peri-menopause: A phenomenological study Australia	To investigate women's experience of being well during the peri-menopause	n=18 Age: "Postmenopausal" Gender: Female Design: Heideggerian interpretative phenomenology Data collection: Interviews Analysis: Not stated but suggestive of thematic analysis	Positive views of the menopause: Hot flushes and other symptoms were not experienced as problematic as they did not disrupt the familiar patterns of life. Those who did not suffer hot flushes were surprised by their absence Negative views of the menopause: Only one participant described experiencing psychosocial symptoms Changes related by participants to the menopause: Hot flushes Menstrual pattern changes Other findings: An incremental change with first symptoms were experienced in a background way Coping strategies already in place due to gradual development of heavier bleeding. Other events are in the foreground rather than menopause

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				Comparisons made between themselves and other women (sisters and mothers). Some judged their experiences as less problematic than other women
19.	Mackey et al. (2014) Knowledge, attitudes, and practices associated with menopause: A multi ethnic, qualitative study in Singapore Singapore	To explore knowledge, attitudes and practices associated with the menopause	n=58 Age: 40-60 15 pre- 11 peri- 35 postmenopause Gender: Female Design: Descriptive qualitative Data collection: Interviews Analysis: Thematic analysis using NVivo	Positive views of the menopause: Sharing and socialising with friends was a common supportive strategy Attitude of acceptance Menopause is a normal life experience, “part and parcel of life” (p.519) Negative views of the menopause: Unpredictability about changes generated an attitude of fear Loss of a familiar self and worry about who they might become Loss of youthfulness and looking old Changes related by participants to the menopause: Irregular menstruation Hot flushes Changes in mood for example a 'hot' temper Changes in libido Feeling bloated and fat Other findings: Tendency to use lay sources for information and it was unusual for women to turn to mothers for information. Strong intention not to use hormone therapy due to fear of side effects but instead chose over the counter supplements such as: Vitamins, minerals and Evening Primrose Oil.

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				Coping strategies included: Listening to the radio, going out for a walk, watching TV, doing housework. Strength was drawn from religion and prayer
20.	Madden et al. (2010) First Nations women's knowledge of menopause: experiences and perspectives Canada	To understand and describe the menopause experiences and perspectives of First Nations women residing in north western Ontario	n= 18 Age: Not stated, peri and post menopause Gender: Female Design: Phenomenologic approach Data collection: In-depth interviews Analysis: Thematic analysis	Positive views of the menopause: Open communication with other women = knowledge shared across generations Respected as they become older; a woman with wisdom Menopause viewed as neutral or positive Changes related by participants to the menopause: Mood swings Hot flushes Other findings: No consistent word for menopause More information needed particularly from healthcare professionals Menopause is not openly discussed
21.	Mahadeen et al. (2008) Menopause: a qualitative study of Jordanian women's perceptions Jordan	To describe the perceptions of Jordanian midlife women about the menopause	n=25 Age: 40-55 Gender: Female Design: Descriptive qualitative Data collection: Interviews Analysis: Descriptive qualitative study	Positive views of the menopause: Freedom from potential pregnancy and reproductive obligations Liberation in sexual life Feeling clean and pure Age of hope and not despair; becoming a wise woman Changes related by participants to the menopause: Weight gain Increased wrinkles Increased nervousness

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Sleeping problems Increased body odour Decreased libido Other findings: Menopause is rarely discussed by Jordanian women Some women experienced no symptoms Self-care included exercise, proper nutrition, herbal teas, being in the sunlight, decreasing or stopping smoking, reducing stress and taking vitamins and calcium. Some use of HRT Information gained from female family members, friends, the media, reading and healthcare providers Not enough education was provided and women were not getting assistance from healthcare providers therefore they used intuition to guide through the menopause. Sharing as part of the study was identified as positive Tended to focus on menopause as wellness experience</p>
22.	Makuwa et al. (2015) The perceptions of African women regarding natural menopause in Mamelodi, Tshwane district South Africa	To explore and describe the perceptions of African women regarding natural menopause	n= 18 Age: 46-55 Gender: Female Design: Qualitative, explorative, descriptive, contextual	<p>Positive views of the menopause: Natural process Cessation of menstruation and no need for sanitary protection Negative views of the menopause: More vulnerable to illness as menstruation protects against illness Changes related by participants to the menopause: Headaches, backache, painful joints and general body pain</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			Data collection: Semi-structured interviews Analysis: Eight steps of data analysis (Tesch 1990)	Dark, wrinkled skin Change in body size Other findings: Lack of knowledge, understanding and information about the menopause Women became more knowledgeable as they experienced menopause
58 23.	Marnocha et al. (2011) The lived experience of perimenopause and menopause USA	To give voice to the menopausal experiences of women	n=13 Age: 46-70 Gender: Female Design: Phenomenology Data collection: In-depth interviews and drawings Analysis: Intuiting, analysing and describing (Spiegelberg 1975)	Positive views of the menopause: New beginning Cessation of menstruation Negative views of the menopause: Confused and embarrassed by the lack of control at being unable to hide hot flushes, unexpected and unpredictable bleeding. Felt taboo to talk about with mothers or not talked about at all Changes related by participants to the menopause: Hot flushes and Night sweats Changes in menstrual cycle patterns Fatigue Mood swings and crying Sleep disturbances Weight gain Vaginal dryness Skin changes: acne and facial hair Other findings: Three themes: Changes to my body; sharing with others not my mother; going on with life

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				Support and information gained from: Sisters, friends, healthcare providers, online and literature. Women became engaged once the experience began wanting normalisation rather than prescriptions. Women felt they became visible to men around 12 and invisible around 50 years old
24.	Matarese (2005) Navigating the journey to menses cessation: A study of change in an emancipatory context USA	To explore women's perceptions of menopause, synthesise the means of evaluating available information and facilitate the process of envisioning and creating change in the women's life world should they wish to participate in that change	n=9 3 peri- 2 post- 3 surgical 1 chemical menopause Age: 49-63 Gender: Female Design: Qualitative Data collection: Facilitated group meetings Analysis: Thematic coinvestigation	Positive views of the menopause: Improvement in skin and hair Freedom from pregnancy and the care needed during menstruation The tendency to 'speak their minds' was liberating but troubling to others Reclaiming their voices and sharing their wisdom Negative views of the menopause: A constant struggle for control of a changing body Younger co-workers acted as though their ideas were archaic Irritation at being called "dear" or "ma'am" (p.41) which represented being considered older by others. Becoming invisible and being ignored due to a cultural bias towards youth, newness and attractiveness. Changes related by participants to the menopause: Hot flushes Sleep disturbance Menstrual changes Bloating Emotional changes

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Changing relationships within the family, socially and in the workplace</p> <p>Other findings:</p> <p>A need for more self-time</p> <p>Information gained from perceived experts, peers and female family members, self-knowledge, intuition, books library resources, magazines, health information material and internet sources.</p> <p>HRT recommended by healthcare professionals but women also wanted information regarding alternative therapies.</p> <p>Relief when their experiences were mirrored by others</p>
25.	McCloskey (2012) Changing focus: Women's perimenopausal journey USA	To explore women's own definitions, meanings and considerations as they move through this midlife experience	<p>n=19</p> <p>Age: 44-59</p> <p>Gender: Female</p> <p>Design: Grounded theory</p> <p>Data collection: Focus groups and interviews and journals</p> <p>Analysis: Constant comparative technique</p>	<p>Positive views of the menopause:</p> <p>Relief experienced from naming the changes as a menopausal symptom</p> <p>Self-prioritisation: the women's focus moved from others to themselves</p> <p>Sense of freedom, a journey of discovery and becoming a wise woman</p> <p>Increased assertiveness and confidence</p> <p>Focus moves from being a reproductive being to a whole being</p> <p>Changes related by participants to the menopause:</p> <p>Heavier bleeding</p> <p>Change in metabolism and weight</p> <p>Hot flushes</p> <p>Worsening memory</p> <p>Emotional changes</p> <p>Negative views of the menopause:</p> <p>An unanticipated process</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>More concern from Caucasian women seeing it as part of ageing compared to African American women who take it in their stride.</p> <p>Other findings: Wanted reassurance from other women that their changes were similar Similar experiences as mothers Support from a network of trusted women; only women can empathise Need to be healthy in body and mind: drink tea, eat vegetables and exercise An individualised approach to menopause was wanted Increased visibility of menopausal discussion can help women Health care professionals need to develop a range of information for women in partnership with them</p>
26.	McGinnis et al. (2009) Perception of quality of life during the menopause transition USA	To gain greater understanding of the factors that influence the quality of life during the menopause	n=12 Age: 41-57 Gender: Female Design: Grounded theory Data collection: Semi-structured focus groups Analysis: Qualitative data analysis using QSR NUD*IST NG	<p>Positive views of the menopause: Some women had a positive self-image that could withstand negative societal influence.</p> <p>Negative views of the menopause: Menopause signifies being old Decreased awareness of what to expect and where to go to seek information Described as “the road to death” (p.12) as it was the end of fecundity. Unpreparedness due to a lack of information</p> <p>Changes related by participants to the menopause: Sleeplessness Hot flushes and night sweats Anxiety Sexual discomfort, vaginal dryness and change in libido</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
62				<p>Other findings Coping strategies: walking, yoga, strength training, circuit training, vitamins, herbal supplementation, HRT, medications for mood enhancement, bladder control and osteoporosis. Support systems were: Partners, family, friends or colleagues There was a perception of menopause experiences being linked to attitude to life Time of uncertainty with changes often attributed to other factors Menopause is not an isolated life event but a life transition</p>
27.	Morgan et al. (2012) Uncertainty during perimenopause: perceptions of older first-time mothers USA	Exploring older first-time mothers' perceptions of health during their menopause	n=13 Age: 45-56 Gender: Female Design: Hermeneutic phenomenological approach Data collection: Interviews Analysis: Thematic analysis	<p>Negative views of the menopause: Women were not prepared finding a lack of support from credible sources Menopause was viewed as a state of uncertainty with an uncertain timeline Some women looked to their mothers for information about perimenopause but mothers did not want to talk about it. Perceptions of getting older, taking medication, causing depression, being emotional, angry, irritable, scared, losing control, and something they had to get through. The menopause was considered a predominantly negative process</p> <p>Changes related by participants to the menopause: Menstrual changes Mood swings, irritability, feeling more emotional Hot flushes and night sweats Losing control Various levels of depression</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Other findings: Most participants did not recognise menopause changes but thought it was something else. Pre-understandings about the menopause conditioned them to expect night sweats, hot flushes and menstrual irregularities. Women expected their physicians, nurse and midwives to provide information</p>
28.	Morrison et al. (2014) Voices from the Hilo women health study: Talking story about menopause Hawaii, USA	To describe how a multi-ethnic sample of women living in Hilo, Hawaii describe menopause	n=185 57 pre- 69 peri- 59 postmenopause Age: 45-55 Gender: Female Design: Mixed methods Data collection: Qualitative Semi-structured interviews/General health survey Analysis: Broad coding after the first 10 interviews. QSR	<p>Positive views of the menopause: Embraced as a time to create a post-menstrual identity as wiser women entering a new womanhood. Liberation based on not having to fear pregnancy Practical and financial benefits of no longer bleeding Other sub-themes were accepting menopause as a cycle of life, a time of empowerment, its relationship to ageing and becoming an elder and crone. Many felt uplifted, confident, and physically and emotionally healthy A time to take care of themselves rather than focus on their families Gratitude for having a mild or tolerable menopause</p> <p>Negative views of the menopause: Fearful and anxious regarding all aspects of menopause from the sexual to the physical and the psychological Apprehension of potential hormone rage, personality changes and becoming dysfunctional Some felt anger about the changes</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			N6(2002) NVivo after 2002	Western culture is inherently age-phobic and this may influence how women feel about the menopause. Changes related by participants to the menopause: Hot flushes and night sweats Irritability Other findings: Concern regarding the medicalisation of women's health and specifically of menopause.
29.	Murphy et al. (2013) The hopeless age? A qualitative exploration of the experience of menopause in Arab women in Qatar Qatar	To describe and examine the expectations and experiences of the midlife menopause experiences in Arab women living in Qatar	n=41 Age: 40-60 pre- peri- postmenopause Gender: Female Design: Qualitative Data collection: Semi-structured focus groups Analysis: Atlas.ti qualitative software used and examined for the creation of codes and emerging themes	Positive views of the menopause: Most women saw it as a period of maturity and wisdom Postmenopausal women unanimously felt that the cessation of menses increased their participation in religious activities that they previously could not attend when menstruating. Religion plays a supportive role and some saw it as a protective factor. Religion secured close social networks, which in turn, prevented the possibility of depressive outcomes. It is part of a set of specific stages in a woman's life. Negative views of the menopause: Many women did not tell their husbands fearing they would marry younger wives Changes related by participants to the menopause: Postmenopausal women described symptoms consistent with general knowledge such as: hot flushes, tiredness and mood swings. Other findings:

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Pre-menopausal women were unaware of symptoms</p> <p>The level of support from husbands rather than female family members was crucial to how women viewed their menopause experiences.</p> <p>The experience of menopause is heavily impacted by, and related to religion</p> <p>Some women believed that Western women did not have the appropriate support from husbands and families that Arab women have during menopause.</p> <p>Environmental heat leads to less physical activity impacting of fitness</p>
30.	Natipagon-Shah (2005) Navigating the change of life: The menopausal transition of Thai immigrant women USA	To explore and describe the menopause as experienced by Thai immigrant women	<p>n=12</p> <p>Age: 49-61</p> <p>Gender: Female</p> <p>Design: Grounded theory</p> <p>Data collection: Interviews and participant observations</p> <p>Analysis: Dimensional analysis</p>	<p>Positive views of the menopause:</p> <p>More respected socially and emotionally and felt more valued</p> <p>Freedom from menstruation</p> <p>Sense of tranquillity</p> <p>A sense of comfort when the experience is shared with other women</p> <p>Self-support for example natural remedies, diet, exercise and yoga</p> <p>Felt good once they were postmenopausal becoming more confident and not afraid to express feelings.</p> <p>Financial and emotional security</p> <p>More freedom and flexibility</p> <p>Negative views of the menopause:</p> <p>Getting older</p> <p>No longer able to conceive/devalued as no longer menstruating</p> <p>Feeling of loss due to irreversible body changes impacting on intimate relationships.</p> <p>Changes related by participants to the menopause:</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Menstrual irregularity Warmth (hot flushes day or night) and sweating Deterioration in physical health and weight gain Tiredness and fatigue Headaches Dry/thinner skin, wrinkles and grey hair Sadness and depression Emotional changes such as: Irritation, anger, crying and worry Vaginal dryness Other findings: Grounded theory model: Navigating the change of life; Perceiving changes; Living differently; Managing life changes; A new me; An inevitable natural event Husbands were the single most important person in offering support with other support from: Religious beliefs, peers, healthcare professionals, reading, watching TV, lectures and workshops. Women who accessed information prior to menopause were more likely to view changes as normal Unfamiliar changes were generally recognised as a sign of the beginning of menopause</p>
31.	Nosek et al. (2012a) 'Chaos, restitution and quest': one woman's journey through menopause	To probe into the multifaceted complexity of a contemporary menopause experience	n=1 Age: not stated Gender: Female	<p>Negative views of the menopause: A sense of losing control over the body Impact on sexual relationship Impact on work and money</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	USA		Design: Narrative analysis Data collection: Interview Analysis: poetic restructuring (Gee 1985) and Labov (1997) elements of a true story	Changes related by participants to the menopause: Poor sleep and low energy due to night sweats Sense of panic Uncertainty leading to changes being thought to be pathological Physically and mentally exhausting Reduced self esteem Reduced level of self-care
32.	Nosek et al. (2012b) Distress during the menopause transition: A rich contextual analysis of midlife women's narratives USA	To examine experiences of distress in women during the transition to menopause	n=15 Age: 40-60 Gender: Female Design: Narrative analysis Data collection: Interviews Analysis: Narrative and thematic analysis using ATLAS.ti 5.0	Negative views of the menopause: Distressed by unpredictable emotional changes such as anxiety and irritability Lack of recognition of themselves Reduced quality of life due to symptoms Changes related by participants to the menopause: Hot flushes and night sweats Vaginal dryness and decreased libido Menstrual changes: unpredictable, heavy and painful periods Sleep disturbances
33.	Odiari and Chambers (2012) Perceptions, attitudes, and self-management of natural menopausal symptoms in Ghanaian women	Investigation of how women in low-resource settings manage menopausal symptoms without HRT	n=34 Age: Not defined, average 58 Gender: Female	Positive views of the menopause: A natural part of life A concept of naturalness and spirituality Negative views of the menopause:

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	Ghana		<p>Design: Constructivist inquiry</p> <p>Data collection: Open ended questions during one-to-one interviews</p> <p>Analysis: Constructive inquiry methodological framework</p>	<p>Some women believed that bleeding was cleansing and therefore thought that menopause was "disease entrapment" (p.570)</p> <p>"I have to live with the experience and it really bothers me" (p.566)</p> <p>Changes related by participants to the menopause:</p> <p>Brings sickness and general discomfort</p> <p>Hot flushes</p> <p>Irritability</p> <p>Sleeplessness</p> <p>Other findings:</p> <p>Information was gained from people who had already experienced menopause, health care providers, media, books and church meetings.</p> <p>Symptoms linked to a premenopausal unhealthy lifestyle</p> <p>Attitudes equally divided between acceptance and discontent</p> <p>Symptoms managed by eating more fruit, drinking water, exercise, shea butter, paracetamol for pain and complementary and alternative medicines.</p> <p>Shared knowledge = Shared symptoms = Management strategies developed</p>
34.	Ohemeng (2008) The meaning on menopause among Ghanaian-Canadian women Canada	To examine the meanings and experiences of menopause for ten Ghanaian-Canadian women	<p>n=10</p> <p>6 natural</p> <p>4 surgical menopause</p> <p>Age: 40's, 50's and 60's</p> <p>Gender: Female</p> <p>Design: Qualitative</p> <p>Data collection: Interviews</p>	<p>Positive views of the menopause:</p> <p>A normal process that everybody goes through</p> <p>The menopause is a relief from the risk of pregnancy</p> <p>A positive sign of ageing resulting in becoming leaders in their families</p> <p>Negative views of the menopause:</p> <p>Women would be shown more respect in Ghana than they received in Canada</p> <p>The beginning of general weakness and reduction in strength</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			<p>Analysis: Not explicitly stated but suggestive of thematic analysis</p>	<p>Secrecy surrounds women's bodily processes Ill health attributed to the cessation of menses Changes related by participants to the menopause: Hot flushes and cold sweats Swollen feet and knee pains Burning of the body Dizziness Mood swings Changes in libido Other findings: Medicalisation of life: Women felt that doctors didn't approve when their advice was not followed. A vast array of symptoms were in the media Women knew they would cease to menstruate but didn't know what caused menopause to happen. Never discussed with relatives or friends Only started to investigate after symptoms had started Exercise, active work, positive thinking and diet regulation to regain strength Most believed that because menopause is not a disease it does not warrant medical intervention.</p>
35.	Ong et al. (2019) Experiences and Needs of Perimenopausal Women with	To increase the understanding of the experiences and needs of perimenopausal women	<p>n=20 Age: 47-54 Gender: Female</p>	<p>Positive views of the menopause: Sharing knowledge with the younger generation Seeking support/advice from others with experience of perimenopause Positive self-talk and an enhanced self-awareness</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	Climacteric Symptoms in Singapore: A Qualitative Study Singapore	with climacteric symptoms	Design: Descriptive qualitative study Data collection: Interviews Analysis: Thematic analysis (Braun and Clarke 2006)	Negative views of the menopause: Impact on relationships due to irritability Sense of being lost and isolated Changes related by participants to the menopause: Hot flushes Insomnia and fatigue Headaches Reduced libido, vaginal dryness and dyspareunia Mood swings and unexpected loss of temper Other findings: Five themes: Uncertainty and misconceptions; Changes in the body; Mixed feelings; Social support; Wish list of women There was doubt about symptoms being related to menopause There were misconceptions regardless of level of education Support and information from female family members, friends and the internet More information was wanted Women wanted empathetic healthcare professionals
36.	Price et al. (2008) Menopause experiences of women in rural areas Canada	To explore the menopause experiences of women living in rural areas	n=25 Age: 43-late 60s Gender: Female Design: Naturalistic inquiry	Positive views of the menopause: The experience was viewed as developing greater self-awareness as part of life It was a bonding opportunity for women Negative views of the menopause: A sudden awareness of mortality and of a limited future

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
			<p>Data collection: Focus groups and interviews</p> <p>Analysis: Thematic analysis using NVIVO</p>	<p>Particular concern that memory loss might be Alzheimer’s Disease</p> <p>Considered to be a disruptive and frightening time</p> <p>Loss of control of their bodies</p> <p>Changes related by participants to the menopause:</p> <p>Hot flushes</p> <p>Joint aches and pains</p> <p>Weight gain</p> <p>Heart related symptoms</p> <p>Loss of sexual intimacy</p> <p>Severe mood swings with family members often receiving the brunt of the outbursts</p> <p>Other findings:</p> <p>Many did not recognise the menopause symptoms as such</p> <p>Frequent sources of information were the Internet, reading materials, television programmes on women and menopause</p> <p>Women questioned the credibility of information received because of contradictions</p> <p>Experiences were shared with family and friends and older women hoped they could make things better for younger women and normalise the experience.</p> <p>Something only women can understand and the experience provided a bond to previous generations.</p> <p>Reliance on a sense of humour</p> <p>Main social supports were friends, relatives, other women and female family physicians.</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				A more formalised menopause group support structure was wanted
37.	Ramakuela et al. (2014) Perceptions of menopause and aging in rural villages of Limpopo Province, South Africa South Africa	To explore perceptions of menopause and ageing amongst women in rural villages of Vhembe District in Limpopo Province	n= not stated Age: 40 years and above Gender: Female Design: Phenomenology Data collection: Four tape recorded focus groups with 6-8 women Analysis: Using Tesch's open coding method	Positive views of the menopause: Women received respect and trust from younger women Support from grandmothers and female colleagues sharing their experiences Negative views of the menopause: Viewed as a troublesome old lady if too much support was needed Frustrated and embarrassed by changes A feeling of being isolated Changes related by participants to the menopause: Skin changes: No longer firm and skin had become wrinkled Change in body shape Joint and back problems Memory loss Irritable Genitourinary problems Other findings: Themes identified: Psychosocial challenges and age; menopausal challenges disrupting normal lives; discrimination and stigmatisation; lack of support by family and community A taboo subject
38.	Rubinstein and Foster (2013) "I don't know whether it is to do with age or to do with hormones and whether it is to do with a	Exploration of women's views about menopause and any relationship between these and	n=270 completed surveys and 12 interviews Age: 30-66 for surveys	Positive views of the menopause: Resulted in increased levels of confidence Women felt they were no longer being subject to their hormones or suffering the inconvenience of periods.

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
	stage in your life”: Making sense of menopause and the body UK	several measures of body consciousness	45-61 for interviews Gender: Female Design: Mixed methods Data collection: Survey and interviews Analysis: SPSS17.0. Thematic analysis using ATLAS-ti (version 6.2.11)	Having time and freedom to concentrate on their own lives rather than having to focus on children and partners; a new stage of creativity. The majority of women described physical changes as minor inconveniences Changes related by participants to the menopause: Hot flushes Erratic or heavy periods Mood swings Changes to body shape, increase wrinkles and greying hair A sense of feeling less well Loss of fertility Loss of attractiveness and concern about becoming invisible to men Negative views of the menopause: Diminishing status due to loss of fertility and entering that last stage of one’s life Several women saw fertility as a source of power, and the loss of fertility was mourned. Other findings: Menopause is situated within a context of an awareness of ageing, and changes in outward appearance and is inseparable from understanding ageing in general. There is a lack of realistic older women role models in the media Women hold ambivalent and sometimes contradictory attitudes towards menopause. Women resist the portrayal of menopausal women as being in decline and as sexually unappealing, and are reluctant to believe that women change in any important way.

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				There is no comparable reminder of ageing for men
39.	Sergeant and Rizq (2017) 'Its all part of the big CHANGE': a grounded theory study of women's identity during menopause UK	To explore the impact of menopause on women's identity and consider the effect of sociocultural factors To develop a socially situated theory about how menopause impacts participants' thinking about themselves and their choices	n=11 Age: 46-56 Gender: Female Design: Qualitative methodology Data collection: Interviews Analysis: Thematic analysis	Positive views of the menopause: Relaxed discussing with close female peers, a "hidden sisterhood" (p.194) A time to focus on own development and the beginning of something new Negative views of the menopause: Pressure to conform to expectations of menopausal women Fear of being seen as older, frumpy and invisible by others Anxiety and anger about dismissive narratives Changes related by participants to the menopause: Menstrual changes Hot flushes Dry/less firm skin Weight gain Vaginal dryness Aches and pains Other findings: Inadequate information Categories of the developed theory: It feels like my body's been taken over by aliens; going from one phase of life to another; keeping it hidden; managing my menopause myself; continuing my story while everything changes. Uncertainty about where participants were in the transition Participants didn't think much about it until their own experience

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
40.	Strezova et al. (2017) Cultural issues in menopause: an exploratory qualitative study of Macedonian women in Australia Australia	To explore the attitudes, beliefs, and experiences related to menopause, midlife, and ageing for Macedonian postmenopausal women living in South Eastern Sydney and Illawarra areas	n=81 Age: 45-75 Gender: Female Design: Qualitative methodology Data collection: Unstructured group discussions Analysis: Not stated	<p>Positive views of the menopause: A new found freedom to speak about a previously taboo subject Positive thoughts regarding menopause contributed to a positive experience Enjoyment of worry-free postmenopausal sex Relief at the end of menstruation</p> <p>Negative views of the menopause: Mood changes were the most feared symptom Negative thoughts regarding menopause contributed to a negative experience Feeling that male partners found them less 'womanly' and a fear of the end of physical intimacy. Perception that menopause creates or exacerbates relationship problems</p> <p>Changes related by participants to the menopause: Hot flushes and night sweats Anxiety and depression Decreased libido Headache, backache, joint pain and stiffness Urinary incontinence Unwarranted feelings of hostility toward other people</p> <p>Other findings: Concern that something abnormal was happening Doctors neither acknowledge menopausal symptoms, nor offered any help Lack of support groups or educational sessions Some women had symptoms into their 70s Attitudes toward HRT were ambivalent</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Alternative remedies were used such as natural phytoestrogens, multivitamins, herbal medicines, soy, exercise and a well-balanced diet</p> <p>Feelings of an inability to discuss symptoms 'as openly as Western women'</p> <p>Rarely discussed with partners and felt a need to educate men to encourage acceptance, understanding, empathy and help.</p> <p>Need for more open discussion about the physical discomfort and changing sexual needs during menopause</p>
76 41.	<p>Utz (2011)</p> <p>Like mother, (not) daughter: The social construction of menopause and ageing</p> <p>USA</p>	<p>To explore how and why this redefinition has occurred and what effect it has had on women's attitudes toward health and ageing</p>	<p>n=24</p> <p>Ages: Not defined</p> <p>Gender: Female</p> <p>Design: Qualitative</p> <p>Data collection: Interviews</p> <p>Analysis: Thematic analysis</p>	<p>Positive views of the menopause:</p> <p>(Daughters) More open, more awareness and technical knowledge</p> <p>Relief from not having periods or unwanted pregnancies</p> <p>(Mothers) A developmental period and a time of self-evaluation and priority setting</p> <p>Changes related by participants to the menopause:</p> <p>Hot flushes and night sweats</p> <p>Changes in skin and the inability to lose weight</p> <p>Tension and mood swings</p> <p>Negative views of the menopause:</p> <p>(Mothers) Issues inappropriate for public discussion</p> <p>Fear of ageing and losing control</p> <p>An association with the end of life rather than the end of fertility</p> <p>Other findings:</p> <p>Symptoms consistent across mother and daughters</p> <p>(Daughters) A physiological process of the ageing body, a health problem or disease that should be treated and cured</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				Daughters actively consulted media for information whereas mothers talked to their doctor or allowed the changes to take place without intervention
42.	Villarruel et al. (2002) El Cambio de Vida: Conceptualizations of menopause and midlife among urban Latina women USA	To conceptualize and contextualize the experience of menopause from the perspective of Latina women	n= 16-20 postmenopause Age: 35-60 Gender: Female Design: Qualitative Data collection: Focus groups of 8-10 participants Analysis: Qualitative data analysis QSR NUD*IST	<p>Positive views of the menopause: Represented a period of significant and positive change within themselves Associated with positive aspects of ageing and viewed as a satisfying time in their lives Increased energy and pride Marked their assertion of their own needs and wants, primarily within the family Freedom from monthly periods and from worry about pregnancy brought on a renewed interest in sex. Viewed as just something to go through and symptoms were a natural part of life</p> <p>Negative views of the menopause: Described as a difficult time, full of work and family responsibilities with little time to rest.</p> <p>Changes related by participants to the menopause: Hot flushes - a cause for embarrassment Heavy and prolonged menstrual periods were often disruptive to daily life and their sexual lives. Back and neck pain Insomnia and night sweats</p> <p>Other findings:</p>

Review article Number:	Author(s), year of publication title, study location	Study aim(s)	Study participants, design, data collection and analysis	Key findings
				<p>Frequent description of feelings of anxiety, sadness, wanting to be left alone and experiencing frequent crying spells. However, these were rarely attributed to menopause.</p> <p>Limited information available</p> <p>Rarely discussed within the family and limited to the communication of myths</p>

2.7 Stage 5: Collating, summarising and reporting the findings

The scoping review had two objectives. The first objective was to map how researchers have explored the menopause from the perspective of women since the publication of the WHI. The sections below start by collating the retrieved studies by country of origin, methodology applied and participants included illustrating an initial mapping of the literature against these criteria achieving the first objective of the scoping review. The second objective is achieved in reporting the findings and identifying the experiences, views and perceptions of women during the menopause reported in the current literature illustrated from section 2.7.4.

The following sections draw on the data articulated in Table 2.11: Charting the data. The numbered articles are shown below using square brackets [] for ease of cross referencing to Table 2.11.

2.7.1 Country of Origin of the Final Retrieved Studies

The 42 studies retrieved indicated a global interest in the menopause with studies undertaken in: USA = 17 studies [1, 7, 11-13, 15, 23-28, 30-32, 41, 42], Australia = 4 studies [4, 14, 18, 40], UK = 4 studies [5, 6, 38, 39], Singapore = 3 studies [19, 16, 35], Canada = 3 studies [20, 34, 36], South Africa = 2 studies [22, 37] and one study each from the following countries: UK and India [10], Cyprus [2], Ghana [33], Iran [9], Jordan [21], Occupied Palestinian Territories [8], Qatar [29], Sweden [17] and Turkey [3].

There was one study from Hawaii [28] and although this is in the USA the study authors were exploring the menopause from the perspective of the Hilo, the indigenous population of Hawaii and used similar culturally sensitive data collection techniques to those outlined below in the Jurgenson et al. (2014) study.

2.7.2 Methodology Applied in the Final Retrieved Studies

Twenty two of the 42 retrieved studies applied qualitative approaches with associated data collection methods but did not specifically identify the methodology [3, 5, 6, 8, 11-14, 16, 19, 21, 22, 24, 29, 33- 36, 39-42].

The specific methodologies applied in 17 studies included feminist theory [1,15], grounded theory [2, 7, 25, 26, 30], ethnography [4], narrative theory [31-32], phenomenology [17, 23, 37], hermeneutic phenomenology [9, 18, 27] and Madden et al. (2010) who suggested a phenomenological approach was being used but did not explain if this was resulting in a more

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descriptive or interpretative analysis. Three studies adopted mixed methods design using an online survey with selected follow on interviews [10, 28, 38]. The methods of data collection aligned with the reported methodologies and research design.

Recorded face-to-face interviews were the method of data collection in 21 studies [2-5, 7, 9, 16-22, 27, 31-35, 39, 41], or used as an adjunct to focus groups in three studies [14, 36] with one study [25] using interviews as one of three data collection methods alongside focus groups and participant journals. Marnocha et al. (2011) invited participants to draw and describe their perimenopausal and menopausal journeys after completing the in-depth interview. Two theses [1, 30] stated that participant observation was used alongside interviews.

Various group methods were used: audio recorded focus groups [6, 26, 29, 37, 42]; audio recorded 'affinity' groups, described as "a naturally existing social group (typically, 5-8 friends, neighbours, work colleagues) meeting together in a familiar setting" (Strezova et al. 2017 p.309) and the Delphi technique [24]. Im et al. (2008; 2010; 2011) were the only researchers who recruited to and used an online forum to collect qualitative data. Lazar et al. (2019) analysed forum posts however this data was collected from an already established forum rather than specifically set up for the purpose of research.

Decisions about data collection methods were made to elicit qualitative experiences and cultural sensitivity was a strong feature in a number of studies. Jurgenson et al. (2014) were influenced by the cultural context of Aboriginal women valuing 'yarning'. 'Yarning' is a relaxed and informal way of sharing experiences that is valued by tribal communities with rich oral traditions (Kovach 2009; Geia et al. 2013). Morrison et al. (2014) used a similar technique, 'talking story', in their interviews with women from Hilo, Hawaii. Geia et al. (2013) and Singh and Major (2017) highlight the importance of research methodologies being both culturally safe and respectful to engender the sense that researchers and participants are working collaboratively in exploring issues. Geia et al. (2013) suggest that cultural sensitivity becomes evident when the atmosphere is relaxed enough to enable participants to share their stories as part of a two-way process between participant and researcher. Murphy et al. (2013) made culturally sensitive decisions about the use of focus groups having identified through a literature search that this was an approach that fits well with the oral traditions of Arabic society (Winslow et al. 2002). Im et al. (2010) and Im et al. (2011) alludes to this but it is not strongly reported in the justification for the use of online forums to recruit women of colour and Asian women to their study respectively.

McCloskey (2012) was the only researcher to use participant completed journals to complement interviews. One participant decided to complete only a journal rather than being involved with the other data collection methods offered. It was not made clear by McCloskey how many other

participants used journals as an adjunct to further explore their thoughts or how she used the data. Journals offer an opportunity for participants to continue to reflect on the phenomena and can provide rich temporal data (Meth 2003; Jacelon and Imperio 2005). The use of journals may generate significantly more data but they can also facilitate triangulation with other data collection methods helping to identify the convergence and divergence of findings (Casey and Murphy 2009). Bazeley (2013) argues that convergence strengthens the inferences made thereby enhancing the validity of the data analysis and findings.

Thematic analysis was the most frequently used data analysis method to identify themes from interview data transcribed verbatim (Appendix C) with twelve studies reporting the software used to analyse and code data [4, 5, 9, 17, 19, 26, 28, 29, 32, 36, 38, 42]. Mackey (2007), Ohemeng (2008) and Strezova et al. (2017) did not state the data analysis method but the description was suggestive of thematic analysis. This method is appropriate for analysing qualitative data and may be completed manually or using one of the available qualitative software packages (Bazeley 2013).

Of the three mixed method studies [10, 28, 38], Rubinstein and Foster (2013) and Hunter et al. (2009) generated statistical data using a statistical analysis package, SPSS, to manage the quantitative data generated by questionnaires. In the first stage of their study Rubinstein and Foster (2013) incorporated four validated tools, one to explore attitudes to menopause and the other three measuring women's body consciousness. The descriptive statistics were used to summarise the data identifying correlation between the validated tools used, for example body consciousness having an impact on attitudes to menopause. The results from the questionnaire were used to recruit women who scored high in self-objectification (worried about how they looked) or scored low on self-objectification (not worried about how they looked) for the qualitative interviews. The use of mixed methods provided additional richness to the study results in understanding the potential impact a women's views of herself may have in managing physical changes that are perceived as being noticed by others. Morrison et al. (2014) only articulated the data analysis using QSR N6 (2002) for the qualitative component of the study there was no information provided about the postal survey other than it being a women's health survey from which the participants were recruited. Hunter et al. (2009) was the only study to compare the experiences of three groups of women within different contexts, UK Caucasian, UK Asian and Asian women living in Delhi. The use of the questionnaires and the thematic analysis of interview data is clearly reported along with the methodological challenges in making cross country comparisons.

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The concept of transition has been presented in the literature in Chapter One, section 1.3.4 (Turner 1969; Meleis 2010; Lindmark et al. 2019). However, in the literature that was retrieved for the scoping review I explored how the concept of transition was applied either analytically or from a theoretically informing perspective and only one study had applied the concept. Marnocha et al. (2011) used transition theory developed by Meleis (2010) to present the findings from 13 semi-structured interviews and drawings of women's lived experiences of the perimenopause and menopause. Marnocha et al. (2011) used Meleis' theoretical framework to highlight the need to provide education to women to normalise their experiences. There is, however, little discussion about the point women became aware they were experiencing changes related to menopause or the expectations they had in relation to the marker events, described by Marnocha et al. (2011) as the cessation of menstruation. The lack of use of the concept of transition within the literature poses the question about why it continues to be used to describe menopause when it is not strongly supported by the current evidence base.

Interestingly Meleis (2010) developed transition theory for use in nursing practice but this was not evident within the retrieved studies. The link to nursing practice might suggest that authors affiliated to nursing may use the concept of transitions. However of the nineteen studies [9, 11-13, 16-19, 21, 22, 24, 25, 27, 31, 32, 35-37, 42] linked to schools of nursing or nursing journals none used a transition framework suggesting that they are not widely known or used within nursing practice. Furthermore Im authored and co-authored book chapters on the concept of transition (Meleis et al. 2010; Im 2014) but there was no evidence of transition theory being used in the three empirical studies meeting the inclusion criteria for this scoping review and written by Im et al [11-13].

The lack of studies exploring the qualitative experiences of women themselves may represent the taboo nature of discussing issues related to the female reproductive system and in particular, menstruation. It may also be characteristic of the medicalisation of menopause leading to more research influenced by dominant biomedical discourse, correcting the oestrogen deficiency, than focusing on how to support a 'normal' life experience.

2.7.3 Participants Included in the Final Retrieved Studies

Forty-one studies stated the demographics of the female research participants. One study, [15], did not identify the participant group specifically as they accessed forum threads. Breidenbach (2009) was the only study to state that lesbian women were recruited which reflected the focus of the study.

The age of participants ranged from 20 to 75 years old reflecting the wide range of experiences of women. Jurgenson et al. (2014) recruited the widest age range to their study (20 years to 67 years old). The younger age of participants would not normally be expected, unless a woman had a surgical intervention or chemotherapy resulting in menopause in her twenties. Jurgenson et al. (2014) recruited 7 women under 40 years old and describes 8 participants as premenopausal and 5 participants as having had a hysterectomy. It was not clearly stated if any of the younger women made up the group of 5 participants who had hysterectomies or if they were all premenopausal. Two other studies recruited younger women aged 30 [38] and 35 years [42]. Rubinstein and Foster (2013) included women of any menstrual stage in collecting survey data about body consciousness and subsequently interviewed peri and postmenopausal women aged 45-61 years. Villarruel et al. (2002) states that all participants were postmenopausal (aged 35-60 years) but provides no information about how menopause status was established. The participants recruited to the study reported in this thesis were predominantly within the expected age range for menopause although two participants experienced early menopause (40 and 42 years) as defined by the NICE Menopause Guideline (NCC-WCH 2015). Studies recruiting premenopausal, perimenopausal and postmenopausal women aimed to gain a better understanding of menopause experiences and perceptions across the different groups.

Six studies did not clearly state the age range [9, 12, 33, 36, 37, 41] and two studies did not attempt to identify the participants ages [15,31]. Nosek et al. (2012a) could have stated the age of the one participant presented in the in-depth case however for Lazar et al. (2019) it was not possible to retrospectively collect age data given the analysis of threads written on an established online forum.

Participants were representative of a range of cultural and ethnic groups: Greek Cypriot [2], Azeri [9], Australian Aboriginal [14], Chinese Singaporean [16], Canadian First Nations [20], Hilo [28], Arab [29], Ghanaian Canadian [34], Australian Macedonian [40] and Latina [42]. Im et al. (2010) focuses on the experiences of women of colour and Im et al. (2011) explores on Asian women in the USA with Hunter et al. (2009) comparing the experiences of UK Caucasian, UK Asian to women in Delhi.

Morgan et al. (2012) recruited first time older mothers with the aim of understanding menopause in this particular group while raising younger children.

Charting of data fulfilled Objective 1 of this scoping review: *To map how researchers have explored the menopause from the perspective of women since the publication of the WHI*. The remainder of this section presents an overview of the reviewed materials and a descriptive account of the findings rather than a full synthesis of the best available evidence (Arksey and

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O'Malley 2005; Syadia Ab Latiff et al. 2016; Peters et al. 2017). This process allows the researcher to gain a sense of the main areas of interest and identify any obvious gaps in the literature.

Rumrill et al. (2010) suggest that the narrative descriptions of the themes, gaps and trends gained from carrying out a scoping review can facilitate decision making when designing a study.

The retrieved studies will be summarised and reported in response to scoping review Objective 2:

To identify the experiences, views and perceptions of women during the menopause reported in the current literature. Thematic analysis (Braun and Clarke 2006) was applied as the analytic process with four themes being developed from the review of the final 42 papers. These were: Physical changes experienced during the menopause (Figure 2.2), emotional changes experienced during the menopause (Figure 2.3), women's beliefs about menopause (Figure 2.4) and the impact of the menopause (Figure 2.5). Within each theme experiences were further grouped into being viewed by women as being positive or having a positive impact (red circles), negative (blue circles), or being viewed as neither a positive or negative experience and thereby defined as being neutral (orange circles).

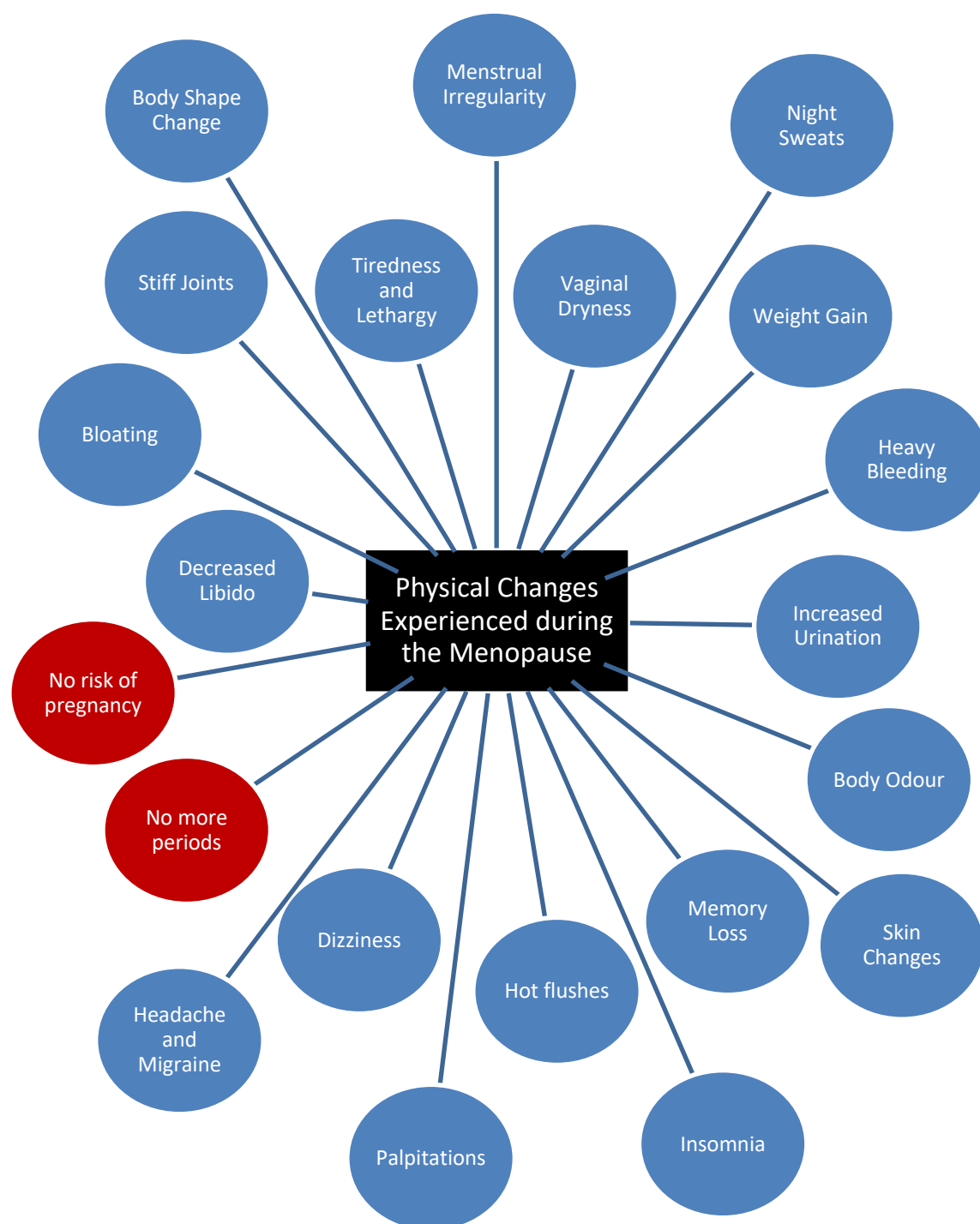
2.7.4 Theme One: Physical Changes Experienced during the Menopause

Physical changes included a wide range of 'symptoms' that women attributed to the menopause itself. Figure 2.2 illustrates the range of physical changes from across the studies. The most commonly reported issues were hot flushes (31 studies), menstrual irregularity (15 studies) and changes in sexual relationships (15 studies).

Hot flushes and night sweats were an expected part of the menopause regardless of cultural group. Intensity varied from feeling hot to dripping perspiration and ranging from a minor inconvenience to annoying and embarrassing [4, 6, 16, 38]. The embarrassment was reported to be resulting from the visibility of hot flushes making a women's reproductive ageing visible to the people around her [3, 6, 23, 42]. Price et al. (2008) argue that women are unprepared for the experience and can be shocked by the intensity. This can leave women feeling they have no control over their body particularly when they may also experience erratic and heavy menstrual bleeding [2, 10, 23, 24, 27, 31, 39].

Findings from studies indicate that women believed their symptoms could be pathological, particularly in relation to changes in menstrual cycle length and flow [1, 6, 11, 14, 16, 36]. The most common reason for women consulting a medical practitioner was to establish the cause of the physical changes due to the uncertainty about the start and duration the menopause.

Figure 2.2 Physical changes experienced during the menopause



Blue = Negatively viewed changes

Red = Positively viewed changes

Participants in 11 studies reported reduced libido [2, 3, 5, 6, 14, 16, 19, 26, 32, 34, 35] with women in seven of these also disclosing experiencing vaginal dryness [2, 3, 5, 6, 26, 32, 35]. Three studies conveyed both increased and decreased libido [7, 21, 40]. Increased libido was attributed

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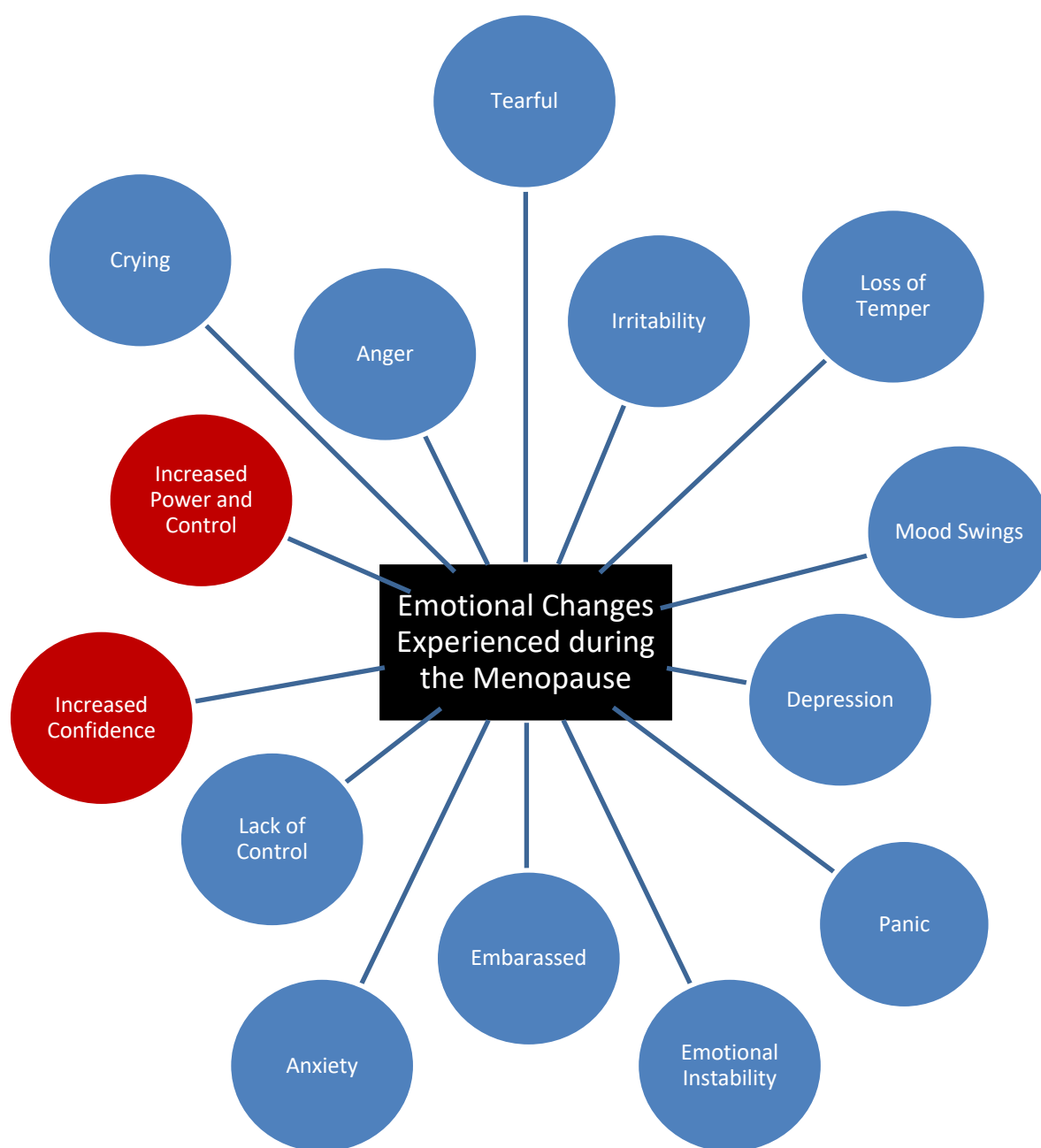
to enjoying renewed sexual freedom including a lack of concern about unintended pregnancy and no longer needing to consider contraception [17].

Despite suggestions that menopause is a biopsychosocial and cultural experience the initial focus of participants tended to be on physical changes. These may be more easily recognisable particularly those that are frequently reported as being linked to menopause such as hot flushes and menstrual changes. What is apparent within this theme are the wide range of physical 'symptoms' linked to menopause with most being perceived negatively. The findings of Im et al. (2010) demonstrated that women of colour were too embarrassed to discuss symptoms. Only a minority of women viewed physical changes positively resulting in two groups, those who experienced increased libido and women who could participate more frequently in religious activity following the cessation of menses. The focus on religious activity tended to be studies whose participants were from Middle Eastern and Asian cultural groups [9, 10, 29]. Women who reported the positive impact of religious activity also experienced less emotional changes during the menopause [9,29].

2.7.5 **Theme Two: Emotional Changes Experienced during the Menopause**

Emotional changes were attributed to the menopause across the studies (Figure 2.3). Anger, irritability and 'mood swings' were the most commonly reported emotional change in 24 studies [2, 3, 5-7, 10, 13-15, 19, 20, 23, 27, 29, 30, 32-38, 40, 41]. The intensity and unpredictability of emotions was common and along with anger, most frequently directed at intimate partners and family members, participants also described becoming tearful, both emotions were articulated as unexpected and considered undesirable in the majority of studies.

Figure 2.3 Emotional changes experienced during the menopause



Blue = Negatively viewed changes

Red = Positively viewed changes

Similarly to Theme One, emotional changes were predominantly viewed as being negative. Christoforou (2018) links her findings to Norbert Elias' theory of the 'civilised Body' in which a lack of control equals a lack self-discipline leading to lack of status in Western society. Within the

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other studies emotional changes appeared to be generally accepted as a normal part of the menopause. Theme Three below illustrates the negativity towards the menopause beginning to shift a little to show some positive beliefs about the menopause.

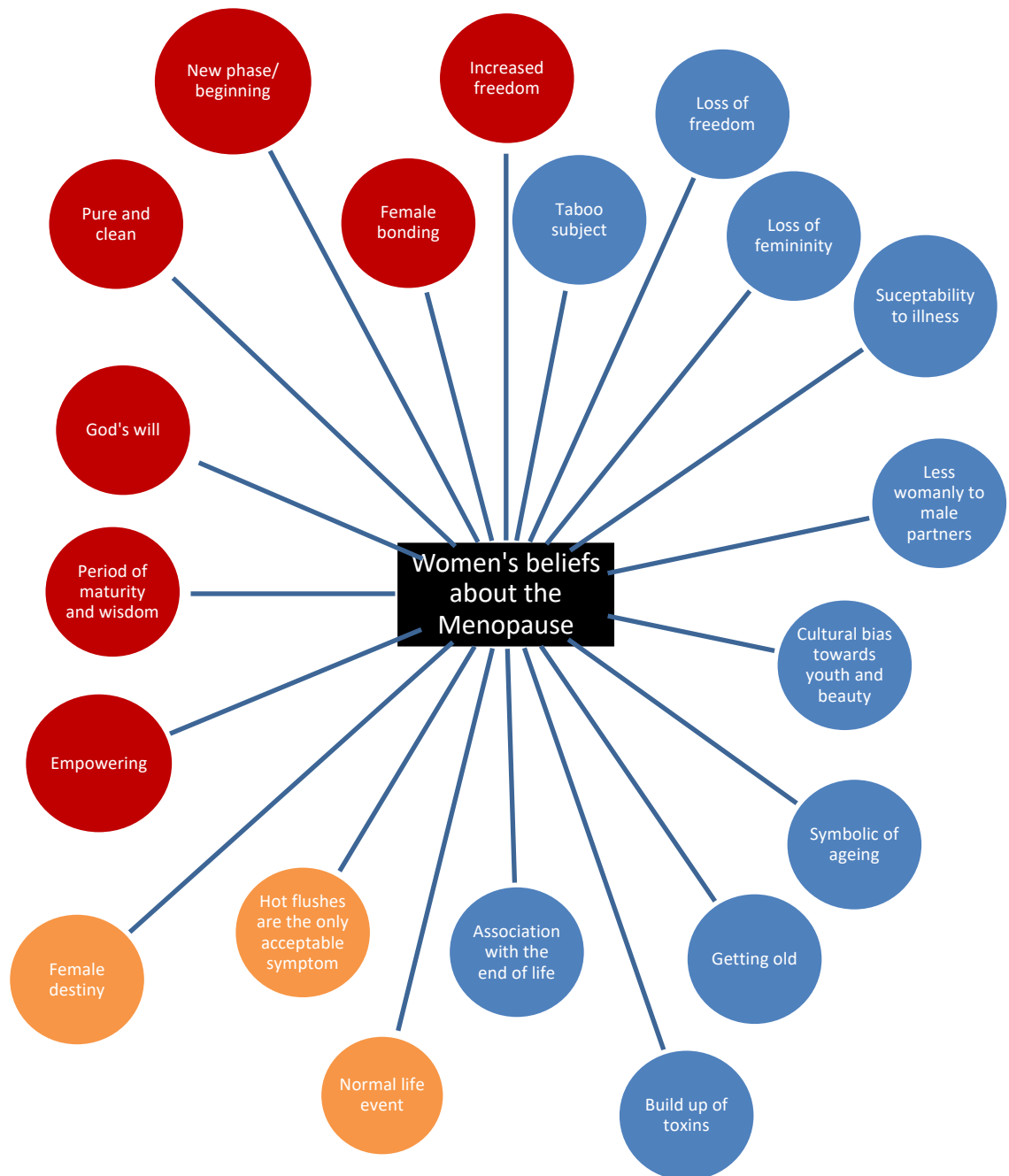
2.7.6 Theme Three: Women's Beliefs about the Menopause

Thirteen studies identified that women believed menopause was a natural or normal life event [1, 2, 5, 8, 9, 11, 13, 16, 22, 30, 33, 34, 32]. As well as being viewed as a normal life stage study findings reported women believed menopause was a new phase [7], a new beginning [23] and in one study participants described menopause as a metamorphosis representing a positive change into a stronger person [1]. Figure 2.4 illustrates women's beliefs across the studies reflecting some positive and neutral beliefs but predominantly negative views.

Women in one third of the studies (n=14) related this life stage negatively to becoming older [2, 3, 5, 9, 10, 14, 17, 19, 26, 27, 30, 37, 39, 41] reflecting the dominant westernised cultural bias towards youth. One participant described her fear of being seen as "just another frumpy menopausal woman" (Sergeant and Rizq 2017 p.193) and another participant described the ending of fertility as "the road to death" (McGinnis et al. 2009 p.12).

Positive beliefs about ageing alongside negative beliefs were often held in cultures in which older women gained respect from the community [3, 8, 9, 11, 14, 20, 21, 25, 28-30, 34]. Within cultures of respect women described themselves as positively contributing to the community often gaining power and respect, leading to a feeling of being valued as 'elders' or 'wise women' [9, 14, 28]. Breidenbach (2009) reported only positive views in their thesis aiming to present a fresh narrative of menopause using a feminist sociological design to explore the views of 12 lesbian women living together as a community. Breidenbach's study clearly demonstrates the positive impact of a supportive environment of women in normalising and embracing the menopause as a positive natural life stage.

Figure 2.4 Women's beliefs about the menopause



Blue = Negatively viewed beliefs

Red = Positively viewed beliefs

Orange = Neutral beliefs

A lack of knowledge about the menopause was reflected in the studies regardless of how recently the data was collected or the educational level of participants. Information tended to be obtained from other women, usually known older women rather than consulting the wide range of information sources that are now available. The inability to speak openly about the menopause

may contribute to the lack of awareness about this life stage and potentially impact on women's menopause experiences.

2.7.7 Theme Four: Impact of the Menopause

The impact of the menopause was mixed with women describing negative and positive attributes. Figure 2.5 illustrates the impact of the menopause across the studies with some changes leading to a feeling of liberation.

Over half the studies (n=24) clearly stated some participants were postmenopause and therefore looking retrospectively at their experience [1, 2, 5-7, 9-14, 16-20, 24, 26, 28, 29, 32, 34, 41, 42]. There was a tendency for postmenopausal women to view the impact of menopause more positively having been through the experience. The menopause stage was not stated in five studies [4, 8, 15, 30, 37] or articulated as 'menopausal' which has multiple meanings and makes it difficult to compare experiences across other studies [22, 33, 36].

Eight studies provided a comparison between the experiences of pre, peri or postmenopausal women [5, 12-14, 17, 19, 28, 29]. The findings suggested that women felt they lacked knowledge, particularly in the premenopausal groups. Singaporean women (n=58) in the Mackey et al. (2014) study considered themselves premenopausal until their FMP thereby not recognising the existence of menopause related changes. Women in the other groups stated that they also felt they lacked knowledge resulting in a lack of understanding about any changes and not feeling confident in explaining these to others, such as intimate partners.

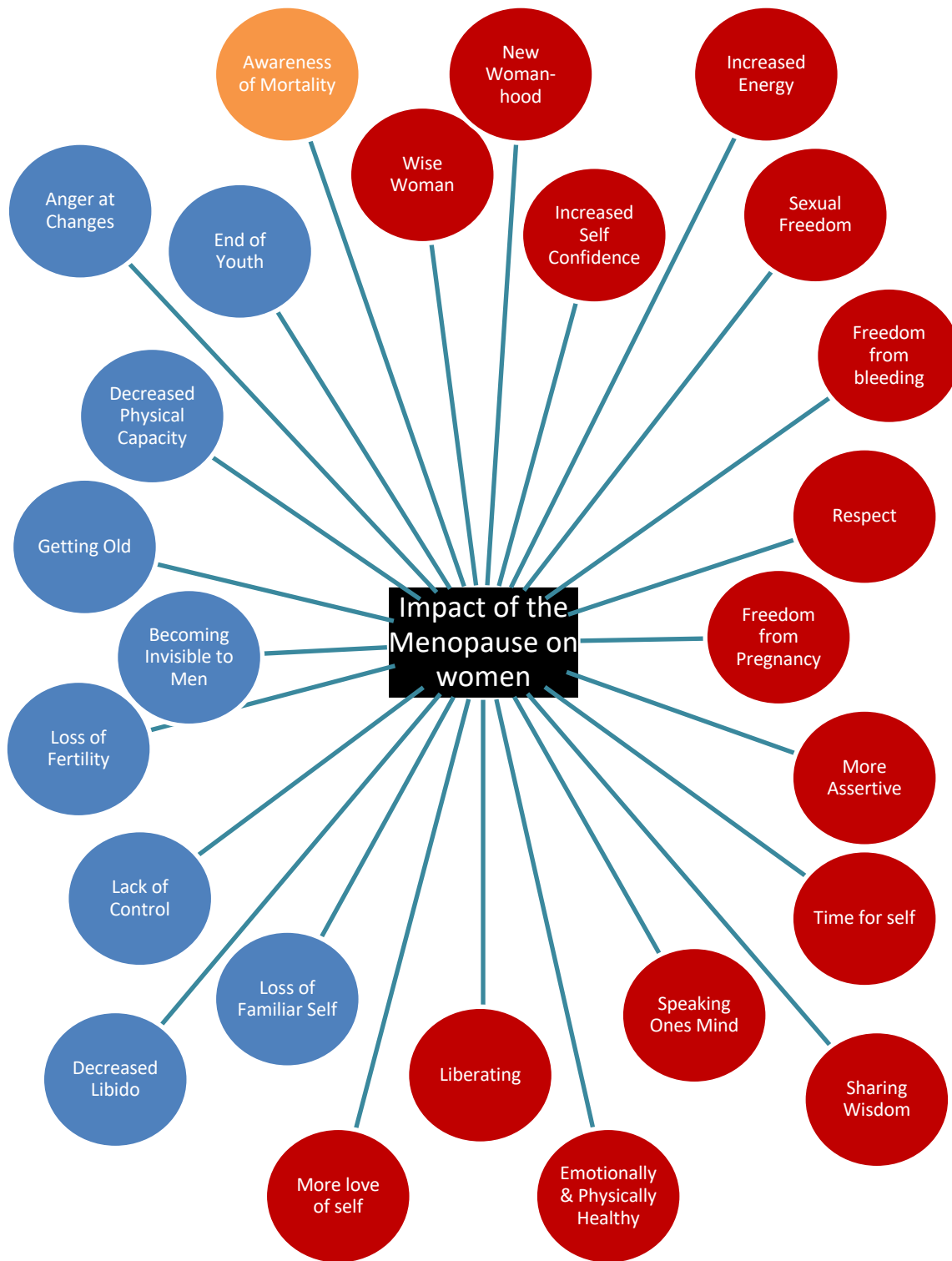
Murphy et al. (2013) found that Qatari and non-Qatari premenopausal women were unaware of symptoms and experiences with all women articulating the importance of their husbands' support in ensuring a positive experience once changes started. This reflects the findings of Natipagon-Shah (2005) when using a grounded theory approach to explore how Thai immigrant women (n=12) living in the USA navigated their menopause articulating that husbands were the single most important person in offering support. Partner support and empathy was mentioned in easing the menopause experience in four studies [14-16, 26] although predominantly it was other similarly aged women who were considered most supportive.

Women in eight studies described menopause as a time to focus on themselves rather than the needs of others [8, 14, 24, 25, 28, 38, 39, 42]. Within Theme Two, women articulated challenges with the strength of some emotions however in this theme it appears strong emotions may have enabled women to feel more liberated by, for example, speaking one's mind or being more assertive [15, 24, 25]. This may lead to an increased self-confidence and a sense of a new

womanhood. Alongside this there was a sense of loss which appears to be interlinked with the view that “Western culture is inherently age-phobic” (Morrison et al. 2014 p.12) which may negatively impact of attitudes to reproductive ageing. McCloskey (2012) was the only study of predominantly Western women (n=19) where women articulated they were becoming a ‘wise woman’.

Eleven studies articulated the cessation of menses as positive both from the perspective of not having to worry about managing menstruation but also the freedom from the risk of pregnancy [2, 7, 10, 12, 13, 15, 24, 28, 40-42]. In three studies, women described a re-emergence of their sexuality and a sense of sexual freedom that they had not previously experienced despite contraceptive availability [5, 21, 40].

Figure 2.5 Impact of the menopause on women



Blue = Negatively viewed changes

Red = Positively viewed changes

Orange = Neutral views

The impact of the menopause demonstrates significantly more positive attributes than the previous themes reflecting more strongly the experience of women who were postmenopausal rather than those who were pre or perimenopausal. Postmenopausal participants had the ability to compare their experiences before and after the cessation of menses, something the women in the other groups were not yet be able to do and this may account for more positive views of the actual rather than perceived impact.

Stage 5 has collated, summarised and reported the findings from the 42 retrieved studies achieving the first objective by mapping *how researchers have explored the menopause from the perspective of women since the publication of the WHI* and by using thematic analysis to identify *the experiences, views and perceptions of women during the menopause reported in the current literature* (Objective 2). The final stage of the scoping review was considered optional in the original Arksey and O'Malley (2005) framework but was later suggested as a useful component to enhance the review (Levac et al. 2010; Peters et al. 2017). The next section outlines how stage 6 was applied in this scoping review.

2.8 Stage 6: Consultation

The final stage of the scoping review framework is described by Arksey and O'Malley (2005) as optional but it is suggested this stage can enhance the review by providing additional references and insights. Peters et al. (2015) highlight the importance of consulting with experts throughout the review process. Throughout this scoping review I have consulted with the librarian for advice regarding the search and accessed research supervision to develop a 'team' approach to the literature selection and theme development. Research supervision enabled me to gain additional insights, references and discussion to challenge my thinking in considering the menopause.

2.9 What does the literature tell us?

The purpose of this review was to use the Arksey and O'Malley (2005) scoping review framework to explore the literature to answer the scoping review research question: *What is currently known about the experiences of women during the menopause?* This has been achieved by mapping *how researchers have explored the menopause from the perspective of women since the publication of the WHI* (Objective 1) and by using thematic analysis to identify *the experiences, views and perceptions of women during the menopause reported in the current literature* (Objective 2).

Globally across the studies menopause is viewed as a natural, normal life stage but there was a lack of consistency in the use of language related to menopause. Within the literature the

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language used to refer to the changes that occur as women move to the cessation of menses was often used interchangeably. Although menopause has a specific biomedical definition referring to the FMP, the term 'menopause' was often used by women and reported in the literature to refer to the period before the cessation of menses as well as the years after menstruation had ceased. 'Menopausal' was another term used interchangeably to mean being postmenopause, having changes related to menopause while menstruation is still taking place and experiencing 'symptoms' such as hot flushes either before or after the cessation of menses. Christoforou (2018) was the only study to explicitly state the word 'menopause' was being used to refer to the transition to menopause reflecting the language and interpretation of the peri and postmenopausal study participants. Other terms used in study titles were transition to menopause [2, 11, 13, 16, 17, 26, 30, 32,], perimenopause [18, 23, 25, 27], the journey to menses cessation [24] and in one the perimenopause and climacteric [35]. In view of the terminology 'transition' not being widely used by researchers and participants not considering menopause as a transition this thesis will refer to 'the menopause' to reflect the words of women themselves.

The studies retrieved in this review show a global perspective of menopause. Of the 42 studies four had participants solely from the UK [5, 6, 38, 39] and one had some (n=103) UK participants [10]. Hunter et al. (2009) demonstrated similarities across cultural groups in the UK participant population. Furthermore, the other UK studies demonstrated similarities in the reporting of negative experiences aligning with retrieved studies from outside the UK. Moreover, participants discussed their experiences of a 'normal' life stage but their focus was the range and impact of experiences, particularly physical changes, perceived to be associated with menopause.

There was also lack of knowledge about the onset of menopause which may in turn perpetuate the difficulty women have in distinguishing early indicators of onset from other potential causes for example pregnancy, fibroids or gynaecological cancers. Initial physical and emotional changes were mainly perceived negatively but as postmenopausal women reflected on the overall impact of the menopause the balance shifted to a more positive focus.

The gaps in the knowledge base identified by this review are the lack of consistency around the language used to describe the period before and after the cessation of menses along with the focus on negative physical and emotional aspects despite women articulating more positive views postmenopause. Furthermore, it is unclear how women gain knowledge of menopause, when women become aware that changes are taking place and how women then begin to make sense of the changes as part of the experience of menopause suggesting that despite the availability of knowledge from a variety of sources the menopause remains an area of female reproductive change that is not fully understood.

This scoping review identified 42 studies that met the inclusion/exclusion criteria. The dominant naturalist methodologies in this review are grounded theory, phenomenology and hermeneutic phenomenology which are helpful in adding to a growing body of knowledge of women's experiences, perceptions and views of menopause. There were no studies in the scoping review using interpretative phenomenological analysis as a methodology to give voice to women's experiences. This would offer a nuanced, micro level exploration of the individual experience of menopause and is described by Smith and Osborn (2015 p.41) as providing "an account of the lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions". The choice of methodology is useful for examining phenomena that is complex, ambiguous and potentially emotionally laden such as menopause. In contrast to grounded theory that aims to draw on individual accounts to illustrate the resultant theoretical claim, IPA emphasises the individual analysis and the convergence and divergence for a small group of participants. IPA can be viewed as complementary to other research methodologies and may help enrich the development of more macro accounts (Smith et al. 2009). The methodology is discussed in detail in Chapter Three. Overall in the field of menopause research there is a dominance of positivist research and a lack of focus on naturalist inquiry thereby limiting our knowledge in understanding how women make sense of the experience of menopause from the voices of women themselves.

This study will use interpretative phenomenological analysis to answer the research question: *What are women's lived experiences of the natural menopause?* This will be achieved by exploring how women make sense of the menopause and the meaning they attribute to their experiences within the context of their lives (Research objective i) and understanding the shared perspectives of women as they experience menopause (Research objective ii).

Chapter Three presents the methodology and methods that underpin this study aiming to add to the body of knowledge exploring the lived experiences of the menopause.

Chapter 3 Methodology and Methods

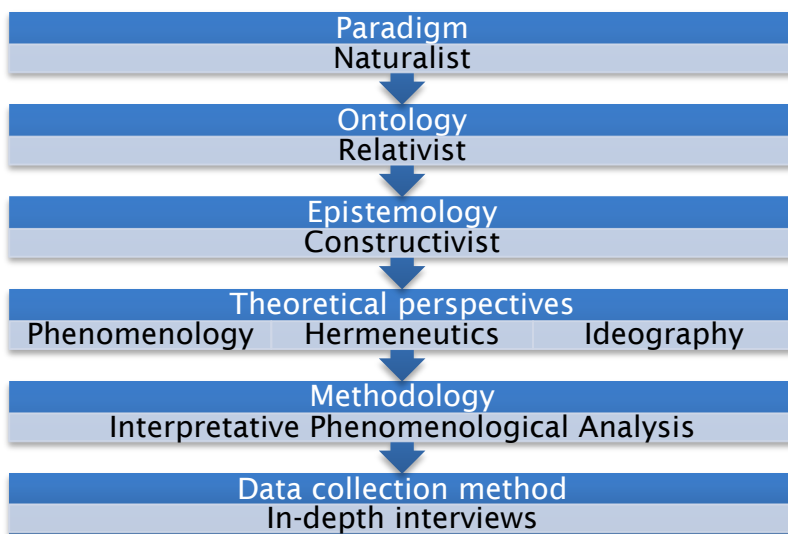
3.1 Introduction

Chapter Three presents the methodology that guided this research project. Sapsford (2006 p.175) defines methodology as "the philosophical stance or worldview that underlies and informs a style of research". It is important that the methodology aligns with the research question to ensure that the question is addressed and high-quality findings are achieved. The purpose of this study was to answer the question "*What are women's lived experiences of the transition to natural menopause?*" The main aims of the study were: to explore how women make sense of their transition to menopause; and the meaning they attribute to their experiences within the context of their lives; and to understand the shared perspectives of women as they transition to menopause.

The worldview of the researcher informed the decision making around methodological choice, as did the research question. Moreover, the literature review identified the need for more naturalistic inquiry to 'give voice' to women's experiences (Section 2.9) and to develop the alternative discourse to that provided by the dominant positivist paradigm. According to Denzin and Lincoln (2018 p.19) paradigms are "interpretive frameworks" which can be characterised through their ontology, epistemology and methodology. Whilst an epistemology that legitimises knowledge generation through scientific objectivity is important for the study of, for example, the physiological effects of HRT, it does not address ontological questions such as; how does the use of HRT impact on the lives of women or how do women make sense of menopause? These forms of questions are reliant on exploring the subjective experiences of participants, therefore a methodology from the naturalist paradigm of inquiry is required.

Furthermore, as people individually construct their understanding of a phenomena an epistemological stance that acknowledges the influence of social, cultural and historical contexts on individual meaning-making was needed aligning with a relativist ontology. In line with this rationale a methodology that would capture the meaning-making of women who have experienced the menopause was selected and that methodology was Interpretive Phenomenological Analysis (Figure 3.1).

Figure 3.1 An overview of the foundations underpinning the research study



3.2 Interpretative Phenomenological Analysis (IPA)

IPA is a methodological approach that has been used in the UK and gained popularity, particularly in health, education, humanities and social sciences since the 1990s (Pringle et al. 2011; Eatough and Smith 2017). Smith et al. (2009) argues that IPA offers an experiential qualitative methodology that is complementary to the quantitative approaches dominant in Psychology (Tuffour 2017). Smith et al. (2009) consider the process of IPA to be accessible to researchers while offering a flexible approach that is applicable to practice. This is important in the field of human sciences where practitioners are interested in the convergence and divergence of experiences of a particular phenomenon (Larkin et al. 2006; Smith 2007). IPA has the potential to enhance healthcare practitioners’ knowledge of experiences from the perspectives of service users to develop practice and services accordingly (Biggerstaff and Thompson 2008; Pringle et al. 2011).

IPA is informed by three theoretical perspectives: phenomenology, hermeneutics and idiography (Smith et al. 2009). These perspectives are relevant to studying how people make sense of their world as IPA is committed to exploring, describing and interpreting participant’s making sense of their experiences (Tuffour 2017).

Phenomenology

Phenomenology is a philosophical approach characterised by a number of themes rather than a specific approach thus accommodating a wide range of interests amongst researchers (Moran

2000; Smith et al. 2009) and is “committed to the examination of how people make sense of their major life experiences” (Smith et al. 2009 p.1). Phenomenology has been shaped by many philosophers but Smith et al. (2009) identifies four philosophers considered key in shaping phenomenological inquiry and influencing Smith's development of IPA, German philosophers Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976) and two French philosophers Maurice Merleau-Ponty (1908-1961) and Jean-Paul Sartre (1905-1980).

Edmund Husserl the founder of phenomenology, aimed to examine human experience and how people make sense of their own experience of a given phenomenon (Crotty 1998; Smith et al. 2009). This requires the person to 'step outside' of their own experiences in order to consciously examine and reflect on the experience by disengaging from what is already known and taken for granted. To facilitate this Husserl was a proponent of 'bracketing' (discussed below). Smith et al. (2009) suggests that Husserl's contribution to IPA can be found in the process of reflection and reflexivity through his work in providing a thorough examination of our (the researcher) lived experience.

Heidegger, a student of Husserl is credited with the development of interpretative phenomenology. He argued that people cannot be meaningfully detached from the world and are influenced by social, historical and cultural context and therefore judgements are made through a hermeneutic lens. Heidegger's work contributes the importance of considering the person's interpretation, 'meaning-making' which is central in phenomenology, within their particular context (Smith et al. 2009). Merleau-Ponty further built on Heidegger's work by considering the importance of the unique embodied experience on the person's meaning-making and the importance of researchers trying to understand the embodied experience while acknowledging that it cannot be entirely captured (Smith et al. 2009; Larkin et al. 2011; Eatough and Smith 2017).

Sartre emphasised the importance of the person being seen in context, indicating that "the self is not a pre-existing unity to be discovered but rather an ongoing project" (Smith et al. 2009 p.19). Sartre articulated a complex action orientated engagement with the world and meaning-making which is influenced by the interpersonal, affective and moral nature of experiences, as well as the embodied experiences described by Merleau-Ponty.

The identification of preconceptions or 'bracketing' is a concept that consistently generates debate within IPA literature and more recently within IPA forums. It is representative of the tension between the two schools of thought within phenomenology, Husserl and Heidegger, with regard to 'bracketing'; the identification of preconceptions. Husserl wanted to identify preconceptions imposed by personal, social and cultural contexts to enable people to suspend or 'bracket' preconceptions (Moran 2000). Husserl believed that understanding preconceptions

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enables people to attend to and consider how a 'taken for granted' experience is consciously perceived (Eatough and Smith 2017). This is achieved through a descriptive process in which researchers identify, clearly describe and thereby set aside their preconceptions. Heidegger, adheres to more contemporary constructivist view that 'bracketing' is not possible. He postulated that human beings are 'questioning beings', and therefore naturally 'make meaning' of phenomenon to cope with life and being in the world (Moran 2000). Consequently the researcher cannot 'bracket' their preconceptions, only recognise and articulate them developing an awareness of how they influence the research process.

Within IPA the researcher attempts to identify their preconceptions, a task that has been identified as difficult early in a study (Creswell 2013; Tuffour 2017). Smith et al. (2009) links the challenges to Heidegger's belief that phenomenology is an interpretative activity involving a complex relationship between hermeneutics and preconceptions. The researcher needs to develop an awareness of, and set aside, their preconceptions and assumptions to allow the focus to remain on the participant (Smith et al. 2009). Tuohy et al. (2013) argue that by recognising and acknowledging influences, rather than setting them aside, the researcher can be more open to the meanings of others and reduce bias. Rodham et al. (2015) highlight that the process of identifying preconceptions can be challenging until fully engaged with the data, as this is the point where preconceptions may emerge. Reflexivity is required throughout the study to identify preconceptions as they become evident. Biggerstaff and Thompson (2008) recommend the use of a reflexive journal to assist with the recognition of preconceptions and the impact these can have on interpretation of data (see section 6.3 for more detail about the use of a reflexive journal in this study).

The influence of philosophers has resulted in a broad discipline within phenomenology however, according to Crotty (1998), there remain three common philosophical assumptions:

Phenomenology is the study of the lived experience; the person has a conscious awareness; and experiences are conscious ones. In considering the lived experience the IPA researcher has a key role in interpretation informed by hermeneutics.

Hermeneutics

Heidegger proposed that a human being could only be understood within their cultural and historical context. His work made more explicit the importance of interpretation in phenomenological analysis (Smith et al. 2009) and the importance of hermeneutics, the theory of interpretation. Originally developed to scrutinise the interpretation of biblical texts and subsequently legal documents and the interpretation of written language, later modern hermeneutics incorporated psychological interpretations through listening to people and

interpreting exchanges (Crotty 1998; Moran 2000). Moran (2000 p.276) describes the work of Dilthey, a German philosopher (1833-1911) credited with developing Schleiermacher's (1768-1834) account of general hermeneutics and influencing Heidegger, as "an attempt to get inside the mind of the other, while still treating the other *as other* [an individual] and not reducing it [the phenomenon] to what is within one's own experience". This is thought to lead to getting into the participant's mind to understand their interpretation of the phenomenon from their perspective rather than the researcher's perspective. Dilthey argued that this results in a dynamic interpretative relationship between the individual part and the whole (Moran 2000). Heidegger brought together Dilthey's hermeneutics and Husserl's phenomenology as hermeneutic phenomenology.

As the researcher gains an understanding of how individual parts of the data relate to the bigger picture (the whole), they then revisit the part with a renewed understanding and back again to the whole aiming to develop an in-depth interpretation of the particular idiographic experiences. Interpretation between the part and the whole occurs on a number of different levels as the analysis moves backwards and forwards between them (Table 3.1). The researcher thereby becomes involved in the hermeneutic circle to develop depth of analysis (Smith 2007). Smith et al. (2009) argues that using the hermeneutic circle as a way of thinking offers an iterative, non-linear, dynamic interpretation of the data.

Table 3.1 Concept of the part and the whole in the Hermeneutic Circle⁶

The Part	The whole
The single word	The sentence in which the word is embedded
The single extract	The complete text
The particular text	The complete oeuvre (interview)
The interview	The project
The single episode	The complete life

(Smith et al. 2009 p.28)

It is through the interpretation, hermeneutics, of the detailed 'rich' data that the researcher begins to explore and understand the participant's perspective (Smith 2007; Morgan and Wells 2016). Within IPA, as well as moving between the parts and the whole, interpretation is via a double hermeneutic involving the researcher trying to 'make sense' of the participant trying to

⁶ Reprinted from; Smith JA, Flowers P and Larkin M (2009) *Interpretative Phenomenological Analysis*. London: SAGE with permission from SAGE Publications Ltd

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'make sense' of their experience (Smith and Osborn 2003). In interpreting the parts of the participant's individual experience, it is necessary for the researcher to understand the context of the participant's whole experience, and vice versa ensuring an ideographic focus.

Ideography

The third theoretical perspective underpinning IPA, ideography is concerned with the 'particular' and how the phenomenon has been understood within the unique context of the individual's experience (Smith et al. 2009; Eatough and Smith 2017). The focus on the unique embodied experience of the individual means the ideographic stance results in statements specific to participants and the group rather than universal generalisations (Pietkiewicz and Smith 2012).

The ideographic stance required when applying IPA is achieved by: a commitment to detail leading to depth of analysis of each case, and a commitment to understanding from the particular person's perspective and context. How data is collected therefore, is an important consideration. Smith et al. (2009) recommends in-depth interviews as the data collection method of choice as a well-conducted interview facilitates researcher access to the participant's private views (Morgan and Wells 2016). This is needed if the researcher is to gain an understanding of phenomenon as experienced by participants in their particular context.

Analysis aims to maintain an idiographic focus and this is achieved through a detailed, rich, nuanced examination of a single case before moving onto a detailed examination of the next case (Smith et al. 2009). As analysis progresses areas of convergence and divergence are identified and themes developed that represent the collective and unique voices of participants (Brocki and Wearden 2006; Tuffour 2017). The purpose of IPA is not to generalise but to 'give voice' to both individual and shared experiences and while commonality may provide insights into wider implications, any understanding and explanation can only be applied in the participants particular contexts (Pringle et al. 2011; O'Mullan et al. 2017). O'Mullan et al. (2017) highlighted that using IPA as the research methodology enabled the women in her study to identify and define their own experiences of sexual difficulties rather than focusing on biomedical explanations. The idiographic focus of IPA offers an opportunity to generate new knowledge and understanding of women's lived experiences of menopause given the dominance of biomedical perspectives discussed in Chapter One.

Whilst IPA is now a popular methodology in health sciences IPA studies have been criticised for being too descriptive and lacking interpretation (Hefferon and Gil-Rodriguez 2011; Murray and Holmes 2014). Smith et al. (2009 p.103) recognise this as an issue stating that "novice researchers tend to be too cautious" in developing deeper levels of interpretations. It is recommended that

researchers new to IPA need to take time and seek support to move from the descriptive to conceptual levels of interpretation (Biggerstaff and Thompson 2008; Smith et al. 2009; O'Mullan et al. 2017). I used the process of research supervision and a peer support network of academics who had completed PhDs to challenge my thinking to address these concerns. Brocki and Wearden (2006) identified in a review of 52 IPA studies that researchers did not always recognise their preconceptions or their influence on data interpretation which Morgan and Wells (2016) identified as leading to potential bias. The nature of hermeneutics, particularly the double hermeneutic means that the findings are always an interpretation of what the researcher thinks the participant is thinking requiring in-depth auditable records of the research process so that potential bias is avoided, or is identified as part of a quality assessment process (Yardley 2000; Smith et al. 2009). Whilst completing the research process there were key quality issues that need to be considered and the process of establishing quality in this study is outlined in the next section.

3.3 Establishing Quality

Amongst qualitative researchers there has been debate about the most appropriate way to assess the wide range of methodologies encompassed within the naturalistic paradigm (Mays and Pope 2000; Høyland et al. 2017). Smith et al. (2009) argues that there may be a risk that quality assessment becomes superficial and prescriptive through the use of checklists that do not consider the nuances of interpretative approaches. While recognising that quality is important proponents of naturalistic inquiry have rejected the terminology imposed by positivism whereby the focus is validity and reliability in favour of criteria aligned to qualitative research focusing on transparency and credibility (Bazeley 2013). While there is a difference in terminology across paradigms the fundamental principles are the same; to demonstrate a high quality piece of research (Long and Johnson 2000; Yardley 2000; Smith et al. 2009).

Establishing that the completed research is credible (Long and Johnson 2000) is achieved by carrying out an assessment of quality. To achieve this assessment there are different frameworks available including Lincoln and Guba (1985) and Walsh and Downe (2006). The quality assessment framework applied in this thesis is that developed by Yardley (2000) which proposes four principles against which a quality assessment can be made. Table 3.2 outlines how the four principles were applied within this study.

Table 3.2 Quality assessment based on Yardley's framework

Principles:	How these are being addressed:
Sensitivity to context	Reviewing the literature
	Engaging with General Practitioner (GP) 'gatekeeper' and practice staff
	Establishing a rapport with potential participants
	Demonstrating empathetic and sensitive interviewing techniques
	Developing a collaborative relationship with participants
	Keeping the participant at the centre of the analysis
	Recognising and recording personal thoughts, feelings and assumptions through the use of a field diary and personal journal
	Considering the influence of the interviewer on the interviewee (insider-outsider perspectives)
Commitment and rigour	Attending to the participant and demonstrating 'presence' to conduct a high-quality interview
	Maintaining in-depth auditable records at all stages of the research process
	Developing the skills and competence to complete a thorough data analysis that remains true to the principles of IPA
	Maintaining a critical stance when engaging with the data.
Transparency and coherence	Clearly articulate the research question and objectives
	Provide a detailed description of the research process
	Linking the theoretical assumptions with the research process and the study outcomes
	Reflexivity through the use of: Field diary: to assist in maintaining a coherent approach to the data Reflexive journal: used to capture responses during the analytic process and shared with research supervisors
Impact and importance	Demonstrated via the study findings
	Sharing the research process and outcomes with others through conferences, publications and lecturing

A field diary and reflexive journal were used to assist in maintaining a coherent approach to the data and capturing responses during the analytic process. This provided a written record to share with research supervisors while contributing to transparency, coherence, commitment and rigour within the quality process.

Consideration was given to member checking my analysis of participants data. However member checking is strongly advised against in IPA (Smith et al. 2009; Larkin and Thompson 2012; Gauntlett et al. 2017). In single case analysis member checking can be productive because the interpretation is from one person's account (Larkin and Thompson 2012). However, for cases where interpretations use multiple participants commentaries member checking is considered to be counterproductive due to the amalgamation of accounts, researcher interpretation and the long time frame between data collection and asking for participant validation. The use of peer (fellow researchers) and sample validation (people who were eligible but chose not to take part) are argued to be more valid ways of checking the researcher's interpretation in IPA studies (Larkin and Thompson 2012). This was achieved in this study by engaging with research colleagues (peers) as well as other women in the academic environment where I work (sample), through discussions and presentations of the themes and findings. Aligning with ethical approval (section 3.4.1), maintaining confidentiality and anonymity (section 3.4.3) and ethical research practice at no point was data shared outside of the supervisory team. Sharing data analysis through regular research supervision also formed an important part of checking the interpretation that was subsequently reported in this study.

This thesis provides a detailed record of the development of both the study and my skills as a researcher. This level of transparency and rigour throughout the IPA process enables others to assess the overall quality and trustworthiness of the study conclusions (Smith 2007; Allan and Eatough 2016).

3.4 Research Process

3.4.1 Ethical Approval and Ethical Considerations.

This study was approved by the University of Southampton Ethics and Research Governance Committee (ERGO ID:11468) and the NHS Health Research Authority (IRAS ID:132231) following peer review in August 2016. Further ethical approval (ERGO ID:11468.A2) was obtained in July 2019. However ethical considerations and ethical practice are about more than meeting the requirements of ethics committees. The DH (2005 p.7) states 'The dignity, rights and wellbeing of participants must be the primary consideration in any research study'.

3.4.2 Dignity and Wellbeing of Participants

People choose to become involved in research for a range of reasons that may not be overt to the researcher, such as forming part of a healing process, being able to share their stories to an interested, attentive, listener and having an opportunity to express their distress (Lowes and Gill 2006; Dennis 2014). This can make it difficult to predict the impact of the research process on data collection. Participants may show signs of emotion during data collection, for example, becoming tearful when discussing personal experiences and deeply held feelings. It is therefore important to establish if this is a transient moment or if it is escalating into distress. At the point of distress a person may move into a more 'vulnerable' situation which could lead to saying something that they would not have ordinarily said. Researchers need to be conscious of this potential and have a plan in place to manage it with care and compassion to maintain the participant's dignity and wellbeing.

Participant distress may lead to the cessation of data collection and discussion with the participant about continuing (Koivisto et al. 2001; Keogh and Daly 2009; Hurley et al. 2011). Brayda and Boyce (2014) argue that participant interviews can be emotionally charged but this does not mean that the participant does not want to share their experience. Research interviews are not intentionally therapeutic but the process of talking to someone who is interested may be both healing and cathartic for some participants (Lowes and Gill 2006; Mitchell 2011). None of the participants in this study became distressed by the information shared but at different times there were increased levels of emotion.

Researchers also need to be mindful when ending interviews as some participants may feel 'abandoned' (Koivisto et al. 2001; Creswell 2013). This is particularly important if participants have made disclosures of a sensitive nature and the participant may be concerned about confidentiality and privacy issues.

During the interviews carried out in this study participants discussed issues that were personal with one participant disclosing some extremely sensitive information. It was highlighted that she did not need to share anything she was not comfortable with and she was reminded of the anonymisation process that would be applied to her data as part of her right to confidentiality and anonymity. Notes were made directly into my field diary after the interview providing a record of my thoughts and feelings at the time of the interview. Re-reading the field diary gave me an opportunity to reflect on the interview and any changes for future interviews. As a clinician I have a natural tendency to be interested in people which can result in relaxed conversations about difficult topics. I was mindful that this could result in participants making disclosures they may later regret. With this in mind I discussed at the beginning of each interview that the participant

should only share what they feel comfortable with. Furthermore, I tried to ensure extra vigilance for changes in verbal and non-verbal body language that might indicate the participant was beginning to feel uncomfortable to allow for an early reminder that they were in control of the information they shared.

3.4.3 Confidentiality and Anonymity

Smith et al. (2009 p.53) states that 'to say something is 'confidential' is to say that no one else will see it' and that this is not necessarily the case in research. Within qualitative research Saunders et al. (2015) suggest that confidentiality is not possible within the primary research team but is achievable within the wider context. Furthermore the Nursing and Midwifery Council (2012; 2018) states that confidential information must only be shared if consent has been given to share it, or there are suggestions of a risk of harm to the person or others. Confidentiality and anonymity were explained in the participant information sheet and reiterated to participants prior to commencing interviews. However, these elements required additional consideration due to the context of the recruitment.

A key issue for this study was how confidentiality and anonymity would be maintained for staff or students recruited from within the school where I both work and study. Participants who chose to be interviewed within the university were offered a room in a different university building for face-to-face interviews. There was also the option of a telephone interview or for the interview to take place in the participant's home. All options were discussed when I made telephone contact to collect the participant's biographical details, discuss their suitability for the study and answer any queries. All files and biographical details were held in a password protected files on password protected servers and only accessible to myself. Personal information such as contact details were only kept following the interview if the participant requested a copy of the final abstract on completion of the study.

Wiles et al. (2008) explored through interviews (n=31), six focus groups with a total of 35 participants and email responses (n=10) how experienced researchers (n=76) managed confidentiality and anonymity in social research. A significant finding was that protecting anonymity was particularly challenging when detail about the specific context was required leading researchers to change participant characteristics or withhold information to protect the participants. There were a number of steps I took to protect the anonymity of all participants. Following data collection, I was the only person who listened to the interviews which I then transcribed to protect the confidentiality of staff and students recruited from within the faculty. A pseudonym was assigned to each participant at this stage and personal details, such as other

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names, places and organisations were removed to anonymise their data. If participants mentioned their profession this data was also edited to state, for example, a registered healthcare professional or student healthcare professional. If anyone who had a unique role that could make them identifiable this was also removed. Throughout the supervisory process only the pseudonymised data were used to minimise the chance of recognition by my supervisory team. When writing the mini-biographies, I did not include information such as hobbies that I felt may make people identifiable to others in an organisation where people may work closely together.

Participants were also informed before the interview that steps would be taken to anonymise any information used in the final thesis or for publication, but there was potential they may recognise extracts from their interview (Boddy 2007; Smith et al. 2009; Creswell 2013). Within qualitative research, anonymity is a complex process due to the contact the researcher has with the participants. Unlinked anonymity described as “complete anonymity” could not be guaranteed in this study due to the collection of biographical information and the interactions between myself and the participants. Although participants could potentially be linked to their data, the steps taken resulted in an explanation of linked anonymity. This was to ensure that they were fully informed about their involvement in the study and how their contributions may be used (Boddy 2007; Creswell 2013). An explanation was also given about how data would be stored and managed once collected to maintain confidentiality.

3.4.4 Data Storage

In line with the six data protection principles and the University of Southampton (UoS) Data Protection Policy (2018a), hard copy data was stored in a locked filing cabinet in the Faculty of Health Sciences and all electronic data was kept on a password protected university computer. Principle five of the Data Protection Act (2018) states that personal data should not be kept longer than necessary, therefore study data will be retained for a minimum of ten years from the completion of the study as required by the University and recommended by the Medical Research Council (Medical Research Council 2012; UoS 2016). All paper and electronic data will then be securely destroyed in alignment with the recommended practices for the destruction of data; securely shredding and disposing of paper documents and using DBAN for magnetic data (Van den Eynden et al. 2011; UoS 2016; UoS 2018b). Ethical data storage is one of a number of steps in safeguarding the rights of research participants.

3.4.5 Rights of Participants: Consent

Consent is an essential part of ethical research practice to protect the rights of participants underpinned by the 1947 Nuremberg Code and the 1964 Helsinki Declaration (Boddy et al. 2010; Health Research Authority 2017). Potential participants need to have an understanding of the process and be given balanced information in order to give informed consent. The participant information sheet was sent to potential participants when they contacted me for more details about the study (Appendices F, G, I, K, and L). The Health Research Authority (2017) highlights the importance of providing both verbal and written information rather than being heavily reliant on overly detailed participant information sheets.

Understanding the requirement for the study is one part of enabling the person to give informed consent. The other general principles of consent also need to be met; consent must be valid (freely given) and given by a person who has mental capacity (Royal College of Nursing 2017). Consent within research needs to meet additional requirements to demonstrate that participants have not been coerced or misled, that they have capacity to make a judgement about coercion, they are able to control the amount of information they receive, and they are given the opportunity to withdraw consent (Health Research Authority 2017).

A number of authors suggest that sequential consent is best practice in potentially sensitive research (Koivisto et al. 2001; Keogh and Daly 2009; Smith et al. 2009). In this study the consent process was raised at initial contact and again prior to interview (face-to-face or telephone). This was to give the participant time to consider their involvement and the opportunity to change their mind. Copies of the consent form (Appendices M, N and O) were given to the participant to complete on the day of the interview, an explanation was also given about being able to withdraw consent. Participants choosing a telephone interview completed the consent form and returned it electronically before the interview took place. They were advised to keep a copy for their records. On the day of the interview the researcher obtained verbal consent that the completed form was still valid and understood.

Giving enough information about the process was important to ensure that participants were giving informed consent, therefore the purpose of the study, the anticipated length of the interview, 60 to 90 minutes and plans for the research outcomes (final thesis and potential publications) were shared with participants before they signed the consent form.

3.4.6 Rights of Participants: Concerns

Participants should be aware of whom to contact if they wish to raise any concerns about the research process (Appendices F, I and K). Information was therefore provided within the participant information sheet about who to contact for additional support and advice.

3.5 Research Procedure

This study comprised of a pilot study, main data collection (phase one) and an extended data collection (Phase Two). The pilot study recruited two participants in August 2016, between April and June 2017 phase one recruited five postmenopausal women. Phase Two (September to November 2019) recruited a further four participants. The research process from pilot study through to the final phase of the study is discussed below.

3.5.1 Pilot Study

In-depth, individual interviews were the chosen method of data collection for this study and are recommended for IPA research (Smith et al. 2009; Allan and Eatough 2016). The interview schedule included questions and prompts that would facilitate a detailed account of participant experience of the menopause without limiting the discussion (Table 3.3).

Table 3.3 Interview schedule

Interview Schedule (Version 6)	
Questions	Potential prompts
Can you tell me what it was like approaching the menopause?	<ul style="list-style-type: none"> • How did you know that you were becoming 'menopausal'? • Your expectations: concerns, things you were looking forward to.
What were your experiences in the years before the menopause when you were becoming menopausal?	<ul style="list-style-type: none"> • What impact has it had on your life: relationships, health, wellbeing, body image, and sexuality, confidence. • Symptoms: physical health, mental health, mood. • Management: healthcare services used, alternative symptom management e.g. herbal, dietary changes. • If you sought help, what were your experiences of this? e.g. holistic approach, felt listened to. • Was there an opportunity to explore other issues?
Could you tell me what you knew about the menopause before, during and now?	<ul style="list-style-type: none"> • Where/how did you get information? e.g. leaflets, GP, internet, friends. • Was it helpful? • What would you have liked to know? • How would you have liked to obtain this/any information? • What advice would you offer someone who is approaching the menopause?
Can you tell me about your life post menopause?	<ul style="list-style-type: none"> • Positive impacts • Negatives impacts (relationships, health, wellbeing, body image, sexuality and sexual relationships) • Is life as you expected?

A pilot study was undertaken in August 2016 as a means of testing the interview schedule, face-to-face and telephone interviews. Two postmenopausal women were purposively selected and interviewed, one face-to-face and one by telephone. Table 3.4 provides an overview of the biographical information of the two pilot study participants.

Table 3.4 Overview of pilot study participants: August 2016

Recruitment Phase	Pseudonym	Age	Relationship Status	Ethnicity	FMP	STRAW+10 Stage
Pilot study	Jane	57	Married	White	March 2012	+1c
Pilot study	Louise	57	Married	White	June 2016	+1b

The face to face interview for the pilot study lasted 39 minutes and the telephone interview 51 minutes. The data from the two interviews was analysed using the six steps (outlined in section 3.5.8) to ensure the interview schedule was appropriate and able to generate data around experiences of the menopause. The pilot study identified a number of key learning points resulting in developments to the study (Table 3.5).

Table 3.5 Study developments from the pilot study

Issue/challenge:	Change made:	Rationale:
Recruitment: Participant information sheet given on day of interview	PIS to be sent once the potential participant has made initial contact	To give the participant more detailed information about the study and process to improve informed consent.
Data collection: For both face-to-face and telephone interviews a face-to-face meeting was arranged to sign the consent form.	<i>Face to face interviews:</i> Consent to be obtained on the day of the interview. <i>Telephone interviews:</i> Consent form to be emailed to the participant to return before the interview. Consent will be rechecked verbally at the beginning of the interview.	The nature of participants requesting a telephone interview reduces the likelihood of face-to-face contact. The participant may also have requested this because they do not want to meet the researcher. Obtaining verbal consent on the day will ensure that the participant continues to consent to the interview.
Data collection: Participant's setting interview time boundaries.	From initial contact and within the PIS it is made clear that the interview will be no longer than 60-90 minutes. The participant is made aware they can stop the interview at any time and they do not need	The boundaries set by the participant will always be respected. Participants may need permission to feel they can stop the interview.

Issue/challenge:	Change made:	Rationale:
	<p>to answer/discuss anything they feel uncomfortable with.</p> <p>A discussion will take place about the most appropriate time for the participant when they feel they will be happy to talk.</p> <p>If the interview is shorter the participant will be given the opportunity to continue if they wish to.</p>	<p>This is also important in developing a collaborative relationship.</p> <p>It is important that the participant is aware of the potential commitment of time.</p> <p>The researcher wants to ensure that the participant has had the opportunity to say everything they may have wanted to even if the questions posed or the discussion has not facilitated this.</p>
<p>Data collection: When there was a prolonged silence for the telephone interview it was difficult to ascertain the cause.</p>	<p>To ask the participant: Who is in the room or present in the location?</p> <p>To let the researcher know if they are interrupted.</p> <p>To let the researcher know if they need to stop the interview to attend to something.</p>	<p>Interruptions may be distracting for the participant and inhibit the sharing of their experiences. If the researcher has an understanding of this it may give additional context to the interview data.</p> <p>The participant needs to feel they can attend to things if they arise in their location. It is preferable to be able to stop/suspend the interview and reconvene, if the participant wishes, so that the participant is not inhibited in sharing their story.</p>
<p>Data collection and analysis: The telephone recording was poor.</p>	<p>To test the recording equipment immediately before the interview regardless of chosen interview method.</p>	<p>Having a good quality recording is essential to ensure accurate transcription and data analysis.</p>
<p>Data analysis: When transcribing it was challenging to recall what happened or how I felt.</p>	<p>Writing or recording notes/observations/feelings immediately after the interview in a field diary.</p>	<p>Good quality entries allow for a richer analysis, as the researcher is part of the process in generating knowledge.</p>

Issue/challenge:	Change made:	Rationale:
Data analysis: I used lots of 'ums and arrs' in the face-to-face interview which was distracting when transcribing.	To be aware of vocalisations and use more non-verbal communication to affirm I am listening.	To be able to fully demonstrate to the participant that I am listening and attending to them.
Data analysis The pilot study analysis was very descriptive.	Regular supervision to present and discuss data analysis.	To share initial thoughts and have assumptions challenged to provide deeper analysis.
Reflection and reflexivity: Until April 2016 I had only notes about the logistical development of the study rather than personal and researcher development making it challenging to see how my perspectives have changed.	Journal for recording detailed notes about: Project development Personal views and assumptions Challenges Thoughts about data analysis	This should enable me to see clearly my personal development and views providing insight into how these may impact on the analysis of the data and the findings.

3.5.2 Participant Selection Criteria for the Main Study

Recruitment strategies for the study reported here aimed at gaining women who had experienced the menopause and were willing to share their stories. Menopause usually occurs anywhere between 42-58 years of age in normal, healthy females who have not had surgical interventions (Soules et al. 2001). The average age of menopause for women in the UK is 51 years old (NCC-WCH 2015). Women are not considered to have reached the menopause until 12 months after the final menstrual period (Harlow et al. 2012), a decision that can only be made retrospectively, therefore the key inclusion criteria for potential female participants was the date of their FMP (Table 3.6). Initially I had anticipated women recruited would be in STRAW+10 stages +1a and +1b (Figure 1.1), considered as early postmenopause (Harlow et al. 2012) as I felt this group would have the most to share as they remained close to the experience. However, the women who contacted me about the study ranged from one to ten years since their FMP therefore in response to these enquiries from potential participants in late postmenopause and following consultation with research supervisors, these potential participants were included in the study with the aim of providing additional insight into the lived experiences of the menopause by including women who had experience of life postmenopause.

Table 3.6 Participant inclusion/exclusion criteria

Inclusion	Exclusion	Justification
Women aged 45 years to 65 years who believe they are menopausal.	Women under 45 years or over 65 years	There is a wide range of ages in which women can experience menopause. The average age of menopause in the UK is 51 years (NG23 2015).
Natural menopause with a minimum of 1 year since final menstrual period.	Surgically induced menopause/ Poly Cystic Ovary Syndrome, Chemotherapy.	Women who have a surgically induced menopause will not have experienced a natural menopausal which is the focus for this study.
English speaking	Non-English speaking	Participants need to be English speaking as this is a student project and there is no budget to allow for the costs of translating materials or having an interpreter present for the interview.

3.5.3 Sample Size

The architects of IPA, Smith et al. (2009) argue that there is no definitive answer to the question of sample size and it entirely depends on the project. They state that "Given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases" (Smith et al. 2009 p.51). Smith et al. (2009) argue that the sample size needs to be small enough to maintain an idiographic focus, and Hefferon and Gil-Rodriguez (2011) who recommends fewer participants generating a detailed, rich, nuanced analysis of the participants' experience rather than a broader descriptive analysis of many individuals. Smith et al. (2009) tentatively suggests that up to 12 participants is acceptable for PhD studies and therefore the intended sample size was set at 12 participants. In a sample of IPA studies published in the last five years sample sizes are reported between 5 and 10 participants which, according to study authors, have adequately captured patterns of similarity and difference while maintaining an ideographic focus (Al Omari et al. 2016; Morgan and Wells 2016; O'Mullan et al. 2017; Jacobs et al. 2018; Burton 2020).

3.5.4 Phase One: Main Study Recruitment

My original intention was to explore the health-related experiences of women with a pre-diagnosed mental health problems during the menopause. In view of this, the planned initial recruitment site with ethical approval was via a GP practice where the lead GP would act as the gatekeeper for recruitment. The plan for recruitment was for the GP practice to identify potential participants from their electronic patient record system. However, as this option was being explored with the GP team it became clear that although the age of patients were easily accessible the electronic records did not clearly identify women diagnosed with mental health issues.

The practice manager advised that with her knowledge of the service users identified through the search of the electronic records it was unlikely that these participants would agree to take part in the research due to the serious and enduring nature of their mental health issues. Therefore, the focus of the study needed to be amended to increase the opportunity to recruit potential participants.

In view of the identified problems with recruitment via the GP surgery, and following a review of the literature and discussion with supervisors the decision to explore the lived experiences of the menopause from the perspectives of women. The new recruitment strategy and a second site (University of Southampton) was added to increase the potential to gain the intended sample. Approval of substantial amendments was received in August 2016. The challenges for recruitment are discussed in detail in Chapter Six section 6.2.1.

3.5.4.1 GP Recruitment

Posters were placed in the GP surgery reception, waiting room and toilets with information about the focus of the study and the researcher's contact details (Appendix D) for a period of two weeks. Potential participants could use the contact information on the recruitment posters to register their interest by phone or email. Alternatively, potential participants could pick up a participant recruitment pack containing an invitation letter (Appendix E), participant information sheet (Appendix F) and 'What will happen if I take part?' (Appendix G) from the GP surgery reception having seen the posters.

3.5.4.2 Outcome of GP Recruitment

The GP recruitment did not elicit any enquiries despite the GP stating that there was interest from his patient group. No participant information packs were collected from the reception. I visited the surgery on two occasions to check the supply of information packs and to see if new posters

were needed following the removal of the contact tabs. The aim of the visits was also to answer any questions and remind reception staff about the project with a view to gaining participants from the surgery.

3.5.4.3 University of Southampton Recruitment

Recruitment posters were used as outlined above in 'GP poster recruitment': posters were placed in the toilets in five University buildings at fortnightly intervals for up to two weeks (Appendix H). Following a response from the poster the researcher sent the participant information sheet (Appendix I) and "What will happen if I take part?" (Appendix L). Potential participants were then contacted to answer questions and ensure that they met the inclusion criteria (Table 3.6).

3.5.4.4 Outcome of Phase One Recruitment

Seven postmenopausal women responded to phase one recruitment, of these seven, two participants were unable to take part: one potential participant had experienced surgical rather than natural menopause and the second left a voicemail but did not include contact details. Due to the nature of this message the phone did not register her phone number, therefore no contact could be made. Table 3.7 gives an overview of the biographical information for participants recruited in phase one of the study.

Table 3.7 Overview of participants recruited for phase one: April to June 2017

Recruitment Phase	Pseudonym	Age	Relationship Status	Ethnicity	FMP	STRAW+10 Stage
Phase one	Rose	58	Married	White	2009	+2
Phase one	Kate	56	Married	White	March 2016	+1b
Phase one	Sophie	53	Living with partner	Not stated	March 2013/2014	+1c
Phase one	Emma	50	Married	White	2007	+2
Phase one	Lisa	45	Divorced / in a relationship	White	2014	+1c

3.5.5 Phase Two: Extended Study Recruitment

Following PhD viva in June 2019 where a request for further participants was made ethical approval was sought from the University of Southampton Ethics and Research Governance

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Committee (ERGO ID: 11468.A1) to commence recruitment of further participants at one site only (UoS). Phase Two approval was gained in August 2019. Due to changes in General Data Protection Regulation (GDPR) (Data Protection Act 2018) a new participant information sheet (Appendix K) and consent form (Appendix O) were generated and the 'What will happen if I take part?' (Appendix L) was reapproved. Recruitment took place using the process outlined above for the University of Southampton recruitment using posters that were reapproved and reworded (Appendix J). Posters were placed within one building on the university site for four weeks.

3.5.5.1 Outcome of Phase Two Recruitment

Phase two recruitment elicited five enquiries, one potential participant had irregular menstrual bleeding thereby did not meet the inclusion criteria (Table 3.6) of a minimum of one year since the final menstrual period. This resulted in a further four postmenopausal women being recruited to the study (Table 3.8). The recruitment in Phase Two included a snowball sampling technique, recruiting participants through others taking part in the study (Creswell 2013) resulting in two participants being referred to the study by a friend and a third by a friend of a friend, three participants were also from professions unrelated to healthcare.

Table 3.8 Overview of participants recruited for phase two: Sept. to Nov. 2019

Recruitment Phase	Pseudonym	Age	Relationship Status	Ethnicity	FMP	STRAW+10 Stage
Phase Two	Claire	60	Married	White	2016	+1c
Phase Two	Jess	51	Married	White	2017	+1b
Phase Two	Beth	52	In a relationship	White	2015	+1c
Phase Two	Rachel	52	Married	White	2014/2015	+1c

3.5.6 Participant Demographics

The demographics for the participants remained similar, well-educated professionals, or soon to be professional women. The demographic similarities were not unexpected as the participants were recruited via posters displayed in the University and were therefore most likely to be read by women in the academic environment. Smith et al. (2009) argue that homogeneity can be beneficial in analysing in more detail the patterns that emerge relating to the phenomenon. Homogeneity is discussed in more detail in Chapter Six section 6.2.1. Tables 3.4, 3.7 and 3.8

provide an overview of the biographical details of the two pilot and nine main study participants and mini-biographies are provided in section below to give some additional background information for participants recruited in Phases One and Two.

3.5.7 Participant Biographies

The following brief participant biographies are provided to orientate the reader to the personal and social contexts of each participant. As the informing epistemology is constructivist the mini-biographies help 'situate' the individualised experience. In providing the biographies ethical considerations for protecting the confidentiality and anonymity of participants. Saunders et al. (2015) were paramount necessitating anonymisation of data while maintaining the integrity of data. In view of the fact that some participants were recruited from a shared working environment the biographies are intentionally limited in details which may identify the individuals to colleagues who read this thesis.

Rose is 58 years old, married with one grown up child. Rose experienced menopause around 50 years of age. She is a healthcare professional and works full-time in higher education. Rose takes an active part in regular sports, which she also teaches.

Kate is 56 years old, married with one grown up child. Kate is a qualified teacher and is now working part-time in higher education. She describes herself as "a real outdoors person" and enjoys gardening.

Sophie is 53 years old, living with her partner who she will be marrying soon. Sophie is a healthcare professional working in full-time clinical practice and describes herself as "very committed to my work". She has chosen to be child-free and enjoys an active life.

Emma is 50 years old, married and loves horses. She has her own horse and has entered competitions in the past. Emma is a student healthcare professional which is something she had wanted to do for a number of years. As well as studying and completing practice placements she also does additional work to enable her to meet her financial needs.

Lisa is 45 years old, divorced and has been in a relationship for 19 months. Lisa has two children, one is an adult. She lives with her younger child who is a teenager and she is a grandmother. Lisa is a full-time student healthcare professional.

Claire is 60 years old, married with four adult children. She moved to the UK to study and stayed. Claire experienced the menopause when she was 57 years old. She works part-time and

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predominantly from home and is currently working supporting a vulnerable and stigmatised group.

Jess is 51 years old, married with two school-aged children. Jess is a healthcare professional and works full-time in higher education. She is juggling, working, studying and being a mum.

Beth is 52 years old and in a relationship. She is a teacher for young people with learning disabilities. Beth has chosen to be child-free.

Rachel is 52 years old, married with three adult children. She has recently retired as a teacher. Since retiring she has taken up yoga.

The commonalities for all participants are that they were well-educated, professional or soon to be professional women who have experienced the menopause while working in a Western cultural context.

3.5.7 Data Collection

Phase One and Two Interview Process

Phase one data collection took place between April and June 2017 comprising of four face-to-face interviews and one telephone interview. Three face-to-face interviews were conducted on University premises and one in the participant's home. Interviews lasted between 49 and 97 minutes with a median of 69 minutes and a mean of 64.4 minutes.

Phase two data collection comprised of one face to face interview in the participant's home and three telephone interviews between September and November 2019. Interviews lasted between 54 and 105 minutes with a median of 64.5 minutes and a mean of 72 minutes.

Minor additions to the potential prompts of the interview schedule were made to allow for further exploration of the themes identified in phase one data analysis and are in red text in Table 3.9 below.

Table 3.9 Interview schedule for data collection phase two

Phase Two Interview Schedule	
Questions	Potential prompts
Can you tell me what it was like approaching the transition to menopause?	<ul style="list-style-type: none"> • How did you know that you were becoming 'menopausal'? • Your expectations: concerns, things you were looking forward to.
What were your experiences in the years before the menopause when you were becoming menopausal?	<ul style="list-style-type: none"> • What impact has it had on your life: relationships, health, wellbeing, body image, and sexuality, confidence. • Symptoms: physical health, mental health, mood. • Was there a key point you when you can identify changes started? • Did the changes experienced feel like losing something? • Management: healthcare services used, alternative symptom management e.g. herbal, dietary changes. • If you sought help, what were your experiences of this? e.g. holistic approach, felt listened to. • Was there an opportunity to explore other issues?
Could you tell me what you knew about the menopause before, during and now?	<ul style="list-style-type: none"> • Where/how did you get information? e.g. leaflets, GP, internet, friends. • Did the discussions/sharing information feel like women's business? • Was it helpful? • What would you have liked to know? • How would you have liked to obtain this/any information? • What advice would you offer someone who is approaching the menopause?
Can you tell me about your life post menopause?	<ul style="list-style-type: none"> • Positive impacts; were there any gains, liberating experiences? • Negatives impacts (relationships, health, wellbeing, body image, sexuality and sexual relationships) • Is life as you expected?

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There was a risk during the interview in steering the participant to make the data fit the previous concepts. I was mindful throughout the interview of attending to the participant and demonstrating 'presence' aligning with one of the four principles of quality assessment, commitment and rigour (Yardley 2000) needed for a high-quality interview. Therefore, the interview was always guided by the participant and I only asked about a concept if themes were discussed by the participant, as illustrated below (Figure 3.2):

Figure 3.2 An example of the use of questions in phase two interviews

472I don't have that mother-daughter relationship [because she has sons] that I might've had with... a	Author Because it's women's business?
473	mother-son, we talk about other things that could.. not physical things erm and that came home to me	Author Talks with her sons about other things not menopause.
474	when my son, my oldest son got married because what was really lovely was that his now wife erm insisted	Author Having a younger female as part of the family has highlighted differences in the relationship, particularly what is shared, between Claire and her sons and Claire and her daughter in law.
475	that I go along with the wedding dress try outs and you know have my make-up done the same day with the	Author Women's business
476	bridesmaids [! : yeah] I just got, I really would never have expected that because you know it's that kind of	Author Women's business
477	female thing, female sharing erm that I just haven't done with my my children so you know, we've shared	Author Women's business
478	[with her sons] many, many other things but not that [menopause].	Author Women's business
479		Author Women's business
480	I: Do you think these sorts of things seem a bit like they're just women's business and..	Author Women's business
481		Author Women's business
482	P: Oh yeah, yeah, yeah and I think you know yeah and that's been, that's been, that subconscious idea	Author Male environment reinforces women's business
483	had been reinforced again subconsciously by the very male environment that I live in [! : mmm] all of the	Author Male environment reinforces women's business

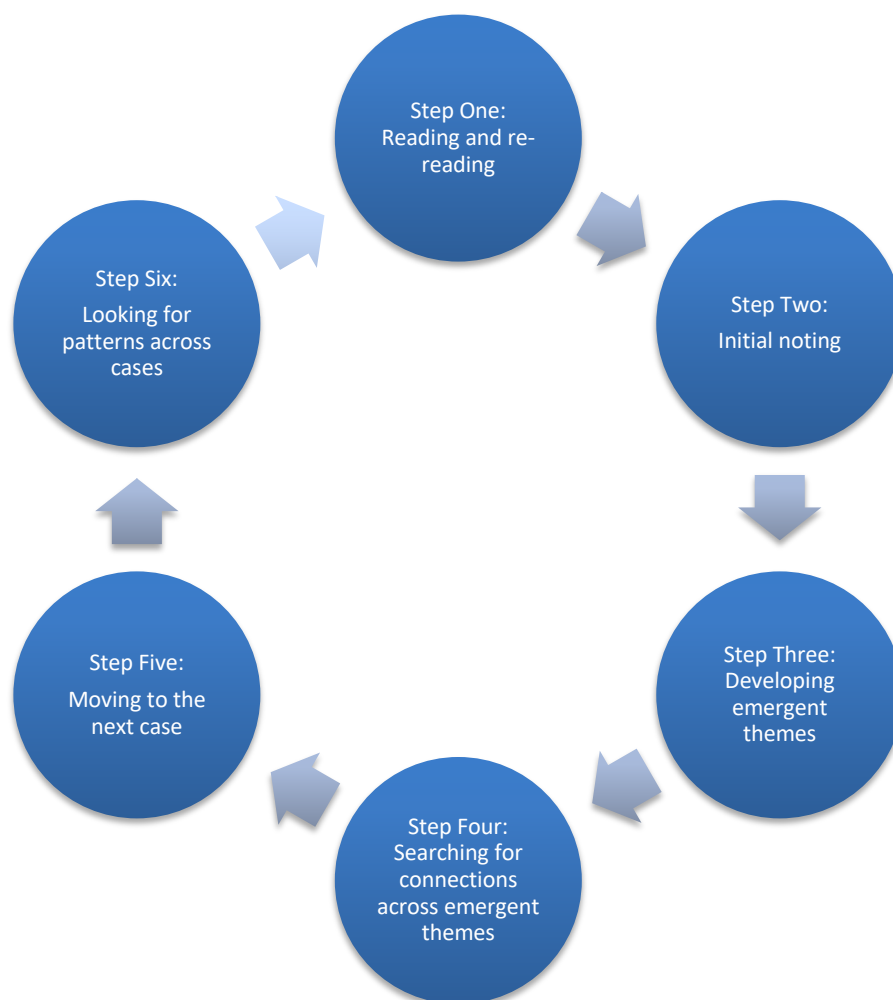
The participant had previously discussed areas that could be interpreted as women's business but at this point in the interview it is the discussion of different relationships and the introduction of her close relationship with another woman that prompted the researcher's question about the theme women's business as outlined in the interview prompts (Table 3.9).

3.5.8 Data Analysis

This section outlines the analytic process recommended in IPA following the six steps suggested by (Smith et al. 2009) and used in this study (Figure 3.3). Chapter Four illustrates the full analytic process.

Smith et al. (2009) acknowledge that there is no prescribed way of completing data analysis and that flexibility is required for analytic development. The priority is to ensure that the underpinning theoretical principles of IPA; phenomenology, hermeneutics and ideography are adhered to.

Figure 3.3 Suggested steps for data analysis in IPA



(Adapted from Smith et al. 2009 pp.82-100)

Once transcription was complete and checked for accuracy, Step One involved reading and re-reading the transcripts. Data analysis was completed for individual interviews (the part) before considering cross-case analysis (the whole). Initial noting (Step Two) involved reviewing each transcript on three to five occasions adding notes. Noting in the form of memos recorded in track changes contributed to the developing audit trail informing subsequent steps of analysis. Coding (words or phrases) were then developed into emergent themes (Step Three) for each participant.

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Step Four requires the researcher to search for connections across the emergent themes. Connections were made by grouping similar emergent themes resulting in super-ordinate themes under which emergent themes were grouped.

Analysis progresses on a participant by participant basis (Step Five), and then moves onto searching for patterns of convergence and divergence across participant data (Step Six). Higher order concepts are developed based on convergence identifying shared experiences of the menopause. Divergence demonstrated aspects of the menopause that was unique to the individual.

Data analysis in phase two: was completed as outlined above while considering the higher order concepts that had been developed following phase one data collection.

3.5.9 Reflexivity

During data analysis reflexivity was established by making notes in memos both on the transcript (as track changes), in my field diary and reflexive journal. Personal perspectives and views can influence the interpretation of the data (Smith et al. 2009; Bazeley 2013) and therefore as a means to 'audit' personal views and their potential impact on different elements of the research I commenced a field diary to capture thoughts, feelings and initial impressions immediately post interview.

A trigger for implementation of a reflexive journal was when my own bias became apparent following the pilot interviews when a participant, Jane was talking about menstruation stating; "it is part of being a woman". I had written in my field diary:

"I find this surprising that 'modern' women would hold this view although when I worked in gynae[cology] many women found having a hysterectomy a sad experience for this reason [the loss of menstruation]".

On reflecting on my comment and the emphasis I had placed on 'modern' women suggested that I had preconceptions about what women *should* think i.e. having similar views to myself that menstruation is a nuisance and not an integral part of being 'a woman'. By recognising this early in the process I acknowledged that my beliefs had the potential to influence other areas of the study. I used a reflexive journal throughout the analytic process to record personal responses including potential power imbalances, views, values and biases (Yardley 1997; Mays and Pope 2000; Walsh and Downe 2006; Creswell 2013).

The reflexive journal was a key tool in monitoring preconceptions and maintaining the ideographic focus. Furthermore, both the diary and journal form an audit trail contributing to a process of quality assessment (Creswell 2007; Bazeley 2013).

3.6 Summary of Chapter Three

Chapter Three has identified the paradigm of inquiry, epistemology, ontology and methodology guiding the completion of the research exploring the lived experience of nine menopausal women. The quality assessment framework has been discussed and the research process has been outlined including: ethical considerations, data collection and data analysis concluding with how reflexivity has been applied. Chapter Four will now present the detailed data analysis following the six-step framework recommended in IPA Smith et al. (2009).

Chapter 4 Data Analysis

4.1 Introduction

Chapter Four illustrates the process of data analysis undertaken in two stages. Phases one and two data are sequentially presented as a means of illustrating the development of one theme from inception to higher order concept utilising the structured process suggested by Smith et al. (2009).

4.2 Analysis in IPA

A key assumption of IPA is that people are self-interpreting beings (Taylor 1985) and therefore analysis is an iterative, holistic process moving between the individual experience (the idiographic focus) to the shared lived experience of the participants (phenomenological perspective) (Smith 2007). This process is articulated as the hermeneutic circle (Table 3.1) whereby the researcher explores the part before focusing on the whole of the phenomena being explored. A key consideration in phenomenology is the concept of the 'double hermeneutic,' the idea that the researcher is interpreting the interpretations of the participants (Crotty 1998). There is a risk that the researcher's views may become dominant in the analysis and therefore it is essential that a reflexive stance is established and maintained throughout data analysis.

Data analysis within IPA is an inductive, iterative process requiring time, reflection and dialogue to ensure depth of analysis increasing the potential to answer the research question and achieve the research objectives.

The research question guiding data analysis was: What are women's lived experiences of natural menopause? Research objectives were: To explore how women make sense of their experience of the menopause within the context of their lives and to understand the shared perspectives of menopausal women.

4.2.1 Preparation for Data Analysis in the Main Study

Completing data analysis in the pilot interviews had generated key learning points, including:

- The need to commit to undertaking and in-depth analysis (Smith et al. 2009). An excerpt in my reflexive journal indicated I had made this commitment: *'This initial data analysis is not something that can be rushed and this is hard for me as I do tend to do things quite*

last-minute and it is difficult to slow down to really, really concentrate on what I'm doing'
(Journal excerpt August 2016).

- The need to be aware of self in the interviews. The pilot interviews provided an opportunity to review my interviewing style before undertaking further interviews. I noted that I laughed and vocalised for a significant part of the interview. On reflection I decided this was due to my own embarrassment at some of the issues being discussed and that as the interview progressed I laughed less and listened more as I became engaged in the participants discussion.
- The pilot telephone interview identified the need to wait while the participant was thinking about their response and therefore the need to be comfortable with silence and also the learning outcome of checking all recording equipment prior to commencement of interviews as the recording of the pilot telephone interview resulted in poor audio quality which was time consuming to transcribe.

4.2.2 Terminology

In preparation for data analysis in the main study I prepared a glossary of terms and definitions to ensure consistency in their application and as part of the developing audit trail. Terms included:

- Code: A word or phrase that is assigned to a portion of the data to summarise salient points (Saldaña 2016).
- Emergent Theme: A phrase that captures what is crucial at a particular point in the text reflecting the participant's words and thoughts and the researcher's interpretation (Smith et al. 2009).
- Super-ordinate theme: Denotes a general class into which emergent themes are grouped (Smith et al. 2009).
- Higher order concept: Super-ordinate themes that cases share (Smith et al. 2009).

4.2.3 Transcribing

Each interview was transcribed verbatim and allocated a pseudonym. Although challenging for a novice typist, transcription provided the opportunity to become reconnected with the participant and their experience. Bazeley (2013 p.73) highlights that the researcher typing their own transcriptions is an ideal opportunity for "building intimate knowledge of your data". Smith et al. (2009) suggests that transcription takes approximately seven hours for every one-hour interview, however in this study transcribing took significantly longer, usually one week. Data analysis started at the point of transcription of the recorded interviews and was an opportunity to re-

engage with the detail of each individual interview and make notes in my journal of my initial thoughts and feelings.

4.2.4 Document Preparation

The transcription of the interview was generated in Microsoft Word with each line numbered to enable attribution of text to participant (Table 4.1). Exemplar quotes (excerpts from participant interviews) are identified by a participant pseudonym followed by the line numbers of the transcript for example Rose: line number 4 was recorded as Rose:4.

Table 4.1 Converting the transcript into a numbered document

Transcript: I: Interviewer P: Participant - Rose	
1	I: If it's OK just to start us off do you think you could just tell me what it's been like for you or
2	what is was like for you in the run up to the menopause?
3	
4	P: erm.... I don't recall too much about run up to the menopause... because I suppose it
5	came as a little bit of a surprise so I wasn't sort of erm cognizant that I was coming towards
6	the menopause [I: OK] coz it was quite early erm.. I think the first signs were when my
7	periods became very heavy and it wasn't till then I realised that the menopause was
8	happening I suppose..
9	
10	I: OK so can you remember roughly how old you were when that [P: I think] started to
11	happen?
12	
13	P: Yeah I think I was around 50 yeah

Brackets [] were used to provide additional detail, for example [laughs] and **[emphasis]**, or points of clarification, for example Rose:474 "it's not yours [men's] to share, it's ours [women's] to own erm and ours to talk about.." Minor pauses were noted with.... and for more significant pauses the length of time was noted, Kate:239 [Pause: 18.44-18.54] "I.....kinda feel like.....they don't". Lines left blank for example, Rose:3 (Table 4.1) provided definition between interviewer questions and participant's responses. Exemplar quotes from across the participant dataset are presented to illustrate the development of super-ordinate themes.

4.3 Data Analysis for Phase One Data Collection

4.3.1 Steps One and Two: Reading and Re-Reading/Initial Notation.

Steps One and Two of Smith's six-step framework merge in analysis as reading and noting run in parallel. Focusing on the transcript line by line produced a detailed set of notes which included my first and second thoughts about what I was reading and what had happened in the interview. I opted to add comments using the 'track change' feature in Microsoft Word (Figure 4.1).

Figure 4.1 An example of the first cycle of initial noting for Rose

<p>246 I: Have you subsequently talked about it? 247 248 P: Erm.... I'm not sure we <u>have..</u> <u>no, no I don't think we have.</u> 249 250 I: I just, I find it quite interesting if it impacts, you think about things that impact on 251 your relationship there might be many things that we would potentially talk about 252 with partners but but in this case its obviously impacted because for one you were 253 talking about the kind of dryness but [P: Yeah] but its not... 254 255 P: <u>Yeah no no I don't think we've ever talked about it..</u> <u>to be honest I'm not sure</u> 256 <u>it's something I would relish talking about,</u> I probably should do, I probably should do 257 but erm I don 't think I'd want to. I am a fairly private person and that extends to my 258 relationship with [my husband] as well and being an only child [I: right] as well I'd 259 rather keep stuff to myself and that's a personal style thing not necessarily healthy 260 but it's just the way I do stuff <u>so..</u> 261 262 I: But you said you are happy chatting with your girlie friends? 263 264 P: <u>Yes</u> yeah very much yeah, yeah it's interesting isn't it? I've got friends I've 265 known..... how olds [my friend]? Probably about 40 years and we'd all had our 266 children together and I think they're the people that I can be absolutely open and 267 honest with, probably the only people I can actually, erm so yeah <u>so we do talk</u> 268 <u>about the menopause and lots of other stuff as a trio.</u></p>	<p>Author Not discussed with husband despite him giving her sideways looks. Left him guessing? Not for men</p> <p>Author not a topic for discussion does not want to talk about it seen as a personal issue (private)</p> <p>Author Private menopause Maintaining control over female knowledge? Only for discussing with the girls?</p> <p>Author talks to female friends (not private)</p> <p>Author Only for discussion with other women.</p> <p>Author <i>Women's business</i></p>
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Initial notation included three types of comments (Figure 4.2): descriptive comments (Black underlined), linguistic comments (*Blue italic*) and conceptual comments (Pink underlined).

Descriptive comments were applied to each participant's transcript and these focused on key experiences as each participant described them. Developing conceptual comments was achieved by the reflexive process of 'interrogating the data' via analytic questions recorded in memos. The

aim of questioning was to achieve an understanding of the meaning of the participant's overall discussion leading to a more in-depth interpretative analysis.

Figure 4.2 Initial notation for Rose

<p>718 P: Laughs...yeah.. maybe not! I don't know, I don't know and again that's something 719 that you have to learn to put to one side coz it would eat you up if you let it. So, and 720 that's been my sort of task <u>suppose</u> over the last few years is to come to terms with 721 that and not let it get to me. 722 723 I: How do you do that though? 724 725 P: Erm.... I think you do it gradually, it's one of those things you have to work 726 through, <u>it's like loss and grieving I suppose, very similar to that process. You fight it</u> 727 <u>to start with erm and then you realise it's absolutely pointless to fight so erm you</u> 728 <u>talk to your girlfriends about it, you say you know we're all going through it there's</u> 729 <u>nothing you can do about it so then you start to come to terms with it, erm so yeah I</u> 730 <u>think it's about loss really, that's what it's about and I'm not sure if I've gained, yes I</u> 731 <u>don't feel a huge sense of loss I think there are some gains with getting older erm</u> 732 <u>but I'm still at the stage mostly now I consider it loss [I: mmm]. I think I will probably</u> 733 <u>move on from that.</u> 734 735 I: So you feel like there's another stage to get to do you? 736 737 P: Yes, I think so yeah, <u>I think once I'm passed 60 and I'm starting to climb towards</u> 738 <u>70 I will be more comfortable with feeling old that's erm [pause] I can never believe</u> 739 <u>I'm getting to 60, it's amazing in it, in my head I'm still in my 30s.</u></p>	<p>Author <i>The use of "I suppose" here suggests that she is not keen on the task of trying to come to terms with getting older.</i></p> <p>Author <u>Grieving for the death of youth rather than the emergence of a liberated, empowered woman? Do we grieve the loss of childhood when we are going through adolescence? Or is adolescence celebrated because women enter their fertile years? Is the grieving for the loss of fertility which is highly valued in western culture? Are older women considered asexual and/or more like men?</u></p> <p>Author A metaphor: Comparing the loss of youth to the grieving process. Is Rose also suggesting that is the death of her youth?</p> <p>Author Need to accept it.</p> <p>Author Support from the "sisterhood" rather than gaining support from her husband. <u>Does this suggest other women of a similar age are valued more: women's business?</u></p> <p>Author Gain: Gaining support from the "sisterhood"</p> <p>Author Acceptance</p> <p>Author Social comparison with friends of a similar age</p> <p>Author Rose describes predominantly a sense of loss. Although she acknowledges some gains there is a sense that she does not value the gains as much as she feels the losses.</p> <p>Author <u>If Rose feels she is in her 30s now and she is 58 in a couple of years will she really feel more comfortable with getting older? Or will she have retired and feel less challenged by the young people around her who are respectfully acknowledging she is older but she doesn't want this?</u></p>
--	--

Linguistic comments are used to identify language use including pronoun use, pauses, laughter, repetition and metaphors. Figure 4.3 demonstrates Rose's use of repetition of the word "ours" to indicate female ownership of the menopause. Within the context of the sentence, the part, and

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then the whole extract the participant indicated that she does not view menopause as being anything to do with men.

Figure 4.3 Example of linguistic comments

467		
468		
469		
470		
471		
472	P: Yeah, yeah, maybe there is a certain thing about a "sisterhood" in it isn't it? You know this	Author Women's business/ "Sisterhood"
473	[menopause] is ours, this [menopause] is something that happens to us, nothing to do with	Author The use of "ours" three times in this sentence emphasises the ownership of the menopause as something that "happens to us" (women) and that women (the sisterhood) have control over.
474	you, you don't experience it... similar to childbirth I suppose erm, it's not yours [men's] to	The use of the word "you" refers to men, nothing to do with you, you don't experience it, it's not yours. Rose keeps the experience outside of the realm of men and this is reflected in her description of not sharing with her husband but with other women and her close friends.
475	share, it's ours [women's] to own erm and ours to talk about.	Within this part of the conversation the researcher appears to have been brought into realm of the sisterhood as Rose does not refer to the researcher as you in the context of this sentence but seems to include me in the 'ours'.
476		Author Men cannot understand because they don't experience it.
477		Author Women's business Women maintain control over this knowledge because it's women's business?

Some participants used similes to describe their experiences while others used metaphors. The use of metaphors was further developed in the cross-case analysis where references to, for example, heat were used to describe both the emotions of anger and the physical manifestations of hot flushes such as waiting to "erupt", feeling like a "pressure cooker" and "boiling alive" (Lisa and Emma).

Temporal comments are described as being related to time and space (Smith et al. 2009), and this level of interpretation provided insight for individual conceptions of the progression of the menopause, although it was not evident with all participants. For example, participants referred

to their belief that the menopause was a time limited period after which you returned to your premenopausal self.

4.3.2 Step Three: Developing Emergent Themes

Step Three in the six-step analytic framework focuses on developing emergent themes via the process of coding. Coding is a process whereby the researcher transitions from the words of the participant to the researcher's interpretation of the data. Codes were developed using the two-stage coding process described by Saldaña (2016): 1) Encoding, where the researcher labels the data with a code. Codes are developed inductively, rooted in the participant's own language, for example in-vivo codes (where the researcher uses the participant's language to label the transcript) may be developed. Codes are defined to facilitate consistency in allocation during analysis, but will be refined in cross-case analysis as the researcher then, 2) Decodes the codes applied to each individual transcript generating a master codes list for the whole dataset seeking commonalities and differences.

Table 4.2 illustrates an example of in-vivo coding ("**blue bold text**") using Rose's language and the associated definition linked to Rose's commentary around her experience of the menopause. Figure 4.3 also illustrates Rose's use of "**sisterhood**". The way Rose talks about aspects of the menopause suggests that she considers the experience to be in the realm of women rather than the business of men. This led to the use of the initial code **women's business** and in-vivo code "**sisterhood**".

Table 4.2 Example of in-vivo coding

Individual case-Rose:	Text	Definition
In-vivo code " Sisterhood "	Rose:438 "I think there's, I think there's a sort of a " sisterhood " around it you know it's a shared experience"	Sisterhood: a shared experience

The sisterhood appears to come from the shared experience of menopause. Rose suggests in later commentary (Figure 4.4) that there is "a nod and a wink [I: mmm] you know we know what's

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going on and it's OK, we understand so..." (Rose:481). The shared understanding between women is an opportunity to gain support from the sisterhood and in turn support other women.

An initial code list was generated for Rose's transcript (Table 4.3) summarising the salient points in each part of the data. Smith et al. (2009) identifies this as an important step in the hermeneutic circle (moving between the parts and the whole) resulting in the transcript becoming a set of parts for further analysis which will be reorganised into a new whole in the final research write up.

Table 4.3 Initial code list for Rose

Initial code list for Rose	
"Stuff of legend"	Lack of awareness
Loss	Inconvenient
Gain	Emotional
Surprise	Volatile
Hidden menstruation	Liberation
Public menopause	Reluctantly accepting
Pragmatic approach	Secret society
Female knowledge	"Sisterhood"
Getting on with it	Shared experience
Women's business	Woman to woman

Having assigned codes to the individual parts of the data the next stage was to identify emergent themes. This was achieved by analysing the exploratory comments made during initial notation and the assigned codes resulting in the identification of phrases (emergent themes) that capture the essence of what was important in the commentary. The emergent themes developed from analysing Rose's transcript are illustrated in Table 4.4.

Table 4.4 Emergent themes for Rose

Emergent themes for Rose	
A shared experience	The " stuff of legend "
Connecting with each other (women)	Concern about getting older
Don't worry so much about upsetting people	No more menstruating
Freedom from contraception	Not for men
Freedom from unintended pregnancy	Ours (women's) to own
Keeping 'it' to ourselves	Women's business
Keeping an " air of mystic "	A sense of sadness
Loss of control over body	Like a secret society
Loss of health	"Sisterhood"
Loss of moisture	Woman to woman
Loss of youth	

Smith et al. (2009) suggests that this point in analysis (emergent theme development) begins to move further away from the participant and includes more of the researcher while requiring the researcher to remain immersed in the participant's lived experience. The resulting themes bring together understanding from the participant and the researcher for example the code 'women's business' was initially assigned to Rose's commentary relating to the menopause not being the business of men because it is "*ours [womens] to own erm and to talk about*" as it captured Rose's views. Women's business was identified as an emergent theme as it also represented her preference to speaking to other women who had also experienced menopause and her belief that this was the most reliable source of knowledge. Rose articulated a reluctance in talking openly with her long-term intimate partner thereby keeping any conversations about the menopause within the realm of her female friends. The theme 'women's business' brings together Roses' commentary and the researcher's interpretation by moving between the individual parts and the whole interview.

The next step is searching for connections across the emergent themes developing super-ordinate themes aligned to Rose's lived experience.

4.3.3 Step Four: Searching for Connections Across Emergent Themes

Searching for connections draws attention to important and interesting aspects of the participant's individual story, the part, which can later be considered within the wider context of the whole study. The process of pattern recognition (abstraction) requires the researcher to

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consider basic connections and decide whether super-ordinate status (denoting a general theme into which the emergent themes can be grouped) has been achieved. Identifying connections was an iterative process involving grouping and regrouping emergent themes (Table 4.4) that were similar. Once grouped, abstraction resulted in four potential super-ordinate themes **“Sisterhood”**, **women’s business**, **losses** and **gains** from Rose’s data (Table 4.5).

Table 4.5 Connections across emergent and **super-ordinate** themes for Rose

Super-ordinate Theme:	“Sisterhood”	Women’s business
Emergent Themes:	A shared experience Connecting with each other (women) “the stuff of legend” Keeping an "air of mystic" Like a secret society	Not for men Ours (women's) to own Woman to woman Keeping it to ourselves
Super-ordinate Theme:	Losses	Gains
Emergent Themes:	Loss of youth Concern about getting older Loss of moisture Diminished sex life Loss of health Loss of control over body A sense of sadness	"Sisterhood" Freedom from contraception Freedom from unintended pregnancy Liberation Don't worry so much about upsetting people No more menstruating

The emergent themes grouped into **“sisterhood”** and **women’s business** (Table 4.5), were noted as being solely in the realm of women. Therefore as **women’s business** appeared to summarise and bring together the related emergent themes it was given super-ordinate theme status (Table 4.6). This process is described by Smith et al. (2009) as subsumption, bringing together clearly related themes.

Table 4.6 Subsumption leading to the development of one super-ordinate theme: **Women's Business**

Super-ordinate theme:	Emergent themes:
Women's business	Not for men Ours (women's) to own Woman to woman Keeping it to ourselves "Sisterhood" A shared experience Connecting with each other (women) "the stuff of legend" Keeping an air of mystic Like a secret society

Figure 4.4 below illustrates an example of the ideographic focus for the super-ordinate theme **women's business** whereby the language used remains closely linked to and is representative of Rose's lived experience.

Figure 4.4 Example of the ideographic focus for the super-ordinate theme: **Women's Business**

450 P: Erm, maybe, yeah maybe and I suppose that's, that's my total ignorance of
 451 how men perceive it, I don't know erm whether working with men would be
 452 different... I do I train with men a lot erm but mostly it's younger women so er I
 453 just sometimes, I think men find it erm just a bit, erm... just a bit..... strange,
 454 you know they sort of roll their eyes a lot when they talk about menopause and
 455 erm it's one of those, it's one of those things that, one of those mysteries about
 456 being a woman that, I used to have a friend that said he used to be totally erm
 457 astounded at what women put in their handbags, there was this sort of mystery
 458 for him around women was what's in a handbag [I: laughs] you know and I think
 459 there's something similar around the menopause that men find it all sort of
 460 magical and mysterious and erm in the way that they talk about it and erm they
 461 don't, they're just, they're not worried it's happening but they don't particularly
 462 want to be involved in it [laughs] because it's a woman's thing you know...
 463
 464 I: I was gonna say do you think that's because they think it's a woman's thing or
 465 do you think that's because we don't talk about it?
 466
 467 P: Yeah probably both actually, yeah, maybe it's something we want to keep to
 468 ourselves, I don't know?
 469
 470 I: Have the air of mystery?
 471
 472 P: Yeah, yeah, maybe there is a certain thing about a sisterhood in it isn't it? You
 473 know this is ours, this is something that happens to us, nothing to do with you,
 474 you don't experience it... similar to childbirth I suppose erm, it's not yours [men's]
 475 to share, it's ours [women's] to own erm and ours to talk about.
 476
 477 I: That's an interesting perspective actually erm..
 478
 479 P: Yeah, yeah. Yeah there is a certain amount of ownership about it isn't it? In
 480 that when you are in a room with people fanning themselves you know there is a
 481 sort of you know a nod and a wink [I: mmm] you know we know what's going on
 482 and it's OK, we understand so...

Author
 Magical, mysterious: like a secret/legend?
 A secret society that men cannot belong to?

Author
 Does Rose's use of the words magical and mysterious link to her comment about a sisterhood and the fact that information shared by women is the stuff of legend (Lines 278-279)?

Author
 It's a woman's thing: Women's business

Author
 Women's business

Author
 Keeping an air of mystery by not sharing the experience with men or choosing not to say anything so that no derogatory comments can be made?

Author
 Women's business/ "Sisterhood"

Author
 The use of "ours" three times in this sentence emphasises the ownership of the menopause as something that "happens to us" (women) and that women (the sisterhood) have control over.
 The use of the word "you" refers to men, nothing to do with you, you don't experience it, it's not yours. Rose keeps the experience outside of the realm of men and this is reflected in her description of not sharing with her husband but with other women and her close friends.
 Within this part of the conversation the researcher appears to have been brought into realm of the sisterhood as Rose does not refer to the researcher as you in the context of this sentence but seems to include me in the 'ours'.

Author
 Men cannot understand because they don't experience it.

Author
 Women's business
 Women maintain control over this knowledge because it's women's business?

Author
 The use of ownership reflects Rose's views above "it's ours to own" (line 475)

Author
 Women's business

Author
 A shared experience among women

Author
 Support from the "Sisterhood"

The process of abstraction and subsumption resulted in three super-ordinate themes representing Rose's experience of the menopause; **women's business**, **losses** and **gains**. Once connections across emergent themes were identified and **super-ordinate** themes for one individual case had been achieved, analysis moved on to repeating Steps One to Four across the remaining four individual transcripts using the same sequence as described.

4.3.4 Step Five: Moving onto the Next Case

A key challenge in moving to cross-case analysis and the development of themes is the potential for the researcher to make the data 'fit' the emergent and super-ordinate themes instead of ensuring that the emergent and super-ordinate themes 'fit' the data. It was at this point in data analysis that I made the most use of my reflexive journal to note anything that started to detract from the idiographic focus, a technique recommended by Smith et al. (2009) in order to help "bracket [thoughts and observations] off for a while". Detracting from the ideographic focus occurred when I started to think about how previous participants' experiences might be linked when the focus was meant to be on one case, this was when I recorded thoughts in my journal as illustrated in an excerpt from April 2018:

"Kate also mentions 'ploughing on' which seems to link with Rose's 'getting on with it' and Sophie's 'cracking on', although on an individual level these do not appear to feature highly as themes in the individual case there is a suggestion that across cases there is a pragmatic approach regardless of how individuals feel about the menopause".

Commentary that invoked an emotional response was another example of a distraction from the participant's experience and when I made journal entries, for example:

"When Kate mentions becoming 'invisible' it makes me feel both sad for Kate, because I feel she is talking about herself and angry that women can be treated this way. Why wouldn't you want to speak your mind/not care so much about what you say if you feel it is the only way to be heard/noticed?" (Journal excerpt April 2018).

The benefit of keeping journal records enabled re-engagement with the participants' dialogue knowing that my thoughts, feelings and opinions could be revisited at a time. Effectively this was an attempt to set aside or bracket what were often thoughts that distracted from immersion in the participants' experience. Larkin et al. (2006) argue that although it may be desirable for the researcher to bracket their views, in reality researchers cannot escape their preconceptions but need to recognise their potential impact on the interpretation of the data. Using a reflexive

journal was useful both to refocus but also to revisit the journal as what sometimes seemed like a random thought later provided additional depth to the analysis.

Smith et al. (2009) acknowledges that researchers will be influenced by the preceding cases but the skill in IPA is to ensure the emergence of new themes for each individual case. He argues that rigorously following Steps One to Four facilitates the ideographic commitment to IPA and individual theme development. Once this is achieved for all cases the next step is to look for patterns across the cases.

4.3.5 Step Six: Looking for Patterns Across Cases

Step Six aims to develop higher order concepts described by Smith et al. (2009) as super-ordinate themes that cases share. The strong emphasis on the importance of other women led to the development of the super-ordinate theme **Women's business** in Rose's individual case and this was further developed into the higher order concept, ***Women's business: The "stuff of legend" that can only be experienced by women*** in the cross-case analysis. The process of development of this super-ordinate theme into a higher order concept is illustrated in the following section.

The coding of individual interviews led to the identification of a list of codes across the cases (See Appendix P for an initial code book example) which were grouped into emergent themes. At this point a workshop with my supervisors was undertaken to challenge my thinking around initial super-ordinate theme development. Emergent themes were written out on individual strips of paper. Each member in the workshop (YM, TLS, MM) individually grouped the emergent themes. Groupings were discussed, regrouped, named and renamed until agreement was reached. Table 4.7 illustrates the agreed emergent themes for **women's business** (See Appendix Q for the groupings of the emergent themes).

Table 4.7 Emergent themes across cases for one super-ordinate theme: **Women's Business**

Emergent themes for: Women's Business	
▪ Not for men	▪ Knowledge from mother to daughter
▪ Ours (women's) to own	▪ Knowledge through experience
▪ Woman to woman	▪ A girl's club
▪ A shared experience	▪ Knowledge from Mum
▪ Connecting with each other (women)	▪ Sharing knowledge with other women
▪ Women's humour	▪ Knowledge from other women
▪ Shared knowledge	▪ Male avoidance
▪ Women's knowledge	

Once agreement regarding the groupings of emergent themes was reached we (YM, TLS, MM) discussed patterns across the group and developed super-ordinate themes which represented the cluster of emergent themes (Table 4.8).

Table 4.8 Potential super-ordinate themes from across cases for development in further analysis

Workshop Themes (version 1)	
▪ Beliefs	▪ Maturity/self-actualisation
▪ Coping strategies	▪ "Sisterhood"
▪ Gains	▪ Thinking about your body differently
▪ Knowledge	▪ Unanticipated things
▪ Losses	▪ Women's business

Further development of the agreed super-ordinate themes (Table 4.8) continued through analysis of all cases which led to the reconfiguring and relabelling of themes (Appendix R). During the analysis both convergence and divergence were sought. Bazeley (2013) suggests that divergent views, negative cases or outliers can be a source of ideas to enrich data analysis. For example, one participant (Sophie) articulated her overall positive attitude toward the menopause at the time of the interview and was therefore viewed as a negative case as her transcript indicated that she did

Chapter 4

not feel as constrained by biological or social expectations nor did she appear to experience the same level of loss as other participants. Gaining divergent views such as Sophie's reminds us that that not all experiences are shared.

The analytic process of moving back and forth across the cases between the parts and the whole was an iterative process starting with five higher order concepts (Appendix R) representing convergences across the group. After eight iterations three higher order concepts were developed from 8 super-ordinate and 52 emergent themes (Table 4.9).

Table 4.9 *Higher order concepts, super-ordinate themes and emergent themes for the group*

<i>Higher Order Concepts</i>	<i>Super-Ordinate Themes</i>	<i>Emergent Themes</i>
<i>Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate:36)</i>	Physical Losses	Loss of health Loss of moisture Loss of sleep Loss of physical strength Loss of muscle tone Loss of memory Loss of energy Loss of skin condition Loss of bladder responsiveness Change in vaginal secretions
	Emotional Losses	Loss of control Sadness Reduced self confidence Loss of temper Loss of humour Increased emotion and crying Embarrassment
	Loss of Social Identity	Loss of body shape Loss of sexual relationship/libido Loss of visibility Loss of femininity Loss of fertility Loss of youth/looking older

<i>Higher Order Concepts</i>	Super-Ordinate Themes	<i>Emergent Themes</i>
<p><i>Liberation: Freedom from “cultural baggage...to feel that you’re becoming yourself finally” (Kate:486)</i></p>	<p>Liberation from Biological Restrictions</p>	<p>Freedom from contraception No more menstruation Freedom from unintended pregnancy Freedom from the expectation to reproduce Increased confidence</p>
	<p>Liberation from Social Expectations</p>	<p>No longer a worrier Focus on self Less worried about upsetting people The real me: “Becoming yourself” (Kate:519) Increased self-awareness Liberation from expected behaviour Getting away with things “Right to say how I feel” (Emma:666) Argumentative streak</p>

<i>Higher Order Concepts</i>	Super-Ordinate Themes	<i>Emergent Themes</i>
<i>Women's Business: The "stuff of legend" that only can be experienced and shared by women</i> (Rose:278)	"Sisterhood" A Shared Female Experience (Rose:438)	Connecting with each other A shared experience "A girl's club" (Emma:1087) "Ours to own" (Rose:475) Not for men Humour when talking with the girls
	Making Comparisons with Other Women	Work colleagues Like mother like daughter Older friends Sister Experience is believing
	Women's Knowledge	Similar age women Professional advice Intergenerational knowledge Own professional knowledge

4.3.1 Social Comparisons

Developing an understanding of participants' use of social comparisons can help interpretation move from descriptive to more conceptual levels. Individual participants appeared to use social comparisons to help them make sense of their experience. Comparisons were made with other women, predominantly mothers, sisters and friends, but also female work colleagues. Rahimi et al. (2017) describe three types of social comparisons, downward, horizontal and upward.

Downward comparisons are most often used to make people feel better about their situation, illustrated by Rose who shared her view that her experiences were less troublesome than other women:

"Erm the actual menopause was fairly straight forward I think comparatively coz talking to friends they had real trouble with things like night sweats [I: Right] which I had but I didn't seem to have the trouble from them that other people did" (Rose:29).

Horizontal comparisons, highlighting similarities within the peer group, were used when describing shared experiences:

"I think [menopause] similar in a lot of ways actually although people [other women] have erm different sorts of erm rates and depths of the experience, the experiences are very, very similar you know the sort of the dryness and the change in the way you look erm....." (Rose:188)

In analysing social comparisons with other women, the code "sisterhood" was developed in cross-case analysis to represent a shared female experience. For example, Rose indicates a number of times that there are things that she is not happy to discuss with men, including her husband but she is more than happy to share with other women, particularly her friends of 40 years. Rose does not speak to her husband about the menopause as it her view, *"it's not yours [men's] to share, it's ours [women's] to own erm and ours to talk about"* (Rose:474) stimulating the idea that the menopause is not the business of men unless women make the decision that it should be. The reference Rose makes that it is "ours" to own and "ours" to talk about relays a strong message that this is within the realm of women and not for men. Analysing social comparisons across cases highlighted the importance of women's business as a higher order concept.

4.4 Data Analysis for Phase Two: Extended Data Collection

The extended data analysis for phase two of the study was completed using the same process used for phase one. The aim of data analysis in phase two was to review concepts identified in phase one analysis, to further explore these concepts and further commonalities across the expanded sample.

4.4.1 Individual Case Analysis (Steps One to Five)

Steps One to Four were applied in the same way as phase one. In a similar way as moving onto the next case, there was a risk of being influenced by the phase one sample and making the data 'fit' the previously identified super-ordinate themes. It was also important to maintain an ideographic focus on the individual parts (each participant's interview in phase two) before exploring commonalities across the whole sample (phases one and two). Figure 4.5 illustrates examples of initial notation, codes, descriptive and conceptual comments and a social comparison for Steps One to Three of the six-step process for Claire.

Figure 4.5 Example of initial notation and comments for phase two data collection

<p>76 I think the thing about about all the changes which in my case were not not you know as</p>	<p>Author Social comparison: downplaying the impact</p>
<p>77 as as painful or as as important as as many of my friends had been telling me that and in in that case</p>	<p>Author Fading away: becoming invisible which is reinforced by the behaviours of others</p>
<p>78 err err the erm it all coincided with this feeling of fading away and just you know you just suddenly</p>	<p>Fading away is linked to a change in looks as well as a change in the behaviour of others.</p>
<p>79 realise that people are not paying any attention to you in meetings and things like that because [I:</p>	<p>Author Does Claire mean loss of vitality or that she is no longer a person who is vital (important to others) to others? Does she no longer meet the social expectations of youth?</p>
<p>80 arrh that's interesting] you know that kind of stuff because you are just, feel that people as sort of</p>	<p>Author Loss of vitality Loss of energy</p>
<p>81 you know you are not to the sort of vital person with boundless energy that you were [I: yeah] and at</p>	<p>Author Knowledge and experience are perceived to be of less value than vitality and energy</p>
<p>82 even though you, that should be counterbalanced by the fact that you've got so much experience</p>	<p>Loss of social status/social identity</p>
<p>83 and your able to speak about things with much more knowledge and you know so much more than</p>	<p>Author Loss of visibility Becoming invisible.</p>
<p>84 you do, it's that lack of energy and vitality that erm that I found really difficult to cope with you know</p>	<p>Author Claire links her fading eyes to stories of elderly women.</p>
<p>85 that fact that by the time I'm mid 50s erm I used to joke about that fact that I no longer had any idea</p>	<p>Is this the first time she had thought about becoming older and the impact of ageing? Is fading linked to for example the fading of a label with age until it disappears, items can fade with age and use. Is Claire using the term fading away to metaphorically describe societal attitudes to ageing?</p>
<p>86 about what colour my hair was because I'd been dying it for so long [I: laughs], you know it was that</p>	<p>Author Loss of control</p>
<p>87 kind of and I just felt I was fading I just felt you know you read in erm stories about elderly women</p>	<p>Author Is Claire suggesting that she doesn't feel ready to think about/accept the changes that are happening. Is it the pressure to conform to societal expectations that focuses positively on youth and relates ageing with negatively such as decline and decay?</p>
<p>88 with faded faded blue eyes and I just felt that was me and I know I've talked about blue eyes twice,</p>	
<p>89 that's really ridiculous because I don't normally think about it very often but thinking about family and</p>	
<p>90 so on, none of my kids have got blue eyes [I: yeah], my husband's got brown eyes so I've always be</p>	
<p>91 "oh this is kind of special' you know [I: yeah] and always... my own family had blue eyes and and I just</p>	
<p>92 felt gosh everything is changing and there's nothing I can do about it and I just don't feel mentally or</p>	
<p>93 physically up to coping with it all erm..</p>	

At this early stage codes appeared to have similarities to the phase one data collection with loss and invisibility demonstrated in Figure 4.5. Within this participant's commentary she discussed a "feeling of fading away" (Claire:78), at this point during notation I made a journal entry corresponding to this point:

"This reminds me of other participants who have felt invisible as they get older. Claire seems to be describing becoming invisible with the perceived fading of her own eye colour and in the eyes of others/society" (Journal excerpt December 2019)

The use of the reflexive journal ensured there was a record of the thoughts stimulated during data analysis that could detract from the participant's lived experience thereby facilitating the ideographic focus and enabling analysis to systematically progress.

Table 4.10 presents the initial codes and in-vivo "**blue bold text**" codes generated for an individual case in phase two of the study. There were similarities to the phase one data collection in relation to losses, gains and the preference to sharing the experience with other women.

Table 4.10 Initial code list for Claire

Initial code list for Claire	
<p>"Fading away"</p> <p>"Fogginess"</p> <p>Gain</p> <p>Hypervigilance</p> <p>Intergenerational knowledge</p> <p>Lack of control over body</p> <p>Like mother like daughter</p> <p>Loss</p>	<p>"Mental Freedom"</p> <p>Shared female experience</p> <p>Getting older</p> <p>Soldiering on</p> <p>Uncertainty</p> <p>Women's business</p> <p>Women's knowledge</p>

Emergent themes were developed to be representative of the individual parts of the commentary for each case. Table 4.11 illustrates the emergent themes for Claire.

Table 4.11 Emergent themes for Claire

Emergent themes for Claire		
<p>"Fading away"</p> <p>"Fogginess" not thinking clearly</p> <p>Focus on self</p> <p>Increased certainty</p> <p>Increased confidence</p> <p>Increased energy</p> <p>Increased weight loss</p> <p>Intergenerational knowledge</p>	<p>Like mother like daughter</p> <p>"Mental freedom"</p> <p>No more menstruating</p> <p>Shared female experience</p> <p>Loss of body shape</p> <p>Loss of confidence</p> <p>Loss of control over body</p> <p>Loss of identity</p>	<p>Loss of libido</p> <p>Loss of moisture</p> <p>Loss of visibility</p> <p>Loss of vitality</p> <p>Loss of youth</p> <p>Uncertainty about changes</p> <p>Women's business</p> <p>Women's knowledge</p>

The connections were considered across the emergent themes (Step Four) and abstraction resulted in three super-ordinate themes, losses, gains and women's business from Claire's data (Table 4.12).

Table 4.12 Connections across emergent and **super-ordinate** themes for Claire

Super-ordinate Theme:	Losses	Gains	Women's business
Emergent Themes:	Loss of body shape Loss of confidence Loss of identity Loss of vitality Loss of youth "Fogginess": not thinking clearly Loss of libido Loss of moisture "Fading away" Uncertainty about changes Lack of control over body	Increased certainty Increased weight loss "Mental freedom" Increased energy Increased confidence Focus on self No more menstruating	Intergenerational knowledge Like mother like daughter Shared female experience Women's business Women's knowledge

Each case was individually analysed before moving onto the next case (Step Five). Step Six involved looking for patterns across the cases for the whole dataset for phases one and two.

4.4.2 Step Six: Looking for Patterns Across Cases

Phase one data analysis identified three higher order concepts, losses, liberation and women's business. The aim within Step Six was to review and further explore the concepts identified in phase one analysis, looking for convergence and divergence across the expanded sample.

The emergent themes for the super-ordinate theme women's business are illustrated below (Table 4.13). The level of convergence across the extended dataset demonstrated data saturation

giving confidence that the original higher order concept women's business was representative of the lived experience of the study participants.

Table 4.13 Emergent themes across cases for one super-ordinate theme: **Women's Business**

Emergent themes for: Women's Business	
Phase 1	Phase 2
▪ Not for men	▪ Intergenerational knowledge
▪ Ours (women's) to own	▪ Knowledge from Mum
▪ Woman to woman	▪ A shared female experience
▪ A shared experience	▪ Knowledge from other women
▪ Connecting with each other (women)	▪ Sharing with female friends
▪ Women's humour	▪ Sharing with sisters
▪ Shared knowledge	▪ Connecting with other women
▪ Women's knowledge	▪ Women's knowledge
▪ Knowledge from mother to daughter	▪ Normalising the experience by talking to other women
▪ Knowledge through experience	▪ A female thing
▪ A girl's club	▪ Men don't understand
▪ Knowledge from Mum	▪ Men aren't interested
▪ Sharing knowledge with other women	▪ Support from similar aged women
▪ Knowledge from other women	
▪ Male avoidance	

This process was applied across the dataset demonstrating there was convergence strengthening the original higher order concepts and emergent themes. One super-ordinate theme was renamed and there were some emergent themes changes resulting from the phase two data analysis (Table 4.14 red text) in which participants commentary provided a more nuanced emphasis on points previously made. 'Change in vaginal secretions' for example, was reworded to 'vaginal changes' reflecting the more detailed commentary around changing sensation and its impact on sexual pleasure. Two further emergent themes, loss of memory and old friends were reworded to "fogginess" and female friends. One emergent theme was added ("**mental freedom**") as it captured the sense of freedom to focus on oneself rather than others. The

emergent theme "fading away" was added to the super-ordinate theme loss of social identity. This theme represented participants commentary in the extended data collection reporting how participants perceived they were viewed by others, and the impact on their perceptions of themselves. In analysing the emergent themes for loss of social identity abstraction resulted in the super-ordinate theme being renamed as loss of traditional notions of feminine identity capturing the lived experience being voiced across the group.

Table 4.14 *Higher order concepts, super-ordinate themes* and emergent themes for the expanded sample

<i>Higher Order Concepts</i>	<i>Super-Ordinate Themes</i>	<i>Emergent Themes</i>
<i>Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate:36)</i>	Physical Losses	Loss of health Loss of moisture Loss of sleep Loss of physical strength Loss of muscle tone "Fogginess" (Claire:55) Loss of energy Loss of skin condition Loss of bladder responsiveness Vaginal Changes
	Emotional Losses	Loss of control Sadness Reduced self confidence Loss of temper Loss of humour Increased emotion and crying Embarrassment
	Loss of Traditional Notions of Feminine Identity	Loss of body shape Loss of sexual relationship/libido Loss of visibility "Fading away" (Claire: 48) Loss of femininity Loss of fertility Loss of youth/looking older

<i>Higher Order Concepts</i>	Super-Ordinate Themes	<i>Emergent Themes</i>
<p><i>Liberation: Freedom from “cultural baggage...to feel that you’re becoming yourself finally”</i> (Kate:486)</p>	<p>Liberation from Biological Restrictions</p>	<p>Freedom from contraception No more menstruation Freedom from unintended pregnancy Freedom from the expectation to reproduce Increased confidence</p>
	<p>Liberation from Social Expectations</p>	<p>No longer a worrier Focus on self Less worried about upsetting people The real me: “Becoming yourself” (Kate:519) Increased self-awareness Liberation from expected behaviour Getting away with things “Right to say how I feel” (Emma:666) "Mental freedom" (Claire:589) Argumentative streak</p>

<i>Higher Order Concepts</i>	Super-Ordinate Themes	<i>Emergent Themes</i>
<i>Women's Business: The "stuff of legend" that only can be experienced and shared by women</i> (Rose:278)	"Sisterhood" A Shared Female Experience (Rose:438)	Connecting with each other A shared experience "A girl's club" (Emma:1087) "Ours to own" (Rose:475) Not for men Humour when talking with the girls
	Making Comparisons with Other Women	Female work colleagues Like mother like daughter Female friends Sisters Experience is believing
	Women's Knowledge	Similar age women Professional advice Intergenerational knowledge Own professional knowledge

The language of menopause

The literature review identified that language was used interchangeably when referring to changes that occur as women move to the cessation of menses. It was after a discussion with examiners in the viva in June 2019 about the term 'transition' that I started reflecting on the findings from the literature review about the use of language (section 2.9). This was pertinent as the research question, objectives and original study title used the term 'transition to menopause' and during phase two data collection it became apparent that the majority of participants did not use the term 'transition to menopause' when discussing their experiences.

This resulted in revisiting the full dataset to explore the use of language by individual participants to describe the period leading to and after their FMP. The language used and the number of occasions they used a term is illustrated in Table 4.15.

Table 4.15 Language used to describe the period up to and after the FMP

Recruitment	Pseudonym	Language used								
		The menopause	It	Menopause	Perimenopause	Journey	Menopausal	Transition	My menopause	Pre menopause
Phase one	Rose	15		2						
Phase one	Kate	8	13	3						
Phase one	Sophie	8		2			2		1	
Phase one	Emma	4		9		8	3		2	
Phase one	Lisa	10		1					1	
Phase Two	Claire	14		3	2			1		1
Phase Two	Jess				24			3		
Phase Two	Beth	6		8	1			1		
Phase Two	Rachel	3	29	1	2		1			
Total use:		68	42	29	29	8	6	5	4	1

The terms used by the majority of participants (n= 8) was 'the menopause' and 'menopause' with 'the menopause' being used most frequently (68 occasions). Two participants used the term 'it', appearing to have a preference to this term when referring to their personal experiences. Across the group terms were used interchangeable to refer to experiences before and after their FMP. One participant referred to premenopause experiences within the context of changes that happened before her final menstrual period.

The term 'transition' was used by three participants in phase two of the study which made me reflect on why this term was being infrequently used in describing changes. When revisiting the individual commentaries in study phase one I had not used the term 'transition' when asking questions but in phase two I had been more specific in asking "Can you tell me what it was like approaching the transition to menopause?" I noted that two participants used the term transition, but only once following my use of this term in the interview question suggesting that the term had been imposed deductively with participant's communication reflecting the question rather than the language they regularly used (Table 4.15). They subsequently reverted to predominantly using 'the menopause' and 'menopause' to describe their experiences. One participant used the term on three occasions but she subsequently stated "*I never for one moment have ever read or thought about the menopause as a transitional process*" (Jess:1036). Her preferred term was the perimenopause and throughout the interview she used the terms in a prescribed way stating that the menopause referred the FMP.

Reflecting on Jess's statement, revisiting phase one of the study and the literature review considering the use of language prompted clarity. The term 'transition' is a theoretical idea that appears to have been imposed deductively on the data and so far it has not been inductively developed in the research that has been carried out. Therefore, looking at the data in this study the language used by participants reflected the interchangeability noted in the literature review. Describing the years before menopause as a transition was something I had to some extent imposed deductively whereas when looking at the data inductively the study participants used a variety of terms interchangeably to describe their lived experience of the menopause. This has resulted in a change of the thesis title to reflect the ideographic commitment of IPA to echo the voices of women within this study.

Undertaking the extended data analysis contributed to the rigour and quality of the phase one analysis through the review of the concepts. The phase two interviews provided a more detailed exploration of the concepts and the analysis demonstrated commonality across the group strengthening the original findings.

The process of moving between the parts (individual interviews) and the whole (phase one and two data collection) during data analysis indicated that the adjustments to the language used in the original super-ordinate themes, emergent themes and the addition of a further two emergent themes (n= 54) provided additional representation of the participants menopause experiences. The three higher order concepts identified in phase one were sufficient (Dey 1999) in explaining the lived experience of the study participants across both phases of study.

4.5 Summary of Chapter Four

This chapter has detailed data analysis using the six steps suggested by Smith et al. (2009) for IPA data analysis. The theme **women's business** has been used to illustrate the analytic process initially from an individual case to the final development of three higher order concepts. The findings drawn from this in-depth analysis are presented and discussed in Chapter Five.

Chapter 5 Findings and Discussion

5.1 Introduction

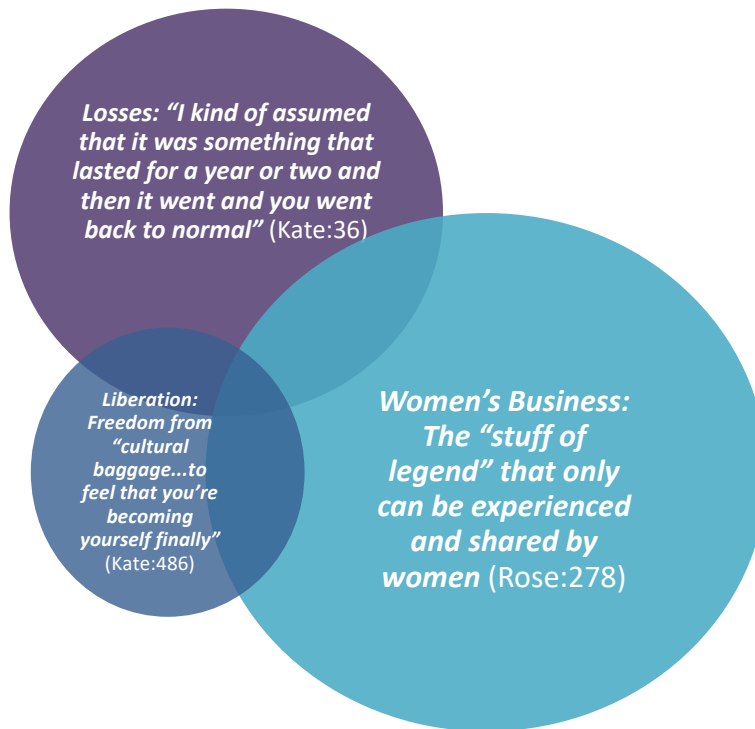
The previous chapter gave a detailed account of the analytical process following the six-step process suggested by Smith et al. (2009). Three higher order concepts (Figure 5.1) capture the biopsychosocial experience of the women who participated in this study. The higher order concepts represent the outcome of following the hermeneutic circle whereby the researcher seeks to make sense of the sense making of participants reflecting on their experience of the menopause.

Chapter Five aims to achieve the research objectives i) to explore how women make sense of their transition to menopause and the meaning they attribute to their experiences within the context of their lives and ii) to understand the shared perspectives of women as they transition to menopause and ultimately answer the research question: *What are women's lived experiences of the transition to natural menopause?*

The higher order concepts presented reveal the complex interplay between the experiences of **losses, liberation** and **women's business** that contribute to the lived experience of the menopause. Participants commentary illustrated that some higher order concepts were more dominant than others in representing their lived experience (Figure 5.1: the larger the circle the more dominant) which was informed by the extended data collection and analysis. The higher order concepts and the associated super-ordinate themes (Table 4.14) will be presented supported by participant quotes using pseudonyms, along with my interpretations. This is followed by a discussion situating the findings within the wider literature, starting with the higher order concept: **Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate:36)**. All participants began their narrative with **Losses** and in representing their lived experiences this is the first higher order concept reported in this chapter. The second higher order concept presented is: **Liberation: Freedom from "cultural baggage...to feel that you're becoming yourself finally" (Kate:486)** as, despite the being less dominant and having a quieter voice, participants felt the menopause offered some gains resulting in a sense of freedom and opportunity. The final higher order concept and most dominant: **Women's business: The "stuff of legend" that only can be experienced and shared by women" (Rose:278)** presents how participants normalise their journey using the support and

advice of other women to develop their own knowledge. The integration of the higher order concepts resulted in and an overarching theme 'acceptance of the changing me' drawing together the three higher order concepts in articulating the lived experience of the menopause.

Figure 5.1 Dominance of higher order concepts



Larger circles = more dominant

5.2 Higher Order Concept: *Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal"* (Kate:36)

The higher order concept **Losses** encapsulated three super-ordinate themes **Physical Losses**, **Emotional Losses** and **Loss of Traditional Notions of Feminine Identity** which will each be presented below. A key finding from research reported in this thesis was the spectrum of losses expressed by participants. Losses and changes are used interchangeably with all the super-ordinate themes being interconnected and reported to negatively impact on participants, physically, emotionally and socially. Across cases the participants articulated that they had expected some changes, mainly physical, but the non-linear process and the permanency of the changes was unexpected and resulted in the feeling of loss. The emotional impact, leading to

reduced self-confidence and the **loss of traditional notions of feminine identity** were postulated as being related to cultural views of ageing. They were considered unwelcome and unpleasant indicators of their journey through menopause and the ageing process that was taking place.

Super-Ordinate Theme: Physical Losses

Participants initially focused on **physical losses** as based on expectations that the menopause lasted for a defined period of time during which 'symptoms' were most likely to be experienced over a one to three-year timeline. All participants indicated a lack of recognition of changing bodily experiences being connected to the menopause. They did not have an awareness of such indicators until an obvious change happened that made them realise physical bodily changes were occurring:

"I suppose it came as a little bit of a surprise so I wasn't sort of erm cognizant that I was coming towards the menopause [I: OK] coz it was quite early erm.. I think the first signs were when my periods became very heavy and it wasn't till then I realised that the menopause was happening I suppose.." (Rose:4).

"I always had trouble with my periods, I had breakthrough bleeding which would cause anaemia and things like [I: mmm] that erm but then that all sort of slowed down and then I'd miss a month to the point where I thought, 'Oh My God' I might be pregnant" (Emma:11).

Menstrual changes were commonly noted as the first change but did not necessarily bring an awareness at the time as being related to the menopause. There was an expectation that menopause occurred in women in their 50s which led participants to consider other reasons for changes. Emma, for example experienced an early menopause and considered she might be pregnant. Although Rose was 50 years old when she experienced menopause, and much closer to the average UK age (51 years), she still articulated uncertainty in using "I suppose" to describe what had happened to her. The uncertainty about changes being an indicator that the journey through menopause had started was consistently articulated and appears representative of the relative silence in discussing this midlife experience as illustrated by Rachel responding to a comment about her being postmenopausal for four to five years:

"Well I'm, I'm kind of assuming that I am [postmenopause], as I say it sort of isn't it, it's hard to say isn't it? I don't know coz I haven't seen anybody [a doctor] [I: yeah] just I think it's not very well.. talked about [laughs]..." (Rachel:38).

Once there was an awareness of changes, uncertainty remained about how long the changes would last. In considering the changes to their bodies participants initially believed they were a temporary inconvenience. Whilst participants articulated their physical changes these were aligned with feelings about returning to 'normal', meaning their premenopausal selves. In considering that they would go "back to normal" and later realising that this was "one big mistake" participants appeared to have given themselves time to begin adjusting to the prospect of permanent changes as their new 'normal'. Along with expectations of returning to normal participants articulated an expectation that the menopause would be for defined period until they started experiencing menopause themselves as illustrated by one participants commentary:

"I thought 'Oh OK it could be a bit of a bumpy ride for a couple of years' then that's it, I kinda assumed that once it was over it was over and that was it, everything was normal again so I kind of viewed it as a little thing that you had to go over erm and now I realise that [it has been much longer].... [Laughs]" (Kate:48).

Being able to attribute bodily changes to the menopause appeared to help participants initially in naming a reason for changes but this was followed by a sense of loss once they realised that their expectations of returning to normal would not be met.

The complex individualised nature of the menopause meant that there was a continuum of experiences across cases. **Physical losses** ranged from a general feeling of change in health to more specific changes in skin condition most often articulated as dry skin or wrinkles. Participants expressed surprise that the dryness and loss of moisture not only affected the skin but impacted on other areas such as the vagina and the eyes. Other losses identified were loss of sleep, energy, memory and physical strength. It was recognised that these could be related to ageing but as such the menopause was also considered pivotal in forcing participants to give consideration to the ageing process.

There was a sense of inevitability once participants recognised, or had the menopause confirmed by a healthcare professional, that they were heading towards the cessation of menses. Language such as "get on with it", "plough on", "crack on", "grin and bear it" and "set it aside" were terms used by participants when talking about how they managed bodily changes such as hot flushes, sweats and heavy bleeding. The terms were used in the context of telling themselves to "get on with it" and as a way of encouraging others to "plough on" as they had done.

Participants used language to diminish the impact of their 'symptoms' and help them cognitively manage their perceptions of a lack of control of their changing bodies giving the appearance to

other people, particularly in the work/study environment, of being unaffected even though there was an impact on their self-confidence:

Participant: *“I think it was very noticeable to other people so I'd be working kind of with one person in a room very closely [I: yeah] and I'd kinda feel like they [the other person] were noticing it [the sweating] and it was a bit distracting and it was a bit, I dunno, I felt a bit like, needed to go home and sniff your armpits [I: yeah, I can imagine] You know, three showers a day [laughs] and that kinda thing and do I, you know, do I smell and am I not noticing? Things like that so you get a bit paranoid about that I think and just, just the discomfort, your clothes are wet sort of [I: yeah]...*

Interviewer: Did that mean that you did anything differently at work?

Participant: *I don't think it did. I think I just kinda ploughed on really”* (Kate:154).

As well as “getting on with it” from the perspectives of managing change and trying to ignore the impact there were also attempts to regain control over unexpected changes. Sophie believed that the anterior vaginal prolapse was a result of her changing hormones and she talked about how she tried to regain control through the use of non-hormonal methods:

“So no children, no constipation issues which is the other thing that might cause an anterior prolapse [I: yeah] so it, it's, I think it's the hormonal change in my vagina, they [GP] tried hormonal replacement in the vagina, gosh that wasn't [10.01-10.05 inaudible] so then I've done pelvic muscle work, I've done shed loads of Kegel exercises and lost more weight thinking about that and I can't, I researched it [vaginal prolapse treatment] extensively myself [I: yeah] and I am now about to go for an operation so everything I have done they've worked but haven't quite done the job” (Sophie:131).

The perceived loss of physical control is an interesting concept that I believe reflects a more medicalised view of the female body and the differing contexts experienced by this generation of women compared to their mothers. Study participants are of a generation that have always had access to the oral contraceptive pill and the various female hormone derivatives such as Mirena coil and Depo-Provera, leading to more control over reproduction and menstruation. Moreover, the sense of control over their premenopausal reproductive system may lead to a deeper feeling of loss of control over their changing bodies particularly if there is a lack of realisation that changes may be related to the menopause.

The depth of experiences was also individual; on the surface it might appear that women were experiencing the same 'symptoms', such as hot flushes and dryness, but the intensity of the experience and how they coped was as individualised as the experience. There was an expectation that hot flushes and night sweats would be for a defined period of time and would not occur before the cessation of menstruation, expected around 50 years of age and the anticipated defined starting point for the menopause. There was surprise that any changes, other than menstrual changes, could happen before menopause and participants struggled to articulate a defined start or end point.

However, once there was an awareness that they might be experiencing the menopause participants were able to consider different strategies to reduce the impact. Lifestyle modifications enabled participants to accommodate the losses, for example working part-time to manage tiredness or trying to plan more periods of rest such as "a siesta" as described by Emma:

"I'm not firing on all cylinders all the time and I do get tired [I: mmm], I like a siesta now whereas it never entered my head [before], I'd be up doing the horses then go home, do the housework [I: yeah] so yeah it's just it's very strange.." (Emma:289).

Participants who experienced sleep disturbances as a result of night sweats found this resulted in increased tiredness during the day as they attempted to maintain their lifestyles. However, the changing contexts in which women are now experiencing their journey through menopause are different from the majority of their mothers' generation, an important difference noted by other researchers in managing the impact of changes (Utz 2011; Sergeant and Rizq 2017). More women are now in the workforce and with the continuing rise in the age of retirement they are more likely to be working through the menopause and for many years postmenopause. This is reflective of the experience of participants in this study, all of whom worked during the menopause or were on a pathway for registration as a healthcare professional. They were managing their perceived losses while trying to balance many other domains of their lives.

In a similar way to adolescence leading to the beginning of potential reproduction, the menopause represents biological changes and links were made by participants. Akin to the adolescence, participants reported biological and emotional losses as they moved towards the end of reproductive potential but, unlike adolescence, they were unclear of a timeframe in which changes would start and end. There was a sense that the changes were wider than had been anticipated affecting the whole person rather than being restricted to the reproductive system. The menstrual cycle, hair and skin were affected along with mood, acting as a reminder of both the changes resulting from the menopause and in teenage years:

"I'd had very heavy and quite painful periods in my teens and early twenties so it was a bit of a return to that, I thought 'mmm something's changed'" (Kate:70).

"It [skin] was always in good condition now it's [skin] like dry beyond belief and I get spots! I mean what is that about? [laughs] Teenage spots!" (Lisa:611).

While some aspects of physical changes were compared to adolescence others such as loss of physical strength, energy, memory and health were likened to the ageing body. Although the tendency was for this to impact the private domain of their lives rather the professional there was a sense of frustration as participants didn't feel "old" but their bodies were a reminder of the physical losses they were experiencing:

"It's just I'm generally more tired but it also feels like physical energy levels, which are kind of different from being tired aren't they? [I: yeah]. If you, you kinda feel a bit tired you think "Oh maybe I won't do something I was going to do, I'll leave it for tomorrow" but I'm talking about, when I say I don't feel as strong that there are jobs in the garden that I would've tackled on my own before that now I ask my husband to help [I: yeah]. Can you do this for me because it's a bit too much? Can you do that for me? Erm and that kind of gender difference starts to get more highlighted..." (Kate:943)

The awareness of physical losses leading to a feeling of becoming older or being perceived as older by others led to participants reflecting on **emotional losses**.

Super-Ordinate Theme: Emotional Losses

Across the cases **emotional losses** took the form of more publicly visible expressions of emotions often leading to a feeling of loss of control. Emotions such as crying and uncontrolled anger were the predominant emotions discussed followed by subtler, less visible internalised emotions, such as embarrassment, reduced self-confidence and a more general feeling of sadness. Emotions were expressed as losses if the participants felt that they had a lack of control over their emotional responses compared to perceived sense of control before the menopause.

Participants reported the emotional impact resulting from their bodies being perceived as behaving in unpredictable ways leading to embarrassment, stress and reduced self-confidence. Descriptive language was often used to express feelings related to emotions as illustrated in two examples from Claire's commentary:

"I also got the feeling that my body was erm, when I say falling away from me I just mean that I was just standing outside my body sometimes [I: yeah] or outside my body and it was going through things that I was not directing and I've just, I didn't feel kind of a hundred percent erm I didn't feel like I was an I was able to erm to control anything" (Claire:58).

"I found, you just, you kind of are like held hostage, you kind of are "what the heck is gonna happened next?" and erm and the the mental effects, the emotional effects [I: mmm] really dragging, I've used that word quite a few times, dragged me down" (Claire 550).

The use of "falling away", "hostage", "dragging me down" and "not directing" articulates a rich picture of feeling a lack of control over the body but also in viewing the lived experience of menopause as a complex whole body experience. It was however the negative emotional impact which was described as a "crying", "moodiness", "anger" and "rage" which was most often articulated:

"Yeah yeah I did cognitively [know about menopause] I knew all that [physical changes] was gonna happen erm but emotionally I don't think I had understood it and I think I have much more sympathy with other women gone past the menopause now... coz I used to think it was just a bit of a fuss, you know... [I: mmmm] just part of life but I now understand the impact" (Rose:177)

"I'd probably feel I just wanna cry but I didn't know why I wanted to cry [I: yeah] you know, silly things that I couldn't [understand] so I'd like sometimes if we were watching a movie I'd think I'm gonna go and make a cup of tea because I know this is going to be a really sad and I don't want to cry but it was because I'd be crying more then if I'd be upset normally you know and [the children] were "why you crying at that Mum" you know.... because it'd be more than you know I'd be sobbing for hours after" (Jess:195)

Participants described emotions such as crying and anger as happening within the private sphere of home rather than the more public work/study environment. The examples below describe two participants' feelings of heat and lack of control:

"you know it's [hot flush] gotta be volcanic [I: yeah] but that is how it makes you feel" (Lisa:1500).

*"They [not making decisions] would be a repressed side of me and that would cause anxiety and that was even fuelling flushes sometimes because I was like this pressure cooker.. **building up** and **building up**" (Emma:672).*

The metaphor of the volcano and pressure cooker provide rich descriptions of the heat of anger, the experience during a hot flush and the perceived lack of control over the physical and

emotional self. This was something participants found an additional unwelcome challenge as they wrestled for control of the changes they experienced during their journey through menopause.

Emotional manifestations of anger were expressed as "out of character", "irrational", "horrible" and "frightening". Furthermore, the externalisation of the anger that was experienced by participants was unexpected for themselves and their intimate partners and there were concerns about the impact on relationships. In relating her feelings Jess uses rich descriptive language to articulate a lack of control but also her anxiety that a repressed part of her 'being' has been released:

"It'd feel like it [the heat] was going on forever but because it [the heat] had this intense, intense, yeah intense rage I suppose, it it mainly it, I must be having the slightly abnormal element of it [the rage] [laughs][I: mmm] you know, don't know why but it [the rage] made me feel, is it something to do with me and my personality [I: mmm]. You know is it [something] in me that has been dormant and now this is kind of unlocked some monster that I can't control" (Jess:390).

The description of "unlocking a monster that I can't control" suggests contravening societal expectations of women behaving in prescribed ways in the private, as well as public domain with bodily control and restraint being the expectation. Haines et al. (2016) USA based study compared data (n=191) using the same questionnaire from an earlier study (n=195) (Deaux and Lewis 2013) exploring gender stereotypes and the portrayal of midlife women. Their findings suggest that gender stereotypes have changed relatively little of the last 30 years despite the changing roles of women. Haines et al. (2016) argue that gender stereotypes are subconscious and deeply embedded in society. The subconscious nature of gender stereotypes suggested by Haines et al. (2016) may explain why participants feel challenged when emotional experiences such as unrepressed anger do not align with gender expectations that have been internalised and framed as participant's own expectation of themselves. The resultant nature of this is that women feel there is something wrong with them or they are not their 'normal' selves which can be interpreted to as participants not feeling like their premenopausal selves. Interestingly, once participants developed an awareness that their experiences may be linked to the menopause there was a sense of relief as they were then able to explain and rationalise to themselves and others their emotions and subsequent behaviour. Those participants most affected by a loss of control implemented strategies to manage their emotions, such as, taking 'time out' from the immediate situation which directly improved their sense of wellbeing and facilitated control of "the monster within".

Super-Ordinate Theme: Loss of Traditional Notions of Feminine Identity

Loss of traditional notions of feminine identity is closely interlinked with the super-ordinate themes physical and emotional losses and was strengthened and supported by the extended data collection. The in-depth analysis of the phase two data gave a more nuanced exploration of this super-ordinate theme which needs to be explained in terms of traditional notions of feminine heterosexual identity within the Western cultural context in which the participants are situated. Loss of a feminine identity was reported as resulting from the impact of physical and emotional losses on participants' perceptions of themselves and how they were viewed by others. Changing body shape, looking older and a feeling of "fading away" were identified as contributing to a loss of libido, loss of sexual relationship and further reducing self-confidence. This in turn was viewed as impacting on relationships with intimate partners.

The participants' perceptions of themselves contributed to the sense of **loss of traditional notions of feminine identity**. Loss of body shape, predominantly relating to weight gain, resulted in feeling out of shape and reduced self-confidence which was attributed by participants to the menopause. Other bodily changes such as vaginal dryness and, for one participant, a vaginal prolapse contributed to feeling less feminine. The lack of confidence in the visual appearance of their bodies often coupled with vagina dryness resulted reduced libido impacting on some participants' sexual relationships:

"By the time I got to the stage where I thought "Oh yeah maybe [to have penetrative sex] I thought oh I can't be bothered [both laughing] so it was, that, that was, but it was a kind of combination of lack of sex drive, lack of vaginal lubrication and and just feeling not attractive, feeling unattractive and that go back again to that fading thing I just felt a bit errrrgh"
(Claire:176).

"I'm not interested [in sex] [I: mmm], which is not like me, having like a really high sex drive all my life [I: yeah] that absolutely is gone down to just about... oh, if I must! [laughs] and that's bad cause I enjoy it [sex], I just think 'I can't be bothered' and that's not like me so I suppose that's had an impact as well, yeah my sex life has definitely, me sex drive has actually dropped off" (Lisa:599).

One participant discussed the impact vaginal dryness had on her sense of self and her intimate relationship:

"I probably would avoid it [penetrative sex], not always but sometimes [when we had sex] but then it almost felt like... a duty, it was uncomfortable but I felt like I should do it [have sex] because we hadn't you know he hadn't, we hadn't had sex for a while and [I: yeah rather than

because you wanted to?] not that he was pressurising me but I felt [I: yeah] sort of bad I suppose... which is probably not the right way to be but erm even though it [sex] was a bit uncomfortable.."
(Beth:107).

Beth did not talk to her intimate partner about the impact on their relationship. This was reflective of other participants in this study. Participants were all in heterosexual relationships with some identifying changes in their intimate relationships such as increased cuddling, holding hands when out in public and kissing in response to a reduction in penetrative sex. What was evident from participants commentary was that in their heterosexual relationships penetrative sex was considered the pinnacle of intimacy in meeting their partner's needs but not necessarily their own. Beth started taking HRT to help with both hot flushes, which often occurred when her intimate partner started to touch her sexually, and for vaginal dryness. Beth clearly articulated a positive impact from HRT but it may also reflect social pressure to conform to cultural norms of feminine sexual attractiveness and the "forever young" discourse (Hvas and Gannik 2008b). Kelly (2008 p.302) states that taking HRT ensures the sexual "availability of women to men as men define it". The participants in this study defined their intimate relationships in terms of gendered norms and the availability of their bodies to their male intimate partners.

What was notable when talking about sexual relationships and in particular sexual arousal was the use of descriptive language such as "*the light just doesn't switch on*" (Emma:563), "*slow burn [becoming aroused]... it needs firefighters!*" (Emma:575) and "Slow [in becoming aroused]....going backwards" (Lisa:1046). In a similar way to the use of the metaphor of a volcano providing a description of anger the use of descriptive language in discussing sex provided an image of the change in sexual responsiveness and, in the use of this language in comparison to their premenopausal selves where arousal happened more quickly and spontaneously. Within the group, participants described being comfortable with and understanding their premenopausal bodies, for example, recognising when they were about to menstruate but they were less comfortable with their changing bodies and how they looked. There was a sense that visual bodily changes due to menopause and loss of youth were closely linked and attributed to negative behaviours from others outside of their personal relationships that contributed to the feeling of **loss of traditional notions of feminine identity**.

For participants the menopause was noted as the first time they had become conscious of becoming older and there was concern about the negative impact that this could have on their lives. Participants' loss of youth was reinforced when people, often in the work environment, no

longer looked surprised when participants revealed their ages or, outside of work, when they were not required to provide proof of age identification and being eligible for healthcare tests and examinations considered to be in the realm of the older person, for example hearing tests.

Concerns about the menopause marking a journey towards old age was reinforced by participants frequently using terms such as “older” and “ageing” and regularly returning to discussions about ageing and the associated perceived losses. Of particular concern was the feeling of becoming invisible to others or as one participant described, a feeling of “fading away”, feeling as if her facial features were fading which was reinforced particularly in the work context:

"It [changes] all coincided with this feeling of fading away and just you know you just suddenly realise that people are not paying any attention to you in meetings and things like that because [I: arrh that's interesting] you know that kind of stuff because you are just, feel that people, as sort of you know you are not to the sort of vital person with boundless energy that you were" (Claire:78).

The act of work colleagues “not paying attention to”, no longer listening to ideas or views as they had when participants were younger reinforced the sense of invisibility and “fading away” which in turn contributed to a loss of self-confidence. The strong focus on concerns about becoming older and the menopause being a marker of a journey towards old age reinforces a “forever young” discourse (Hvas and Gannik 2008b) which values youth and renders older people invisible. An awareness of a sense of loss of visibility was identified as commencing before the cessation of menses and being directly related to fertility ending and becoming an older woman. However, it was changing behaviours in being treated as an older woman that appeared the most prevalent concern. One participant used a term ‘cultural baggage’. In unpacking this concept, the term ‘cultural baggage’ could mean different things to different people. Contextually situating ‘cultural baggage’ within this study, is interpreted as an overarching term encompassing a range of issues that negatively affect women. It includes social and cultural issues that impact on the personal sense of self including feelings of invisibility and cultural perceptions that youth and fertility are preferable to old age. The unconscious, multifaceted nature of cultural issues means that the issues can be difficult to fully articulate and, as such, behaviours that impact on **loss of traditional notions of feminine identity** are subconscious and innate rather than intentionally disrespectful. Overall there was concern about both the menopause and becoming older which were inextricably linked for participants:

"I think it's like ageing because nobody wants to age erm and I always think that as much as we talk about older people and ageing it's never somewhere you want to be yourself is it? Nobody wants to be to be that person and I think maybe that that's the same with the menopause is that

you sort of know it, you acknowledge it but you know, you're putting it off, [l: mmm] you don't really want to engage with it until it actually happens..." (Rose:398).

The awareness of prejudices including feeling a loss of visibility impacted on participants' sense of the composites that make up female identity. There appeared to be a tension between participants feeling young but being viewed by others as old. Participants were all women with the potential for making an economic contribution for many years but they continued to be concerned about traditional Westernised views of youth and ageing. The security that had previously been experienced in knowing and understanding themselves as young was challenged by their changing bodies, the impact on intimate relationships and the behaviours of people outside their immediate circle of family and friends.

Discussion: Losses

Within the higher order concept **Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal"** (Kate:36) the findings underpinning the three super-ordinate themes **physical losses, emotional losses and loss of traditional notions of feminine identity** have been presented. It was notable that losses described were representative of negative cultural stereotypes of menopausal women as being in bodily decline, a view perpetuated by dominant biomedical discourse suggesting menopause as a deficiency disease (Dillaway 2005b; Hvas and Gannik 2008b). Within this higher order concept there was a focus on the 'symptoms' of the menopause in particular hot flushes and menstrual changes. Participants regularly returned to the concerns about 'forever young' discourse described by Hvas and Gannik (2008b p.179) as admiring youth while older people are "belittled and made invisible". Hvas and Gannik (2008a) used discourse analysis of printed texts available to Danish women, from 1999 to 2004 from a range of sources including magazines and newspapers, as well as information distributed by healthcare organisations. They identified seven discourses on menopause: biomedical, 'forever young', health-promoting, consumer, alternative, feminist/critical and existential discourse (Table 6.1) which they also situated the applicability within a global context. Within the higher order concept losses two of the seven discourses reported by Hvas and Gannik (2008b) were evident: biomedical and 'forever young'.

Biomedical discourse positions menopause in purely biological terms as a deficiency of hormones leading to an increased risk of disease requiring medication to maintain control over the body (Hvas and Gannik 2008b). The participants in this study constructed their understanding of menopause in biological terms and described 'symptoms' aligning with biomedical discourse.

However, there was a reluctance across the group to use prescribed medication to maintain control over their bodies. This is a distinct change from Utz (2011) mother/daughter study in which daughters expected access to pharmacological interventions to prevent a loss of control either physically or emotionally. Although the tenets of biomedical discourse remain apparent in the language used by participants to describe their physical experiences there was also a sense of relief once they understood that they were experiencing a normal life stage. Smith-DiJulio et al. (2008) postulate that women who have a sense of mastery over their experience have an increased their sense of wellbeing. While participants in this study were relieved to have a 'label' for bodily changes confirming the experience was not pathological it did not negate the negativity attached to menopause being related to ageing.

The 'forever young' discourse was evident within the super-ordinate theme **loss of traditional notions of feminine identity** with menopause being viewed as a negative symbol of ageing for women. The perception participants expressed of returning to 'normal' is argued by Dillaway (2005b) as maintaining stereotypical views that the older female body does not 'fit' and that a feminine body is an unchanging body representative of youth. This aligns with the opinion expressed by Haines et al. (2016) that views of women have not developed at the same rate as their role change. Christoforou (2018) completed a grounded theory study with Greek Cypriot women (n=10). She outlined her awareness of potential power dynamics during the interview clearly reporting her insider/outside perspective. Although an expectation when using grounded theory, she also helpfully reports her use of reflexivity in facilitating an awareness of the impact of medical discourse on her interpretation of the data. This is something of which I became aware was influencing my interpretations of the data. She does not however give any depth of detail about data analysis or the use of 'memoing', which is considered a core component of grounded theory (Elliot and Lazenbatt 2005; Creswell 2013). This made it difficult to assess the overall quality of the study. Christoforou's participants identified feeling a lack of self-control over their bodies both physically and emotionally something that was articulated as unwelcome in Greek Cypriot culture. Similarly, within the study reported in this thesis participants found the loss of control challenging resulting in the perception that they did not recognise themselves.

Sergeant and Rizq (2017) explored the impact of menopause on the identity of 11 peri and postmenopausal women living in the UK. One of the findings focused on "going from one phase of life to another" and identified a fear of being subjected to negative narratives of old age which "would undermine their status by calling into question their relevance, rigour and attractiveness" (Sergeant and Rizq 2017 p.193). The concerns raised about **loss of traditional notions of feminine identity** and changing status around menopause reflect the fears of being subjected to negative

narratives while inadvertently contributing to reinforcing negative stereotypes. St Claire-Ostwald (2007) suggests there is a complex interplay between patterns of learned and shared behaviours, which in turn, results in culture affecting behaviour without this being recognised or realised. The lack of recognition makes it challenging to affect cultural change in the short term.

In cultures that value ageing, women tend to gain status as they reach midlife describing themselves as gaining respect within their families and communities (Mahadeen et al. 2008; Jurgenson et al. 2014; Hakimi et al. 2016). However, in Western cultures women generally lose social status as they move from their reproductive to non-reproductive lives. Coupland and Williams (2002) argue that societal attitudes continue to suggest stigmatisation of the menopause is a form of societal ageism which is unhelpful to midlife women, a view reflected by Hvas and Gannik (2008a) in the Danish context. Chalouhi (2017 p.129) also describes the cultural view as one in which “youth is considered a trump card, with older women being victimised by a society that fears their ageing bodies”.

Sergeant and Rizq (2017 p.195) analysed accounts of women's (n=11) lived experience of menopause. A grounded theory methodology was used to develop a socially situated theory about the impact of menopause. They provide a relatively detailed account given the limitations of the word count showing the development of the theoretical categories, although, as with the Christoforou (2018) grounded theory study, the use of 'memoing' is less clear. They identified an overarching category of "continuing my story while everything changes" to describe how participants were constructing their identities during menopause while the meanings of menopause were culturally constructed leading women to keep menopause hidden. Greer (2018) suggests that the societal fear of ageing encourages older women to lack visibility by using interventions to hide visual signs of becoming older, such as dyeing greying hair and having cosmetic surgery to reduce wrinkles. For women who experience visual/public signs of their the menopause, such as hot flushes or mood swings, it becomes more challenging to maintain the appearance of youth. Across studies women experiencing menopause continue to articulate the impact of negative societal views of older women (Matarese 2005; Duffy et al. 2011; Morrison et al. 2014; Ramakuela et al. 2014). The findings in this study suggest that participants remain concerned about being subjected to the negative narratives ageing described by Sergeant and Rizq (2017).

Rubinstein and Foster (2013) completed an interesting mixed methods study exploring the relationship between views of the menopause and body consciousness. Data collection included a

survey of 270 UK women, followed by 12 interviews with peri and postmenopausal women. Rubinstein and Foster (2013) provides justification and a detailed audit trail for the use of quantitative and qualitative methods. This is considered essential given the heterogeneity of mixed methods research resulting in a lack of consensus regarding quality assessment (Brown et al. 2015; Halcomb 2019). The detailed process provides transparency in relation to the process although it would have been beneficial to have more clarification of how the research questions relate more specifically to the qualitative interviews. The strength in the study is the use of several validated tools in stage one (the survey) with interim findings suggesting that women who were self-critical of their bodies, scored highly on self-objectification and were more likely to view menopause negatively. The 12 interviews were with women who scored as either high or low on self-objectification. The findings identified concerns about menopause and the body suggesting that all women, regardless of views of their bodies, were concerned about the perceptions of others, particularly men, when their fertility declines. It was however, those who scored highly on self-objectification that were more likely to try to conceal the ageing process to maintain a youthful appearance in order to ensure continuing visibility and hence the attention of others.

In attempting to understand women's menopause narratives de Salis et al. (2018) identified within the narrative of distress, following 48 in-depth interviews with UK mothers aged 49 to 56 years old, there was a belief that fertility and sexuality were interlinked with perceptions that ovulating women must be "subliminally attractive" to men (de Salis et al. 2018 p.529). This is similar to findings of Dillaway (2005b) in which the views of 61 women were considered following interviews (n=53) and focus groups (n=8) exploring their views about their bodies. Dillaway (2005b) found women felt they were both invisible and ignored by others as their bodies became less attractive to others during the menopause. The strength in Dillaway's study are the demographics, with a heterogeneous sample representing women from all socio-economic classes and sexual orientations.

Women's concerns about their changing bodies during the menopause are well reported in the literature (see for example: Dillaway 2005b; Hakimi et al. 2016; Sergeant and Rizq 2017; de Salis et al. 2018). Dillaway (2005a) used a homogeneous subset of the Dillaway (2005b) study to explore the views of reproductive ageing through interviews and focus groups with 45 peri and postmenopausal heterosexual women. One of the findings from the subset were parallels between menopause and menarche for 10 women who described menopause as being similar to puberty, in relation to not having as much control over their bodies as pre-menopause. They concurred that there was more support in preparing young people for menarche than preparing midlife women for menopause. It is not clear in the report if Dillaway (2005a) pre-empted the

menopause/menarche link or if this theme naturally emerged during the interview/focus group process. The physical experiences reported by participants in this thesis relating to skin changes and menstrual changes also reminded them of adolescence. Despite Dillaway (2005a) completing her research fifteen years ago and the wide availability of electronic information there remain parallels between the feeling of lack of preparation articulated by her participants and the experiences voiced by the participants in this thesis

Having a better awareness of changes earlier may have removed participants' sense of loss of physical, emotional and feminine selves. Interestingly Breidenbach (2009) reported predominantly positive views of the menopause in her study of 12 lesbian women and was the only study that recruited participants living in a solely female community. This gave a unique insight into the views and experiences of a marginalised group of women who had chosen voluntary segregation from patriarchal society. While there was uncertainty at times about changes, particularly in relation to menstrual changes, the participants articulated a sense of agency over their bodies rather than the loss of control voiced within this study. Breidenbach (2009) spent time completing fieldwork, participant observation as well as interviews and noted the sense of shared community appeared to break down barriers, for example openly discussing menstruation and bodily changes with the knowledge being considered empowering. Breidenbach (2009) documented the number of interviews (n=12) but not the size of the community of women overall which would have provided additional context regarding the sharing of knowledge. The findings link closely to the higher order concept of *women's business* (section 5.4) and are also a reminder that having knowledge and understanding can result in a sense of control rather than a loss of it, aligning with feminist discourse (Hvas and Gannik 2008b).

It was notable that the language used by women to describe their experiences of the physical changes during the menopause in this study does not appear to have fundamentally changed across the generations. Twenty-one years ago Shore (1999) interviewed 10 UK women between 43 and 60 years old to explore perceptions and experiences of menopause. Using a constructionist grounded theory approach she identified a core category, of "soldiering on" with a sub category of "getting on with it". The findings stated that these terms were used to avoid thinking about menopause. In the more recent study of UK pre, peri and postmenopausal mothers (n=48) de Salis et al. (2018 p.525) also found terms such as "you just get on with it" and "not a big issue" were used to help women perceive unwanted 'symptoms' as unproblematic and part of a normal process. The menopause happens to the majority of midlife women who do not have chemical or surgical interventions but it was not necessarily welcomed. Using terms such as

these appeared to be used as a coping strategy to minimise the experience of being viewed by themselves and others as an older woman.

There appears to be a complex interplay between dominant discourses which combine to reinforce negative attitudes to women in relation to physical, emotional and social aspects of their lives. An alternative discourse identified in analysis was that of liberation, with participants reporting experiences that enhanced their quality of life. This dialogue with women when discussing gains was more reflective of existential discourse viewing the menopause as a “process of self-discovery” (Hvas and Gannik 2008b p.179) which is reflected in the next higher order concept.

5.3 Higher Order Concept: *Liberation: Freedom from "cultural baggage...to feel that you're becoming yourself finally" (Kate:486)*

The higher order concept **Liberation** was underpinned by two super-ordinate themes **liberation from biological restrictions** and **liberation from social expectations**. Participants talked about gains, for example: biological gains through not having to worry about contraception and menstruation and sociological gains resulting from participants' feeling they no longer needed to conform to expected behaviours.

Gaining Liberation gave women more time to focus on themselves. The strong emphasis on the non-conforming self and the sense of passion and freedom that gains could be afforded to women as they journeyed to menopause and postmenopause were key findings.

Super-Ordinate Theme: Liberation from Biological Restrictions

The **liberation from biological restrictions** referred to freedom from menstruation, unintended pregnancy and the need for contraception. Changes in menstrual cycle length and flow were recorded as indicators of the menopause but, unlike menarche, there appeared to be very little discussion or preparation for the ending of menstruation. The word ‘menopause’ is defined as “the ceasing of menstruation” (English Oxford Living Dictionary 2020) perhaps suggesting that menstruation will just stop or the flow will get lighter and fade away. There appeared to be a disconnect from the early indicators of change resulting in participants only noticing when changes became severe, for example sudden heavy bleeding or severe flushes. However once there was an awareness that the changes were leading to menopause there was a sense of liberation that there would be an end to biological restrictions related to the reproductive cycle.

Participants did not make a distinction between the relative regularity of ovulatory menstrual bleeding and anovulatory bleeding that happened, often erratically and unpredictably during the

menopause. Although participants were aware of some bodily changes they were caught by surprise when menstrual cycle changes resulted in an increased rather than a decreased menstrual flow and more frequent bleeding. This had a profound impact on some participants' lives and sense of wellbeing as described by Jess who was trying to cope with heavy bleeding every two weeks while trying to continue with 'normal activities' with two active school-aged children. This was a contributing factor to the sense of liberation at the ending of menstruation:

"I think it was just that constant worry [of bleeding becoming visible] you know so in particular things like when we used to go skiing on holiday things like that, I hated it. You know I thought I don't really want to ski out of the resort that I know because I know where to stop on the piste for toilets [I: yeah yeah] so it kind of affected what I did [I: yeah] more outside of home than work because there were less unknowns so I'd make an excuse "Oh I'm feeling a bit tired or I'm slow skiing why don't you guys go ahead coz you're quicker, I don't want to slow you down, I'll just stay here for the day" But actually it's because I was worried about going to the toilet because people would be saying "why are you going to the toilet so much Jess, you've just been to the toilet an hour ago?" You know, well I just sort of thought I didn't want to make a big deal of or bring attention to it [menstruation] or anything" (Jess:49).

This participant quote highlights issues that resulted in participants finding the ending of menstruation liberating. The impact on participants' lives that a change in the pattern of menstruation makes, which had previously been viewed as predictable, resulted in hypervigilance of bodily functions. Menstruation remains a cause of embarrassment and viewed as being within the private domain of the woman. This is clearly seen when Jess states that she would "make an excuse" and not wanting to "bring attention to it". Although menstruation may be within the realm of women I would suggest that women also contribute to the maintenance of menstrual taboos by not speaking openly even with close family members. The need to no longer hide unpredictable heavy menstrual flow underpinned the feeling of relief and freedom from a burdensome process:

"the cessation of periods erm you know sometimes when I go to the toilets at work and I see a little spot of blood at the bottom I think 'thank god I don't have to cope with that anymore' you know erm so that that was a [plus]" (Rose:290).

*"Yeah... no periods [I: hurray...] which **is great** [emphasis]" (Lisa:983).*

"Not having periods. That's fantastic [I: oh yeah, whoop, whoop] bloody love that. That was just a joy, a total joy" (Rachel:399).

The ending of menstruation also marked the ending of fertility which was viewed positively as a gain across the cases. There was a sense of liberation that pregnancy was no longer a risk for participants who either had the number of children they desired or had actively chosen to remain childfree. Jess, the only participant to say that she had used barrier methods of contraception most of her life expressed a sense of liberation at no longer being restricted by the potential risk of pregnancy:

"I think the most, it's really selfish isn't it [laughs] but you saying [is there anything good about the menopause?] that I think the one thing is that I feel like... I've got a body back for me [I: OK] you know, coz I can't get pregnant, [I: yep] not that I haven't enjoyed having the boys and things like that and it was a decision to get pregnant but I feel like, ooh my body isn't for anybody now but me, people, you know" (Jess:897).

What is interesting is the sense of freedom articulated by Jess in her body only being available for her, but also the need to express that this is a selfish thought. This not only adds to a sense of liberation from biological restrictions but a liberation from the social expectations of women (discussed in the next super-ordinate theme below: liberation from social expectations). Despite the contemporary contexts in which women live there remains an innate need to articulate feeling good about having children and feeling "selfish" about no longer wanting more, suggesting that fertility and the expectation that women desire children is a deeply rooted social norm. The sense of being unable to have children following menopause added to the feeling of liberation for child-free participants.

For child-free participants the liberation from biological restrictions included a feeling of freedom from the expectation of others that they should have children. Freedom from unintended pregnancy was also related to a freedom from the need for contraception. However, the decision to discontinue the use of contraceptives was a bit more uncertain as demonstrated by one participant:

"I think, yeah. I think it was [challenging deciding when to stop using contraception] erm sort of making sure you were, I think it's 6 months since a period isn't it? Erm, I can't remember now, so it's just making absolutely sure that you're at that point [menopause] erm [pause] I'm pretty sure it was 6 months coz sometimes I would go 5 or 6 months without a period and then there'd be another one [I: yeah] erm but I mean at that age [around 51 years] you're unlikely to conceive anyway so..... I think, I think I felt fairly safe at that point" (Rose:352).

Women are often the ones expected to be proactive in preventing unintended pregnancy through the use of various methods of contraception because a pregnancy continues to have the greatest impact on women's lives. The impact of a later unintended pregnancy on the health and wellbeing of the mother and foetus along with a lack of knowledge about the menopause may lead women to use contraception for longer than is necessary. For women who experience menopause earlier than the average UK age of 51 years old this decision may pose additional uncertainty leading to additional reliance on a medical opinion. Although participants tended to be cautious there remained a sense of liberation at the ending of fertility and for some the new sense of freedom from biological restrictions had a positive impact on their intimate relationships resulting in a new-found spontaneity that had not been experienced for some time.

Super-Ordinate Theme: Liberation from Social Expectations

Liberation from biological restrictions is inextricably linked to the sense of freedom felt at menopause from the social expectations of participants. **Liberation from social expectations** was a key finding across the cases that gave participants an opportunity to focus on themselves rather than the needs of others. Participants articulated a sense of liberation from expected conformist behaviours with new behaviours including being less worried about upsetting people, having the *"right to say how I feel"* (Lisa:666) and being able to *"get away with things"* (Kate:495). There appeared to be an opportunity for freedom from the *"cultural baggage"* summed up by one participant and incorporated into the higher order concept **liberation**:

"...so you know you do kind of feel that you're becoming yourself finally and you're not hemmed in anymore by all those expectations and having to conform to what people want you to be" (Kate:486).

There was a sense of increased self-awareness and self-confidence leading to a more assertive self, including feeling liberated from the need to control emotions such as being argumentative or angry. The difference between anger articulated in losses and anger considered as liberating in this higher order concept was that anger was viewed as an opportunity for participants to express themselves without being concerned about the views of others, predominantly intimate partners:

Participant: *"I was volatile emotionally [at the time of menopause] sometimes erm I can remember a couple of times when I got, I got very angry [with husband] erm and I suppose, I can, most of the time I'm fairly placid but I do have a streak of anger in me and I think probably that was more visible when I was going through the menopause, my moods were up and down a bit."*

Interviewer: *mmm did you feel like you had less control over it or you didn't care?*

Participant: *Er yeah it was exactly that.. it wasn't that I couldn't of controlled it... [becoming angry] I didn't want to [laughs] it was like sort of pleasant for me in a way [laughs] that sort of you know I would throw my toys out the pram and not really worry"* (Rose: 224).

The menopause appeared to offer an opportunity to express emotions that may previously have been suppressed to protect the feelings of others. There was a tendency within the group, regardless of having children or not, to having spent their lives caring for the needs of others. Within the context of this higher order concept 'others' were considered to be in the private/personal domain rather than the work environment. The majority of participants had caring responsibilities for children, partners, siblings or parents. However, during the menopause there appeared to be a heightened awareness of the restrictive nature of caring for others impacting on participants taking care of themselves:

"But I know I do it, I put myself under [pressure], like dad now needs a lot of support [I: mmm], not as much as he did bless his heart but emotional support, cause he's never got over mum [passing away], there's never gonna be anyone else, mum died 14 years ago [I: mmm], anything he's uncertain of "Emma, Emma, Emma" and I'm I'm like [will do things], ar I love him to bits and he is my best friend, I love him dearly but sometimes I think "just say no" or don't answer the phone or no I've gotta answer it because [something might have happened] [I: mmm] I've got to juggle all these balls and I can do this [keep juggling] and I'm just starting to [take time], for myself" (Emma:242).

In a similar way to women taking responsibility for the prevention of an unintended pregnancy, the role of caring for others both formally and informally, largely falls to women. Although the recruitment strategy for this study resulted in some participants with backgrounds and experience in healthcare (n=4), formal carers, many participants also had informal carer responsibilities. The majority of participants were in work or study full-time reflecting the changing contexts for working women (section 1.4). The responsibility for informal care, or organising an alternative, continued to be the responsibility of women despite working, in some cases more than partners. The menopause appears to act as a marker for participants to stop and reflect on life, their lives and roles resulting in changing behaviours to allow **liberation from social expectations**.

In moving the focus to themselves participants tended to become more vocal about their own needs within their family and particularly intimate partners. In trying to find their own 'voice' to articulate their needs their new assertive self was an unexpected outcome for both participants and others. My interpretation of the changing behaviours, assertively expressing themselves and

being less concerned about upsetting others was that participants were finding their voice to move from the perception of invisibility to regaining visibility to others as a midlife woman.

In finding their voice, participants gained time and space to reflect on the past and consider how they wanted to spend the future. As a result, two participants decided to commence full-time study to become health care professionals. For all participants there was an increase in self-confidence, and a sense of satisfaction in feeling able to focus on themselves rather than others, as demonstrated by two participants:

"It's just time for me to enjoy myself, to do [whatever], that's how I look at it, it's my time now and if the menopause is part of that, which it is, then you know then, then that's what it is" (Lisa:985).

"I'm mindful about me a bit more [I: mmm]and I think it is the menopause because I've never had to look at [think about] myself, just gone with the flow and "oh shit OK I'll sort it [any problems] out" [I: mmm] but I've had to think about me a bit more [since menopause]" (Emma:286).

Discussion: Liberation

The findings in the higher order concept ***Liberation: Freedom from "cultural baggage...to feel that you're becoming yourself finally"*** (Kate:486) suggests that the menopause is an important time that stimulates women to rethink their lives and the expectations of socially imposed gender roles such as caring for others. It was articulated as a time for reflection with a view to making changes to a focus on 'self' rather than 'others' without the concern of social expectations or biological restrictions offering participants an opportunity to 'be' the person they wanted to be. Sartre indicated that "the self is not a pre-existing unity to be discovered but an ongoing project" (Smith et al. 2009 p.19). The menopause is a key marker for change in the context of this study. Successfully changing the focus to themselves added to the sense of liberation expressed by participants being accepting of themselves and their needs rather than being focused on the needs of others. The focus on self closely aligns with the individualization thesis described by Beck and Beck-Gernsheim (2002) as moving from 'living for others' to 'a life of one's own'.

When discussions focused on the benefits of reaching menopause the talk quickly returned to concerns, predominantly about becoming older. The liberation experienced during the menopause, particularly **liberation from social expectations**, appears to be something that is recognised retrospectively postmenopause.

In reflecting upon their experience for this study, participants were able to articulate that being postmenopause had some positive elements such as having time to focus on themselves and their own personal aspirations aligning with the findings of other studies (Villarruel et al. 2002; McCloskey 2012; Jurgenson et al. 2014; Morrison et al. 2014; de Salis et al. 2018). Moving the focus of one's life away from others to focus on oneself was deliberated by Beck and Beck-Gernsheim (2002) in their paper considering individualisation thesis and women. The sociological perspective presented argues that women are influenced less by 'traditional' roles and have more choice. Role changes have happened rapidly across three or four generations and it has been predominantly the ability to gain employment with at least a reasonable salary that has led to a resulting independence for women from 'traditional roles'. While Beck and Beck-Gernsheim (2002) acknowledge that women continue to have more responsibility for 'family' tasks than men, the ability to access work and new experiences provides a comparison with others resulting in moving away from a focus on others to a life of their own. Although there has been criticism that individualisation theory (Beck and Beck-Gernsheim 2002) is representative of only middle-class views of individualisation (Dawson 2012), the changing focus from others to themselves speaks to the participants' experiences in this study, perhaps because they are also middle class. The experiences of menopause are articulated as a trigger in making changes and participants taking more time to focus on their needs.

Granville (2000 p.292) noted in the findings of her PhD thesis that the menopause was a time for women "to pause, review and reconsider aspects of their lives". In reconsidering their lives, Morrison et al. (2014) identified the importance of developing postmenstrual identity as a key finding in their mixed method study which included 185 semi-structured interviews with pre, peri and postmenopausal women aged 45 to 55 years. Data analysis is briefly described and would benefit from additional detail as having an understanding of data analysis is key to assessing the quality of the findings and understanding how the interviews contribute to the overall study (Brown et al. 2015; Halcomb 2019). In reporting their findings about postmenopausal identity women articulated the ending of fertility as a time to recreate their identity as well as having a sense of empowerment including a lack of "tolerance for issues or people who depleted their energy" (Morrison et al. 2014 p.8).

In thinking about a lack of tolerance, participants articulated changing behaviours particularly with intimate partners. In moving the focus from others to themselves intimate partners appeared to be the people most affected. If partners are not recognising or receptive to the changing needs of women this may help to explain the change in behaviours. By exhibiting more overt behaviours, such as anger, the focus of the relationships moved from the male partner to

the woman aligning with Beck and Beck-Gernsheim (2002) individualisation thesis. The feeling that participants were developing a new assertive self, particularly within intimate relationships also led to an increase in self-confidence.

Very few studies present predominantly positive experiences of midlife and the menopause. The focus tends to be on the negative 'symptom' experience even when questions are designed to elicit a range of responses, they tend to represent the dominant biomedical and cultural views positioning midlife and particularly menopause as a time of decline and psychological distress (Atwood et al. 2008; Perz and Ussher 2008; Jack et al. 2019). Perz and Ussher (2008) recruited 21 employed Australian women aged 41-56 years to explore women's midlife transitions. The aim of the interviews and open-ended questions were asked to promote reflections on women's experience of the body, meaning of life and change. They give a succinct overview of data analysis with the resulting themes demonstrating some positive experiences. A key finding was that midlife marked pivotal point in participants feeling positive and looking forward. The subthemes of increased confidence, time for self and self-awareness and self-worth are reflected in the sense of liberation articulated by participants in the study reported in this thesis. When talking about self-confidence Perz and Ussher's (2008) participants expressed feeling a sense of empowerment in valuing their own opinions rather than trying to please others. It would have been interesting to see if the responses would have been similarly positive if the interview questions had asked about menopause rather than midlife.

There appears to be a tension between the feeling of concern about losses and the sense of liberation identified in this higher order concept suggestive that women can hold multiple but equally valid views of their experiences. This tension is referred to by Hvas and Gannik (2008b) as a plurality of discourses. They suggest that different discourses can occur simultaneously offering insight into prevalent cultural attitudes. Focusing on themselves and changes that result in an increased self-confidence aligns with existential discourse viewing menopause as a time for "having confidence to hold one's own opinions" (Hvas and Gannik 2008b p.179). The journey through menopause appears to be pivotal in moving toward more assertive behaviours to meet personal needs, leading to a sense of **liberation from social expectations**.

Participants viewed anger during the menopause both with a lack of guilt and a sense of freedom. Similar to findings exploring the experience of women during the premenstrual period King and Ussher (2012) identified that many of the women in their study (n=47) articulated being premenstrual as a legitimate reason for expressing anger. Moreover Burkley et al. (2016) argue

that while endorsing a stereotype may protect self-esteem, for example using the menopause as a reason to express emotion, it may also have the unintended consequence of reinforcing the stereotype, particularly in the eyes of men. Anger may however, be a way of offsetting the feeling of invisibility articulated in section 5.2. Anger, although mentioned in many studies (see for example, Elliott et al. 2002; Morris and Symonds 2004; Cifcili et al. 2009; Lim and Mackey 2012), is not explored in any depth, the tendency is to focus on crying as a more socially acceptable behaviour for women.

The journey through menopause was an unexpected “acceleration point” (Kate:530) for change. The acceleration point provided motivation to move forward in meeting personal needs for growth and development without feeling constrained by others, aligning with existential discourse that menopause is “uplifted to a process of self-discovery” (Hvas and Gannik 2008b p.179). The impact of the reflective process and increase in self-confidence becomes apparent in the decisions made by participants about relationships and careers. Increased self-confidence has been reported in other studies as occurring around the time of menopause (see for example: Natipagon-Shah 2005; Lindh-Åstrand et al. 2007; Sergeant and Rizq 2017; Lazar et al. 2019). In thinking about the journey through menopause as a potentially transformative process an awareness of behavioural changes may act as a critical point in developing an awareness of and adjusting to change (Meleis 2010). The adjustment to focusing on 'self' rather than others suggests a more active engagement in gaining an understanding of the permanency of changes. Maslow’s hierarchy of needs suggests that esteem is important in reaching self-actualisation, with respect, status, recognition, strength, freedom and self-esteem contributing to this (McLeod 2017). Self-actualisation, or the desire to be the best one can be was seen as participants in the study reported in this thesis began to embrace their new sense of self and feel a sense of liberation from biological restrictions and social expectations afforded by the ending of fecundity.

Liberation from the biological restrictions was evident from the feeling of freedom following the cessation of menses. Laws and Campling (1990) argued that there has been an etiquette of silence surrounding menstruation that starts at menarche and continues throughout a women’s reproductive life cycle (Allen et al. 2011; Jackson and Falmange 2013; Rubinsky et al. 2018). Tan et al. (2017) present a review of mythologies, historical and cultural views of menstruation and uterine bleeding arguing that it is predominantly religion that has situated menstruation as taboo. With the exception of Sikhism and to a degree Christianity, restrictions have been placed on menstruating women limiting their participation in a range of activities from worship to domestic activities, including restrictions on intimate relationships. The suggestion being that menstruating women are unclean, impure and have the ability to pollute the people and environment. While

such views should be confined to history Tan et al. (2017) argue that contemporary attitudes continue to perpetuate the idea that menstruation should remain hidden, a stance articulated by other authors and study findings (Laws and Campling 1990; Stubbs 2008; Allen et al. 2011; Jackson and Falmange 2013).

Rubinsky et al. (2018) recruited 165 participants, aged 18 to 37 years old and identified as female (one participant was assigned male at birth) via a range of social media. Participants were predominantly white (n=100) with 65 participants from a range of ethnic groups. Data was collected using an open-ended online questionnaire. The study aim was to identify supportive communication around menarche and menstruation. The authors provide a brief description of coding and it would have been interesting to see a sample of their final codebook and how these linked to the final themes. The overall finding however, demonstrated a lack of supportive communication and a fear of menstruation becoming visible to others, for example heavy bleeding or being noticed carrying feminine hygiene products resulting in “self-silencing” to keep the experience hidden (Rubinsky et al. 2018 p.6). Participants articulated that other people also reinforced the need to keep bleeding hidden in adolescence which was perpetuated into adulthood. Some participants in the study reported in this thesis demonstrated a fear of bleeding becoming public and took steps to avoid exposure by for example, giving careful consideration to and avoiding activities, the proximity of toilet facilities and not sharing with others, not even family members their concerns about heavy bleeding. The unpredictability of menstrual cycle length and flow during the menopause explains the sense of relief and liberation on reaching the cessation of menstruation.

The sense of *Liberation* discussed in this higher order concept was articulated as an important aspect in moving to a focus to self rather than others. The menopause is a purely female experience and within this study there was evidence that women had a key role in helping each other through this natural life stage explored in the next higher order concept.

5.4 *Women's business: The "stuff of legend" that can only be experienced and shared by women (Rose:278)*

Throughout the interviews the participants clearly articulated that they preferred to speak to and hear from other women about experiences of the menopause. There was a reluctance to speak to men and exceptions were not necessarily made for intimate partners. The need for other women is reflected in the final higher order concept ***Women's business: The stuff of legend that can only be experienced and shared by women*** (Rose:278). Three super-ordinate themes underpin the

higher order concept: **"Sisterhood": A shared female experience, Making comparisons with other women and Women's knowledge.**

Super-Ordinate Theme: "Sisterhood" - A Shared Female Experience

"Sisterhood" used in the super-ordinate theme **"Sisterhood": A shared female experience** was the only super-ordinate theme to use an in vivo code from the interview with Rose that appeared to sum up the sense of shared support that is afforded by sharing and drawing on the experiences of other women. There were two distinct types of shared experiences. One was when women recognised and connected with another woman who was experiencing visual indicators of the menopause. The other was sharing with close friends, sisters, mothers and female work colleagues.

Participants sought out other women believing they would have a better understanding because they have experience which men do not. In some cases, it was felt that men were only interested if there was an impact on them, for example on sexual relationships as described by one participant who had experienced vaginal dryness and felt her partner's interest peaked when she started taking HRT:

"I don't think men are, I don't think they're that are that interested [in menopause], that might be a bit controversial but I don't think they are, I don't think they really want to know, I mean they can be sympathetic and they'll listen but they don't [really want to know], you know it's, they're not going through it so unless it's affecting them I mean that's [I: yeah] that's the sex thing [I: yeah] erm, that sounds really cynical to say that but I, I mean my partner was never really, we never really had an in-depth conversation about the menopause particularly but you know when it, when it's affecting sex, like he was quite interested that I was on HRT" (Beth:515).

Beth felt the need to say a couple of times that what she was saying may be "controversial" or "cynical" although her views and feelings were valid. All participants had male partners and there was a perception that men were not really interested in hearing about menstruation and menopause leading to the general feeling that sharing with known women of a similar age was the most supportive experience. For some participants there was a strength of feeling about not discussing anything related to the experience of menopause even with intimate partners:

"You know this is ours, this is something that happens to us, nothing to do with you [men], you don't experience it... similar to childbirth I suppose erm, it's not yours [men's] to share, it's ours [women's] to own erm and ours to talk about.." (Rose:472).

"I can tell him [husband] anything but I will not broach this because it's [menopause] my weakness" (Emma:951).

Weakness referred to a feeling of vulnerability in talking openly about the menopause with others if there was a risk that behaviours would be framed as related to menopause and participants might be labelled as 'being menopausal'. In a similar way to not wanting to be viewed as an older woman discussed in section 5.2, women did not want to be defined by the menopause. This appeared to be more of a risk with intimate partners where behaviours were perceived as changing or when making requests to focus on themselves, as described by one participant:

"I just need that little bit of time and if he [husband] doesn't give me that I will go **"I'm just trying to unwind [husband]" [emphasis]** "Ooooooh bit menopausal are we" [Emphasises her husband's words with a sarcastic tone]" (Emma:527).

In avoiding interactions that might be labelling, participants actively sought support from other women, usually female friends where relationships were more comfortable and relaxed:

"I'd rather talk to my female friends [I: yeah], I feel more comfortable and I can sort of share it in way that's more relaxed and frank and with them" (Beth:530).

"Oh yeah well and also there's always some alcohol involved [when talking to friends] [laughs] so that tends to make the conversation [flow] but we have had you know [discussions] over coffee conversations with female friends [discussing menopause] as well and I think the thing that comes from everybody [friends] is the fact that nobody talks about it properly [I: yeah] that's that's the number one complaint" (Rachel:262).

Although relationships were key there was perceived to be a lack of societal openness in that "nobody talks about it properly". This is a contradiction as participants spoke with female friends, family members and work colleagues and therefore they were talking to somebody. I have interpreted 'nobody talking' as meaning that there was a perception that the menopause was not discussed outside of participants' private domains but also a reluctance to talk about women's business outside of the "sisterhood". Rachel gained an awareness she was experiencing changes related to menopause when she heard a Women's Hour radio broadcast, until then she had been unsure what was happening. This highlighted that women outside of close groups were talking about 'it' but until participants were aware they were experiencing the menopause themselves they did not necessarily talk about the experience with others, even close friends as illustrated by one participant:

"I suppose it is the fact that you know it was that stage [the menopause] because the fact you then go into the menopause [cessation of menstruation] [I: yeah] that confirms it because you sort of think I'm now entered that stage [I: yeah] and I think it's the fact that you talk about it [the menopause] because you don't talk about it [the menopause] at the time, it's that reassurance it's, that's what it was [I: yeah] it's like you are seeking reassurance from other people [girlfriends] that have gone through it [menopause] that that is what it was, because that's what it was like for them" (Jess:365).

This was reflective of other participants' experiences once they recognised that changes were related to menopause. The "**sisterhood**" provided a safe, private forum to normalise experiences through sharing and providing support.

Participants also described reactions to their mothers' experiences related to menstruation and menopause that they had observed growing up. Comments or jokes were made to their mothers within both the private domain of home and the more public work environment:

"Dad would call it [pre-menstrual period] "tin hat time" and he actually [laughs] bought a tin hat, like an ex-soldier's hat [I: yeah] and he'd wear it around the house and he was like "Oooh it's that time" [I: laughs] and mum would get through it half smiling but she used to get very emotional" (Emma:230).

"She [Mother] worked in a small room within the factory, an office I suppose with a couple of other people [I: mmm huh] erm who were men [I: right] and she'd come home and complain about the arguments they'd had about whether she could have the window open or not!" (Kate:18).

My interpretation of these experiences are that the impact of observing or hearing about the, potentially negative, reactions of others to menstruation and menopause experiences of mothers may have impacted on the lack of openness with intimate partners. There may be concerns that participants could be subjected to similar assumptions and stereotypes. If, as reported in the higher order concept: **Losses** (section 5.2) women feel they have reduced self-confidence, seeking support from other women who are a similar age or have experienced menopause may be a coping strategy to protect themselves from being subjected to jokes or labelled as 'menopausal'.

Sharing within the "**sisterhood**" included the use of humour which facilitated connecting with each other, gaining support and as a way of coping, particularly with physical changes. Sometimes the connection was subtle, just noticing the experience of others with a "*nod and a wink*" to show understanding. In other instances, the connections were explicit, particularly with known females such as friends, sisters and work colleagues and took the form of laughing and joking. I found that

whilst men making references or attempting to joke is viewed as unwelcome regardless of their relationship, joking amongst women who share the experience is considered connecting and supportive:

"It's certainly something that when I'm with my girlfriends we have a good giggle about [I: yeah] we think a lot about how our bodies are changing coz they've they've both got weak bladders, if we go anywhere in the car we 've only gone 10 yards down the road before they want to stop for a wee, it just makes us hoot with laughter but I think that, that's helpful [I: yeah, yeah] when you can laugh about it" (Rose:439).

The experience of the menopause was viewed as a shared experience. This meant that participants had something in common with other women regardless of socio-economic class and could offer a way to connect with women across the social divide within similar cultural groups.

Emma sums this up as an *"unspoken word that they've bin through it"* (Emma:1083) and being *"Like a girl's club"* (Emma:1087). Having a similar, shared ethnic and cultural context may also be important in enabling connections with other women.

The focus on a shared experience through **"sisterhood"** and the lack of sharing with men, particularly intimate partners, may be a way of gaining support and women protecting themselves from comments that may undermine confidence and wellbeing. This ensures that the experience of the menopause remains **women's business: The "stuff of legend" that can only be experienced and shared by women (Rose:278)** excluding men and putting control of what/how the menopause are discussed within the realm of women.

Super-Ordinate Theme: Making Comparisons with Other Women

Sharing with other women was important to participants and one way in which they appear to use this to navigate their own experience was by **making comparisons with other women**. Participants preferred to compare themselves to their mothers and this was closely followed by other known women including sisters, close friends and female work colleagues. Female networks of known women appeared to be important in offering valuable support in normalising the experiences of the menopausal journey.

The mother/daughter social comparison was most often used for comparing experiences with participants identifying predominantly physiological similarities. Participants compared their experiences with their mothers' experiences of physical changes which may have been more

socially acceptable for the age group of the majority of mothers. The exception was Lisa, whose mother was 16 years older than her, and a similar age to the older participants. Their open and direct mother/daughter discussions may be reflective of generational differences whereas other participants tended to compare rather than discuss experiences:

"...so when she [mother] was going through the menopause and he [step-father] was about she still enjoyed sex but it wasn't as often so you know it wasn't entirely unexpected for me to feel this way [during the menopause]" (Lisa:1069).

"My mother went through the menopause very early, she was early 40s [I: Oh wow] and she's got erm a crumbling spine now so erm I don't know maybe it's [bone health] something I'll go back and sort of make a fuss about [I: mmm] I mean I do a fair amount of weight bearing exercise so I think my bones are in reasonable nick but erm, erm it's something that worries me a little bit [since menopause]" (Rose 549).

Participants tended to be teenagers when their mothers experienced menopause and they were able to recall memories of their mother's experiences. This could explain the reason for comparisons to physical changes, particularly hot flushes which may have been more visible or commented on. Comparisons made to, for example, bone health were being made in the knowledge that the health issues identified alter across the life course which participants subsequently linked to menopause. In making social comparisons to their mother's participants may also feel able to downplay their experience in the knowledge that a medical intervention such as HRT could be available if they felt 'symptoms' were unduly impacting on their lives.

Social comparisons with close friends or other known women were frequently made in forming judgements about the severity or relative ease of the menopause. The use of comparisons appeared to offer support by normalising shared experiences with other known women. The supportive nature of these relationships and the ability to make comparisons with each other were considered part of the shared and unique experience of the **"sisterhood"**:

"It always makes me smile when I see someone I think I know what's going on with you' erm.. I think there's, I think there's a sort of a sisterhood around it you know it's a shared experience" (Rose:437).

The conceptualisation that the experience of others was considered more severe than one's own appeared to result in a sense of relief. In making the social comparisons to others this allowed participants to rationalise their own experience as being less challenging than other women:

"I have a [group] I'm really, lots of [female] friends in the group, there's 7 of us and er we've been together for about 15 years and every time we get together recently [laughs] there's always been discussion about the menopause and and how the different women are coping with it erm and I have always felt erm you know I didn't have particularly heavily disastrous bleeding which one of them has experienced, I didn't have constant hot flushes which another one [friend experienced]" (Claire:34).

"... I say and comparatively I've had an easy time of it actually going through the menopause coz I have got friends who've used fans [I: yeah] for a decade you know because they're still having the sweats... and I never really did have sweats during the day" (Rose:191).

Interestingly Claire had described herself as having "some horrible, horrible hot flushes" but this was downplayed in the social comparison with a friend who had constant hot flushes. Similarly, rationalisation can be seen in the discussion with Rose, who had herself experienced flooding during a participative sport, and was used by other participants reinforcing the use of social comparisons as a cognitive coping strategy. The social comparison with a work colleague allows Rose to positively reframe her experience and describe it as "relatively unproblematic":

"I used to think 'thank god I'm not her' [work colleague] coz she used to just bleed, bleed, bleed " (Rose:333).

The nature of menopause being a uniquely female experience and the strong relationship built through the "sisterhood" provides opportunities for **making comparisons with other women** and normalising the experience. Through female connections participants were able to develop adaptive coping strategies such as empathy and the use of humour, to help navigate themselves through the menopause. Sharing experiences also enabled participants to gain knowledge from other women which is the focus of the final super-ordinate theme in the **women's business** higher order concept.

Super-Ordinate Theme: Women's Knowledge

The sharing of knowledge was an important aspect of the shared experience. Within this study it was apparent that the participants preferred to access knowledge and advice predominantly from women they knew, female relatives, friends and older women. **Women's knowledge** appeared to have a powerful impact on the participants' views and expectations of the menopause as part of a female journey. The biomedical perspective is reported in section 1.3.1 as the dominant discourse surrounding women's health in Western culture (Cahill 2001; Kelly 2008; Wiczorkowska 2012),

and reflecting this perspective the majority of participants (n=8) sought advice from at least one healthcare professional. Rather than being drawn into the role of being a patient requiring treatment, they were discerning in their decisions to follow or disregard advice. They did this according to the value they placed on the advice received from, predominantly GPs and the value of the advice was closely related to their care experiences.

Healthcare experiences during the first consultation about issues participants considered to be potentially menopause related had a direct impact on decisions to engage in further help-seeking behaviour. Experiences with, particularly male GPs were identified as having a negative impact through either not being taken seriously, not being listened to, or immediately being offered a medical intervention without consulting on the availability of alternatives management strategies:

"I went to a female doctor actually in the end and said "I want to be tested" and she said "yeah' cause the male doctor said "No", his actual words were "No, don't be ridiculous, you're too young!" [laughs] I was like "Mmm OK"... so as soon as I went to her [female GP] she was like "No you can" [have a blood test for menopause related hormone changes]" (Lisa:102).

"My [male] GP was my first point of call when it [vaginal prolapse] first started. I went to the GP and he said "Yes you have, you've got a grade 1 slash 2 [vaginal prolapse], it's not bulging too far out, try this pessary", so I tried and then I thought "I'm gonna research this, this can't be the answer" but then I bought myself a Kegel [pelvic floor exercise] machine, I started to use that [Kegel machine] morning and evening" (Sophie:199).

"He [GP] said "no it's just where you are in life" and I said "well it could be vaginitis, I wanna rule it out" and he said "I've examined you and I'm saying it's not" and I sort of went, I thought "Oh OK" but it wasn't [OK], I would have preferred to have seen a nurse to rule out everything, I thought it was quite a masculine slant on things" (Emma: 761).

In unpacking the term "quite a masculine slant on things" it is suggestive of broader power relationships between male healthcare professionals and female patients. Despite all participants in this study being a homogeneous group of well-educated women there was a reluctance to assert themselves and challenge the views of male doctors. This may be a result of patient perceptions that they are unable to challenge the knowledgeable medical practitioner along with concerns that issues related to the female bleeding, for example dysmenorrhea, menorrhagia and endometriosis, will be dismissed as being a 'normal' part of being a women (Tan et al. 2017; Rubinsky et al. 2018). The indifferent attitude appears to prevail despite all stages of the female lifecycle being drawn into the medical arena and subjected to a medical lens. It appears that medical discourse wishes to experience 'issues of blood' on its own terms rather than the terms of

the women interacting with medicine. The strength of the patriarchal relationship can be seen in the influence that, particularly, male GPs had in their interactions with participants. Whilst participants described themselves in the interviews as being more confident, having the right to say how they felt and being less worried about upsetting people, which I interpreted as having the confidence to be more assertive, this was not followed through in their interactions with male GPs. In describing their interactions with doctors, participants appeared to lack assertiveness and did not demonstrate the sense of the liberation described in other areas of life. The lack of communication resulted in decisions to seek support from female healthcare professionals:

“Well I'm sort of putting off coz the GP didn't seem that interested, he didn't seem to think it [osteoporosis] was a risk and I'm, you know I'm quite compliant like that, I do what I'm told but erm..... maybe it's something that erm I'll think about... next time I go to see the [female] practice nurse” (Rose:616).

The experience of not being listened to and taken seriously by male GP's resulted in anger and frustration which contributed to participants' preferring to consult women they knew or older women. For participants who experienced menopause before they were of 45 years old medical confirmation was essential in providing reassurance:

“It is [important to have a blood test], yeah it was to me because it [blood test] actually gave me some sort of of something some finality for me to say "actually now I'm moving from this stage of my life to the next" [I: mmm] and actually I have to deal with that [laughs]” (Lisa:975).

There was a perception that there would be more empathy and support from other midlife female professionals and this was reinforced following consultations. Only one participant, Kate, was positive when discussing her first contact with a GP about issues relating to menopause:

“I would say that of everybody that actually it's my [female] GP who's been the most help [I: Oh OK], which is probably unusual and surprising [laughs]” (Kate:824).

Kate laughed when she made the comment above recognising this may not be a common experience when discussing menopause related issues. This assumption was correct, when compared to the comments made to other participants by male GPs such as *“just live with it, it's your body's journey, go with it” (Emma:843)* and *“don't be ridiculous, you're too young!” (Lisa:104)*. GPs were perceived as having an important role in helping participants develop their knowledge. However, there was a distinct difference in the relationships with male and female GPs. Kate did not seek support from a male GP but her preconceptions sum up the experiences of

other participants both in relation to the knowledge or advice that is shared and GPs' interpersonal skills:

"I think just that..... she [female GP] actually knows about stuff [menopause], I suspect that a lot of other GPs who are not particularly interested in that area [menopause] will just be, I mean I've been to different GPs for different kinds of problems before and just very aware that their knowledge obviously has to be very broad but it's incredibly shallow in some areas and I just suspect that male GPs, if they're not interested in that area [menopause] will just know nothing erm so it's the level of knowledge and the fact that she listens properly, yeah." (Kate:604).

Within the higher order concept **Losses** (section 5.2) participants identified a lack of awareness about bodily changes indicating the menopause therefore it was a judicious decision to seek advice from a healthcare professional. Professional advice was important in confirming women's beliefs about their changing bodies, allaying fears about underlying pathology and giving them 'permission' to move from one life stage to the next. Although professional advice was sought the most important sources of information were known older women.

The sharing of knowledge from one generation to another appeared to be the most trusted way to gain information and knowledge despite easy access to electronic sources such as the Internet and social media. Intergenerational knowledge was passed on over a period of time often through observing older female relatives. Although they were not always accessible, mothers and their experiences appeared to have a central role in the construction of knowledge and this concurs with the findings of other studies (Morris and Symonds 2004; McCloskey 2012; Morgan et al. 2012). Participants acquired knowledge when they were younger and this often entered back into their consciousness as a result of a discussion with someone else about the menopause, which triggered a memory as articulated by one participant:

"My GP said to me once actually that kind of really made me think was 'well some women have this [flushes and sweats] for the rest of their lives'. I think we were talking about the flushes and the sweats then 'cause I had real problems with sweats [I: Right] erm and I thought 'arr' and that made me remember my mum again and thinking back to what my mum went through and I thought 'oh' 'cause maybe that's the case with her because we used to put it down to thyroid problems and but she always has this, always been warm when other people aren't [I: yeah] and also cold when you wouldn't think it's particularly cold so I'd kinda put that down to other things and then when my GP said that I thought 'arrh' so maybe it never finished for her and it's starting to feel like that might be the case for me as well!" (Kate:52).

In remembering the experience of relatives this resulted in making a comparison with the participants' own experience. Older **women's knowledge** and experience was clearly valued to help participants begin to contextualise their experiences once participants were aware they were experiencing the menopause themselves. Beforehand older women were not necessarily believed which may be a way of younger women coping with the negativity and stigma attached to the ageing process:

"...and I I never did use to believe that about my my auntie erm when she was hot [having a hot flush] it was like [I thought] "No, rubbish!" but erm you can't possibly feel that [I: mmm] hot [during a hot flush] but actually, yeah you can feel that hot! [laughs]" (Lisa:1501).

This poses a challenge in relation to timing the sharing of knowledge and giving women information that may help them prepare for the individualised experience of the menopause. Intergenerational knowledge across generations of female family members had an important role in knowledge acquisition once participants recognised changes related to menopause. This appeared to be the optimal time when participants were ready to hear about the menopause. Nevertheless, it does not help challenge the stigma related to female ageing which may have prevented participants being receptive to accessing early information that could promote their health and wellbeing and reduce anxiety that changes during the menopausal journey were pathological.

Knowledge was also gained from similar aged women who tended to be friends and work colleagues. The shared experience in generating knowledge closely interlinks with the super-ordinate themes "**sisterhood**" and **making comparisons with other women**. The ability to access knowledge and compare experiences from women who were experiencing or had experienced their own journey through menopause contributed to participants' knowledge and helped normalise the physiological changes:

"My experience of talking to other women it's similar, it's the whole thing about dryness your whole body dries up, your skin, your eyes" (Rose:221).

The need for reliable, early information about the menopause was articulated as important but there was clearly a tension between wanting to know and participants not wanting to believe that they were old enough to experience the menopause. This appeared to be closely linked to concerns about **loss of traditional notions of feminine identity** (section 5.2).

"I mean I do wish that there was so much more information out there [about the menopause] and it was open [talked about more] and things like that but but no would I have believed it was going to happen to me at 42? No probably not erm... but it would have been nice to have been sort of forewarned in a way but I I don't know, no I don't think so [I: mmm], I think we'd still be thinking, no that's [menopause journey] not happening to me, it can't be happening to me, you know, I'm not old enough or I'm not ready for this" (Lisa:1513).

Although all participants had access to academic journals as potential sources of information none of them used these skills to find out information about the menopause. There was a perception that the plethora of information available via the Internet lacked credibility and may have been a key reason why participants chose to visit their GP initially as a potential source of information and advice. Professional advice appeared to be viewed by participants as an adjunct to knowledge gained from other known women.

Discussion: Women's Business

Although there is an element of disbelief about journeying to and reaching menopause participants appeared to reconcile their feelings through the **"sisterhood": a shared female experience**. The **"sisterhood"** gave participants access to experiences which in turn provided the opportunity for **making comparisons with other women** and developing an understanding through other **women's knowledge**. The higher order concept: ***Women's business: The "stuff of legend" that can only be experienced and shared by women (Rose:278)*** demonstrates how women in this study contextualised, made sense of, and normalised their lived experiences via the solidarity of other similar age or older women.

The **"sisterhood"** and **"girls club"** was emphasised in the higher order concept **women's business**, with participants articulating that the menopause was considered as being not for men. Studies of other ethnic groups have found a belief that the shared experience is within, rather than across, ethnic groups. Im et al. (2010) recruited 20 black women to join an online forum with the aim of describing their menopause symptom experience. Following thematic analysis of the forum data Im et al. (2010) found a belief that only other black women could provide a shared understanding of the menopause. McCloskey (2012) discovered a similar view amongst Caucasian (n=14) and African American (n=5) women who believed their experiences differed, with Caucasian women being more concerned about the perception of ageing. However, despite differences there was a shared belief that only other women could empathise with this feminine experience. The Australian Aboriginal women (n=25) in Jurgenson et al.'s (2014) descriptive study exploring the

experience and impact of menopause found that women believed they should 'stick together' reflecting the importance of "**sisterhood**" in this study.

Where the majority of studies either focus generally on the experiences of menopause or on symptoms, unusually Mackey (2007) focuses on being well during the menopause. Mackey's phenomenological study of Australian postmenopausal women (n=18) identified that other women were a common comparison which helped them to judge their own experience to be both different and unproblematic. One study focuses solely on comparing and contrasting experiences of menopause for mothers and daughters. Utz (2011) found that, whilst mother's and daughter's physiological experience was similar, the expectations of how this should be managed was different. There was a tendency in Utz's study for daughters to medicalise the menopause and there was an expectation of symptom management through HRT. The participants in the study reported in this thesis, in comparing themselves to their mothers also focused on physical losses and reflected the strength of biomedical discourse.

The reluctance of some mothers to talk about their menopause experience is considered to be generational and was a key finding by Utz (2011). She found daughters born in 1950s were more open to discussing menopause than mothers born during the 1920s and 1930s. A finding within this study was the younger participants, aged 45-53 years, reported openly referring to the menopause as they grew up, with the youngest participant discussing menopause with her mother, including intimate relationships, which may be indicative of a generational shift, the change in social norms and the more recent impact of social media. Jack et al. (2019) identified in the qualitative part of their Australian mixed method study (n=48) that participants credited the 'baby boomer' generation in challenging the silence of menopause. Although the focus was the work context participants identified that discussion about menopause was becoming easier for successive generations.

Intergenerational changes were also noted by Utz (2011) relating to mother's and daughter's social construction of the menopause. Daughters reported that they are more likely to openly discuss their menopause with friends, co-workers and husbands, this finding was not reflected in the study reported in this thesis. Discussions with intimate partners were minimal keeping the menopause within the sphere of **women's business**. Participants appeared to value talking to women they felt would understand. This may be the strength of **Women's business**, not only in helping to normalise the experience but providing a wider female support network regardless of socio-economic class.

The lack of support from men was a key finding in this study with participants' finding male GPs unhelpful when approached about menopause related issues. Participants predominantly avoided having discussions with intimate partners, preferring to speak to other women, and if partner's made comments they appeared clumsy and unwelcome. Barriers to support were identified by Duffy et al. (2011) using focus groups to generate data from 14 UK women, aged 45-60 years old, exploring menopausal issues in the community. One of the barriers in seeking support was the view that society considered menopause as a joke or a taboo subject. Although they did not specifically expand on this point potentially one of the reasons for this could stem from societal attitudes to menstruation beginning at puberty. Allen et al. (2011) explored how male undergraduates in the USA learnt about menstruation by collecting written narratives about their experiences of menstruation from 23 men aged 18 to 24 years. Findings from this grounded theory study articulated views that menstruation was "shameful and gross" and that they remained uncomfortable talking about it as adults. They also identified that boys and men appear to readily joke about menstruation but as they mature it is critical to communicate more respectfully with women.

Discussions about the menopause shared with other women is reported in the literature, but discussions with male intimate partners less so (Elliott et al. 2002; Madden et al. 2010; Duffy et al. 2011). Liao et al. (2015) completed in-depth interviews with male partners (n=8) living in the UK, to explore their perspectives of their partner's menopause. Despite this small sample size, it is one of the few empirical studies reporting the views of men. Findings indicated that: male partners wanted to be involved and supportive but that they felt intimidated by the sexually intimate nature of the menopause leading to embarrassment, and that men used flippancy and humour to deflect from uncomfortable social interactions about menopause. Although there are few studies that have considered the views of men, those that have support the view that this is not a subject that is easily broached with intimate partners and is viewed as a taboo topic (Liao et al. 2015; Cacapava Rodolpho et al. 2016). This may be part of the reason participants in the study reported in this thesis preferred to seek solace from other women keeping the menopause within the realm of *women's business*. Moreover, the higher order concept *Women's business*, appears to be a key component of helping women to get to a point of acceptance of their changing selves.

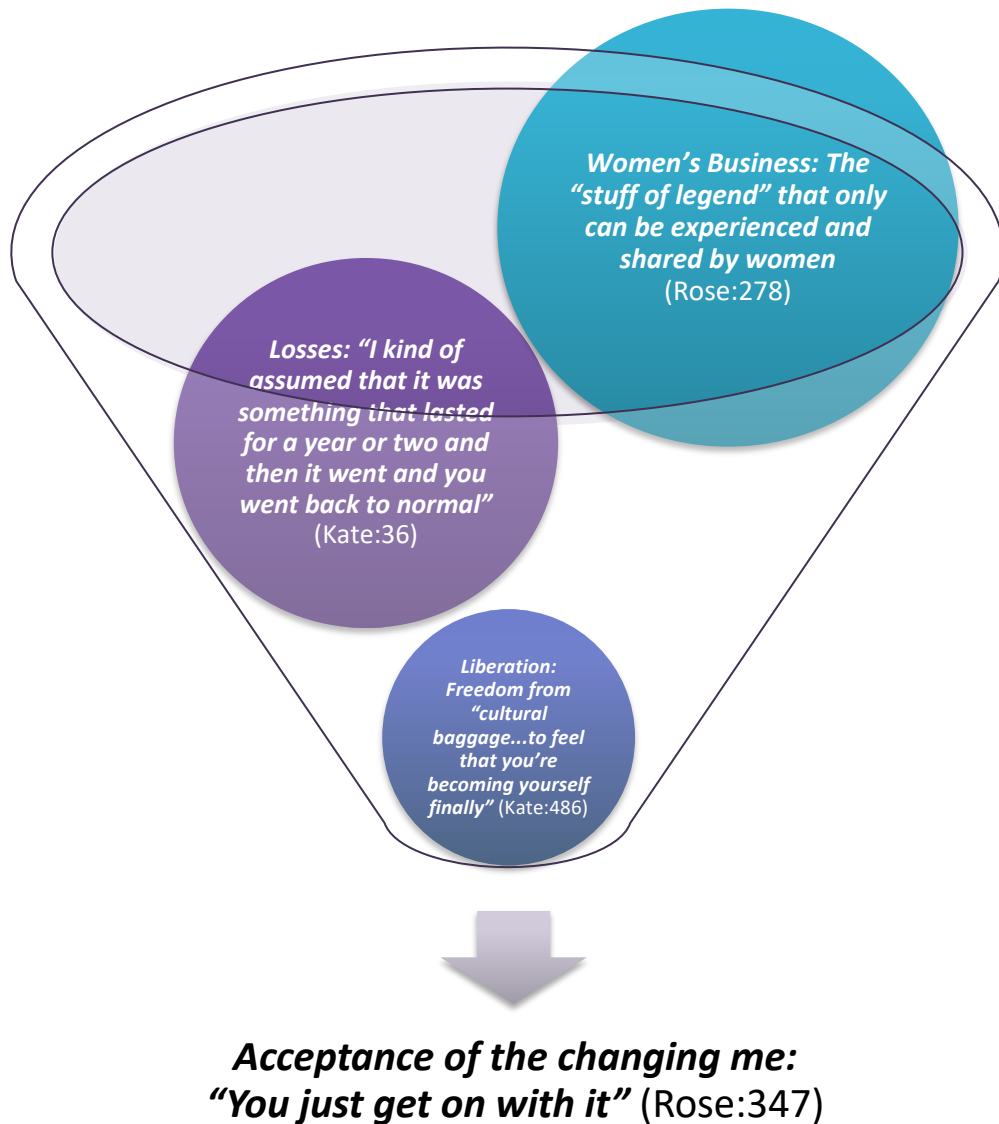
5.5 Acceptance of the changing me: "You just get on with it" (Rose:347)

Participants in this study articulated physical, biological, social and emotional changes that resulted in both *losses* and *liberation*. In making sense of their lived experiences they sought advice and support from other women. Although participants knew the menopause would

happen at some point, the lived experience expressed by participants was that the experience of menopause brought unanticipated changes that had no defined start or ending. The menopause was inextricably linked to the ageing process with all participants developing and accepting a new sense of self as their journey through menopause progressed.

The menopause affects all women who reach midlife but as reported in this study the lived experience is an individually nuanced experience that provided a reminder to stop and reflect on life, including considering the impact of becoming older. Although participants articulated disliking some changes, particularly physical changes, they also identified a positive impact albeit having less dominance than losses. The dominant higher order concept, *Women's business* was used to make sense of and navigate the menopause to help participants normalise their lived experience. Through sharing experiences with other women in the "sisterhood", participants made their experience visible undermining their sense of invisibility and "fading away" developing an acceptance of their new sense of self. This was encompassed by an overarching theme reflecting the lived experience of women in this study: Acceptance of the changing me and summed up by Rose as "you just get on with it" (Figure 5.2).

Figure 5.2 Acceptance of the changing me: “You just get on with it” (Rose:347)



Reaching an acceptance of the changing me appears to be achieved by both cognitive and behavioural processes over a period of time. There was a dominant view of the menopause as a shared female experience whereby participants in this study were able to make sense of their lived experiences by utilising the experiences of other women.

Sense making of menopause experiences took place at a cognitive level by; reflecting on *losses*, rationalising losses and gains (*women’s business*) and acknowledging *liberation* as part of the changing image of how participants saw themselves. Rationalisation has been suggested as a defence mechanism that detracts from engagement with mature adaptive coping strategies (Diehl et al. 2014; Simpson 2016). For participants rationalisation appeared to give them time and space

to begin to make sense of and normalise changes. This is similar to the description given by Stephenson et al. (2016) that a period of denial can give space to enable people to have time to cognitively adapt. The time taken to make sense of their menopause experiences speaks to a period of liminality described as being "neither here or there" (Turner 1969 p.359). The liminal space affords an opportunity to reflect, refocus on themselves with a new sense of understanding. All participants in this study reported the menopause as a time for reflecting on where they had been and what they still wished to achieve as illustrated by one participant:

"It's [menopause] given us [husband and herself] the courage and me the courage, it's given me the courage to think, whatever I do is going to be difficult and lets be spiteful [think about themselves] and take a new challenge" Claire: 585.

At a behavioural level sense making strategies included actively seeking views, knowledge and information to underpin the cognitive processes of rationalising losses. Exercise and the use of alternative therapies and HRT were some options to try to offset the physical changes. A problem-focused coping approach was used by participants to make changes to their lives which may also reflect the nature of their professional roles; using problem solving skills when working with service users and students. Lifestyle changes to improve their own health and wellbeing which might mean dietary changes, keeping fit through exercise or taking time to focus on themselves were strategies used. There was a view that being fit mentally and physically should have a positive impact something Sophie considered throughout her interview:

"I've always been fit and healthy, I'm a vegetarian, I eat a small amount of fish, I am a big exerciser, I still do a lot of exercise, I have holidays so I am... a good weight, I am, although I don't not drink at all, I am a non-smoker and things like that. I think I was very healthy when I hit the menopause and I think that also that mental attitude" (Sophie:110).

Sophie described her positive approach to the menopause which was suggestive of the "holistic approach" similar to that taken when considering the needs of the service user groups she worked with. Sophie appeared to care for herself "holistically" and in attending to her own needs this appeared to enhance her positive self-image. Solberg Nes (2016) argue that optimists are more likely to consider goals as achievable, invest more effort in achieving goals and are less likely to use avoidance strategies thereby increasing the chances of successful outcomes. A holistic perspective of menopause has been described as multidimensional and individual depending on the experiences, perspectives and expectations of the woman (Lindh-Åstrand et al. 2007).

While the medicalisation of menopause has led to a greater understanding of the biological changes that take place it has not resulted in a greater understanding of the lived experience of the menopause nor what is important to women in understanding this natural process. The findings reported here contribute to the slim body of knowledge seeking to understand how women make sense of their journey through menopause and use their experiences to fight for visibility and freedom from societal expectations. They demonstrate a tension between the 'cultural baggage' of female ageing related to Westernised views of youth and a feeling of liberation and freedom that is experienced during the menopause.

The three higher order concepts developed using IPA illustrate the lived experiences of the participants in this study and underpin the final overarching theme of 'acceptance of the changing me'. They demonstrate the complex nature of the journey to natural menopause and how participants made sense of their experiences to get to a point of acceptance of the a new 'normal'.

5.6 Answering the research question

The first study objective was to explore how women make sense of their transition to menopause and the meaning they attribute to their experiences within the context of their lives. Participants in this study clearly articulated the menopause as **women's business**. Through the sharing of experiences particularly with other similarly aged women who were part of the "**sisterhood**" participants began to normalise and make sense of their own menopause within the context of their lives.

The second objective was to understand the shared perspectives of women as they transition to menopause. The three higher order concepts **losses**, **liberation** and **women's business** and eight super-ordinate themes reported in this chapter represent the shared experiences of participants in this study.

This study asked the research question: *What are women's lived experiences of the transition to natural menopause?*

The findings presented have answered the research question by reporting the findings of an in-depth interpretative analysis of the lived experience of menopause as voiced by the participants in this study. In articulating their experiences participants did not refer to their lived experience in terms of a transition, rather as a complex, non-linear experience that was more akin to a journey. Menopause experiences started before and continued after the cessation of menses therefore

their experience was not a transition 'to' menopause but a journey 'through' menopause. The lived experience was reported as comprising of *losses* and *liberation* which were not balanced equally. *Losses* was more dominant than *liberation* but *losses* were counterbalanced by sharing with other women to make sense of their experience and keeping the menopause firmly within the realm of *women's business*.

5.7 Summary of Chapter Five

The findings in Chapter Five report the lived experiences of the participants in this study. Applying the methodology and methods of IPA has resulted in an in-depth interpretative analysis identifying and articulating the wide range of physical, social and emotional experiences that were linked to menopause discourses. Chapter Five has illustrated the shared perspectives and experiences of participants. All participants experienced *losses* as well as *liberation* as a consequence of their journey through menopause and key in facilitating how they made sense of their experience was talking to other women. There was a strong preference for conversations about the menopause to remain in the realm of *women's business*. The experiences of *losses*, *liberation* and *women's business* helped participants reach a sense of acceptance of their individual lived experiences.

The final chapter will report the contribution of this study to new knowledge, the implications of the findings and recommendations. Limitations to the study design will be discussed alongside a reflection on my personal development through the development, implementation and completion of the research presented in this thesis.

Chapter 6 **Conclusions**

The three higher order concepts and eight super-ordinate themes presented in Chapter Five have answered the research question *What are women's lived experiences of the transition to natural menopause?* The two research objectives i) To explore how women make sense of their transition to menopause and the meaning they attribute to their experiences within the context of their lives (section 5.4 and 5.5) and ii) To understand the shared perspectives of women as they transition to menopause (sections 5.2, 5.3 and 5.4) have been met.

Having answered the research question and achieved the research objectives in the previous chapter, Chapter Six will make statements around the contribution of this study to new knowledge, the considerations for clinical guidance and policy, future research and key recommendations. The limitations of the study will be discussed along with illustrating reflexivity as a tool to enhance the quality of naturalist inquiry, in particular the principles of sensitivity to context, transparency and coherence. The chapter concludes with a summary of this thesis.

6.1 Original Contribution to the Knowledge Base

6.1.1 New Knowledge

To my knowledge this is the first study to employ IPA as a methodological approach to answer the research question: *What are women's lived experiences of the transition to natural menopause?* The use of IPA, with its focus on the ideography of participants, enabled the explication of the lived experience of the women in this study presenting a competing argument to dominant perspectives that seek to explain women's experiences of the menopause as a linear, symptom laden experience.

The findings of the study make a novel contribution to the existing evidence base by offering an exploration of the menopause that is situated in women's lived experience. It challenges the predominant narrative in the existing literature which explains the female menopause in terms of a transition. This study found that the term 'transition' was not used by women to describe their experiences which suggests that transition has been imposed as a theoretical lens to explain women's experiences. The term 'transition' was not reflected in the language used by study participants, who viewed menopause as a journey, with no defined beginning or end.

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Findings from this study also showed how the use of language to describe menopause promoted and encouraged menopause to be viewed and experienced in a negative way and contributed to dominant Western cultural discourses situating youthfulness as desirable and rendering older women invisible. For example, participants found their opinions and ideas being ignored in meetings. A further finding was the dominance of language describing the 'symptoms' of menopause which has the effect of undermining any positive menopause experiences. This was frequently reinforced by interactions with GPs, particularly male GPs, whom participants in the study experienced as dismissive, uninterested and ill-informed. This included assumptions about the age of the onset of menopause that meant participants who did not fit into the perceived age range felt that their own views and perceptions about their bodies were ignored and sometimes trivialised.

A key contribution of this study is to 'give voice' to women's lived experiences to challenge preconceived notions of women's experiences of menopause which fail to take into account experiences that are also defined by a sense of liberation and freedom. While the natural menopause is experienced universally by midlife women who do not have surgical or chemical interventions, the lived experience of menopause is situated as a complex interplay between established Westernised views of youth and negative perceptions of female ageing.

6.1.2 Menopause as a Journey

A key contribution made by this research is that participants did not consider their experience in terms of a transition but instead a journey. Participants in this study reported a complex, non-linear, individualised experience extending before and after any recognisable start and end points articulated by both transition theories and staging models cited by authors such as Meleis et al. (2010) and Harlow et al. (2012). For example, STRAW+10 (Harlow et al. 2012) suggests a one to five year timeframe when vasomotor symptoms are most likely but when reading the staging system there is no mention of vasomotor symptoms two years after the FMP. The findings in this study articulate participants lived experience as akin to a journey rather than a straightforward linear process.

Transitions theory with its focus on moving from one stage to another (Bridges 2004; Meleis 2010) does not provide a useful framework to understand how all women experience menopause. The findings from the study reported in this thesis suggest there needs to be an alternate way for women to articulate their own experiences that isn't shaped and influenced by the dominant language which has been normalised into everyday understanding. While contemporary transition theory (Meleis 2010) recognises the complexity of changes across life stages, the first stage still requires recognition by the person that a change is taking place. The FMP is the only defined point

in the menopause experience and even that can only be identified retrospectively, dependent on participant record keeping. Even with this knowledge the participants in this thesis articulated the lived experience of menopause as complex, individualised and occurring over an unpredictable period of time.

This study has identified that the lived experience of participants differs from models which are proposed to illustrate their journey as series of time limited biological events such as the STRAW+10 staging system (Harlow et al. 2012). Participants lived experiences of physical changes were not described as a straightforward process with defined stages but were non-linear, messy and chaotic. Changes were most often only perceived as related to menopause and normalised through connecting with other women who were part of the "sisterhood" and able to share their personal experiences. The importance of the "sisterhood" was articulated as an essential informal network of support and a valuable source of experiential knowledge. The convergence across the group in articulating the menopause as a complex physical, emotional and social experience rather than a linear process was better described as a journey.

To understand the experiences of women requires a challenge to the dominant perspectives and narratives that characterise the menopause as a straightforward linear process. That will only happen with more research making the lived experience of women apparent within the current knowledge base promoting visibility, rather than the feeling voiced by participants in this study of becoming invisible and "fading away". The study reported in this thesis has focused on the experiences of nine, Western, well educated women. **Future research using the same methodology focusing on the phenomenon in different cultural and socioeconomic groups would provide a detailed, nuanced understanding of the lived experience of midlife women whose voices are also currently invisible in the literature.**

Although this study situates the journey through menopause as a uniquely female experience shared by the "sisterhood" there is a risk of excluding people who may experience the menopause but do not identify themselves as female. There has been a growing movement regarding gender identity and if menopause related research is framed only as women's business this population may be excluded. Their menopause may be experienced differently as a transgender or non-binary person but **future research using the same methodology would be valuable in developing our understanding of the menopause across different groups.**

Research is important in influencing a shift in attitudes and perceptions but it needs to be impactful and key messages translated to the wider public. This requires a multi-faceted approach

to include media and popular culture to move away from prevailing views about menopause that are not based on women's experience to ones that reflect their reality.

6.1.3 Healthcare Professionals' Interactions

A second key contribution this study makes to the knowledge base is the interactions of health professionals towards women's menopause experiences. Participants wanted advice, not just about HRT but to be able to make decisions about how best to manage their menopause. Primary care practitioners were perceived as an important and reliable source of information resource by participants in this study but conversations particularly with male GPs, did not meet their expectations. Participants reported an unwillingness or an inability on the part of male GPs to understand and explain their menopause experiences outside medical discourse.

The study reported in this thesis has identified that the lived experience of participants differs from the STRAW+10 staging system (Harlow et al. 2012) and contemporary transitions theory (Meleis 2010). Participants have described how their experiences also differ from the way the menopause is understood by healthcare professionals, namely GPs. Participants noted that gender appeared to influence GP behaviours, whereby they found male healthcare professionals were often dismissive, uninterested or ill-informed, articulating that some participants were too young for menopause. Dismissive behaviours were reported by participants who were neither the average age of 51 years for menopause (NCC-WCH 2015) or were not experiencing vasomotor 'symptoms' suggesting that guidelines were being rigidly imposed thereby limiting healthcare professionals understanding of women's menopause experiences. The STRAW+10 staging system (Soules et al. 2001; Harlow et al. 2012) and the subsequent NICE menopause guideline (NCC-WCH 2015) were developed to provide guidance, however this study suggests that they may be actively restricting healthcare professionals who apply a defined process rather than allowing their advice to be informed by open conversations with women about their individual lived experience.

Conversely female GPs and practice nurses' interpersonal skills were considered validating and empathetic supporting participants belief that they were knowledgeable and reinforcing the menopause as 'women's business'. Fundamentally participants in this study described the menopause as a physical, emotional and social experience viewing the menopause from an experiential perspective with the only valid knowledge being seen as being in the realm of 'women's business'. This highlights the importance of how knowledge is derived by healthcare practitioners and perceived by others. It may be that female clinicians use both experiential and medical knowledge to inform their practice drawing on other experiences of being a woman such as their own menopause or menstruation. Conversely, the unique nature of reproductive systems

means male professionals are not part of the "sisterhood" and are therefore viewed as reliant on predominantly medical knowledge and guidelines to inform their practice.

The NICE menopause guideline (NCC-WCH 2015) was updated in 2019 (NICE 2019a) clearly stating the importance of individualised care for women experiencing the menopause. However, there is no guidance about this in the menopause guideline itself which only refers the reader to another NICE guideline for patient experience in adult NHS services (NICE 2012). This essentially means the voices of women experiencing menopause are not articulated in the guideline that specifically addresses this topic. There is a focus on 'symptoms', diagnosis and hormone treatments thereby highlighting these as important for the practice of healthcare professionals. The result is that within a guideline specifically developed to guide healthcare professionals the voices of women experiencing menopause remains unheard illustrating a tension between biomedical discourse where 'menopause' is viewed as women sharing universal experiences and women's individual lived experiences as reported in this thesis.

The complex, non-linear experiences of women reported in this thesis do not fit into frameworks and guidelines that are rigidly applied by healthcare professionals. **A recommendation from this study is that to balance the focus on symptoms, diagnosis and treatment, the experiences of women need to be more clearly voiced within the guidelines and frameworks used by healthcare professionals.** This can be achieved through empirical studies using naturalist inquiry with methodologies and data analysis approaches that are grounded in the data and findings that are inductively informed.

The overriding finding in the study reported in this thesis was that those participants consulting a female healthcare professional about the menopause felt validated and supported. This may be because of the idea of "sisterhood" and 'women's business'. Participants may have a different starting point in their conversations because there is an expectation that the other woman is a 'sister' and will have some level of empathy and understanding of their experience.

The next step in our understanding is potentially for healthcare professionals to learn from each other. Therefore, **for future research a study comparing the experiences of women engaging with healthcare professionals of different genders to investigate if gender specifically impacts on the experiences of women when discussing menopause or if it is other elements of the interaction, for example communication skills that better confer empathy and validation.**

6.1.4 The Language of Menopause

Another key contribution reported in this thesis is the influence of language on how menopause is articulated and discussed. It is postulated that the use of language, written and spoken, influences subsequent discourse (Shahhoseiny 2013; McCarthy and Clancy 2019). McCarthy and Clancy (2019 p.3) defines discourse as having "meaning in context" with associated behaviours and actions attributed to the language used. Hvas and Gannik (2008a p.158) argue that "the words we choose are important, because they reflect values that colour and constitute what we are talking about" thereby representing cultural views. A number of cultures believe that with ageing comes maturity, wisdom and respect and was reflected in more positive views about becoming older (Cifcili et al. 2009; Jurgenson et al. 2014; Hakimi et al. 2016). The focus on symptoms and ageing reported in the findings in this thesis suggests there remains a need to change the language on menopause within Western societies to promote a culture of inclusivity.

The research reported in this thesis found convergence across the group, regardless of profession in the use of biomedical language used in shaping participants' views of physical change suggestive of a wider cultural acceptance. The use of biomedical language to describe 'symptoms' of the menopause places this personal journey into the medical domain as a disease (Kelly 2008). Physical changes such as hot flushes, menstrual changes and menstrual cycle irregularity, all of which are identified as 'normal' physiological changes (NCC-WCH 2015) were referred to as 'symptoms' by participants in this study. This biomedical language pathologises changes related to a normal life event.

The women in this study in articulating their lived experience discussed challenges characterised by the physical, emotional and social. Initially they talked about physical losses, giving the impression this was the most acceptable way to start the discussion and reinforcing the concordance with language associated with biomedical discourse in referring to changes as 'symptoms'. This was highlighted by the need to have medical confirmation that 'symptoms' were related to menopause or that menopause had occurred.

Hvas and Gannik (2008b) identified biomedical discourse as one of seven discourses used by women when talking about menopause (Table 6.1). The language used by participants reported in this thesis partially speaks to the findings of Hvas and Gannik (2008b) in constructing changes as 'symptoms'. Where there was divergence from Hvas's description of biomedical discourse was that participants viewed their GP as being best placed to offer advice and reassurance that physical 'symptoms' and emotional changes were related to menopause rather than assuming that medication was required to control 'symptoms'.

The language that constructs menopause experiences as 'symptoms' aligning with the biomedical model may be obscuring the experiences of women and suggestive a one-dimensional physiological experience rather than reflecting the non-linear, complex, individualised lived experience as voiced by women themselves in this study. Moreover, language to acknowledge menopause as an individualised emotional, social and physical experience supports Hvas and Gannik (2008b) more positive existential, feminist/critical or alternative discourses (Table 6.1) that views menopause as an uplifting, natural and positive process. Changing the language of healthcare professionals would acknowledge and validate women's experiences as pertinent, important and relevant therefore making it more accessible for people to discuss the topic of menopause in society as a whole.

The other use of language across the group aligns with Hvas and Gannik's (2008b) 'forever young discourse' (Table 6.1) but the findings reported in this thesis provide a more nuanced understanding of the lived experience of becoming older and "fading away". The feeling of "fading away" or becoming invisible was articulated as a physical, emotional and social experience which was reinforced by the behaviours of others resulting in participants feeling their voices were not being heard.

A starting point for change is to bring this invisible topic into the open and find a common shared language not just in relation to the anatomy and physiology of the female reproductive system but by increasing the visibility of women to talk about their experiences and have their voices heard. If the lived experience of menopause is not in the curriculum for the training of all healthcare professionals (doctors, nurses and allied healthcare professionals) how will the language of the lived experienced ever become visible across society? In seeking medical confirmation of menopause there is an opportunity to change the language surrounding it so that people are comfortable talking about and normalising experiences as part of their life journey.

A recommendation from this study is that there needs to be synchronicity of language used in guidelines and by healthcare professionals that mirrors the language used by women to describe their lived experiences. This will acknowledge and validate their experiences as pertinent and important.

Table 6.1 Hvas and Gannik (2008b) Seven Different Discourses for Menopause⁷

Discourse	Explanation
Biomedical discourse	Menopause is seen as a deficiency syndrome caused by declining hormones: menstruation stops, various symptoms occur and the risk of future diseases (especially osteoporosis) rises. Such discourse constructs menopausal women as patients who need medication if they want to maintain body control
'Forever young' discourse	Youth and youthfulness are admired and longevity is promoted, while ageing and old people are belittled and made invisible. Menopause is seen as a negative symbol of the ongoing ageing process; a threat to be counteracted by cosmetic surgery, moisturizers, hair colouring remedies and hormones. Hormones are seen as an age-retarding commodity, or a 'life elixir'
Health-promoting discourse	Good health and physical fitness are increasingly valued and promoted, and menopausal symptoms and risk of osteoporosis are seen to be modifiable by lifestyle changes. Menopausal women are obliged to be fit, to stop smoking and follow dietary recommendations
Consumer discourse	The women should be provided with information in order to make an 'informed choice'. Menopausal women are seen as active, informed and educated, having consumer rights, but they are encouraged to make their choice together with a physician, and can choose often only among choices set up by doctors
Alternative discourse	Menopause is seen as a natural and often positive process, but also as a passing imbalance, eventually straining the body. Symptoms caused by the imbalance could be treated with natural substances such as plants and tofu
Feminist/critical discourse	Menopause is seen as a natural period in women's lives that has become medicalized by the medical profession and international drug companies. Menopause is a neutral or positive transition, but severe symptoms could arise due to stressful events in women's lives. Treatment is seldom necessary, but it is important that women are well informed about bodily changes
Existential discourse	Menopause is uplifted to a process of self-discovery, a catalyst for change and personal growth. It is a question of being able to accept life 'of good and evil', with symptoms not necessarily being something negative, but a part of life itself. Menopause and ageing include a lot of possibilities like becoming more experienced and competent and having the confidence to hold on to one's own opinions. It is also a period of more freedom, with time to spend on one's own interests, and the possibility of becoming a grandmother

⁷ Reproduced from: Hvas L and Gannik DE (2008b) Discourses on menopause - Part II: How do women talk about menopause? *Health* 12(2): 177-192: with permission from SAGE Publishing

6.1.5 Considerations: Clinical Guidance and Policy

To date there is no UK Government policy that explicitly relates to women's experience of the menopause. Working women are covered by the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999 but these do not explicitly relate to menopause. The 2010 Equality Act lays out the responsibility of employers in the fair treatment of staff identifying nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation but not menopause. Unlike other aspects of the female life course such as maternal health, the potential needs of midlife women are largely invisible at this legislative level therefore guidance and policy has been left for development at an organisational level.

The concept of invisibility is further supported by the fact there is only one clinical guideline relating to the menopause which was first published in 2015 (NCC-WCH 2015) and updated in December 2019 (NICE 2019a). The updated guideline included areas where new evidence from clinical trials indicated an update was required which included urogenital atrophy and the long-term benefits of HRT. Although the guideline recommends an individualised approach and suggests that lifestyle advice should be given, the focus on RCTs to provide the best available evidence has resulted in a guideline that largely focused on drug interventions. Consideration is given to other therapeutic interventions such as CBT and acupuncture but any guidance about when to discuss the menopause is lacking. Given that the majority of participants in this study consulted a healthcare professional but articulated a sense of dissatisfaction about the response received, it is essential to give guidance to health professionals about when to engage in menopause discussions and the importance of listening to the voices of women so that they feel validated and supported.

The participants in this study reported that their experience of the menopause began before their FMP with the earliest changes noted as being around 40 years of age. Instead of menopause being seen by professionals as age specific it should be seen as a journey which is not defined by age and FMP. Regular health screening such as cervical smears and breast screening are potential opportunities for healthcare professionals to discuss menopause that do not appear to be taken up. The NICE Guideline for sexual health (NICE 2019b) suggests a list of key points of contact for healthcare professionals to raise the subject and a key criticism of the NICE Menopause guideline is that it does not provide similar guidance about when to instigate a conversation about

menopause. Many women may experience a straightforward and uneventful menopause but for those that have difficulties it is important they are supported.

Guidelines themselves though will not trigger opportunities for conversations. As the menopause is part of women's reproductive health and is viewed as 'women's business' a starting point for change may be through health and wellbeing checks such as cervical smears and mammograms. Furthermore, as these checks tend to be completed by a female clinician this affords an opportunity to listen to and validate the individual experience including advising and referring to other services as appropriate. **A recommendation from this study is the need to identify points in guidelines when a conversation will be triggered by healthcare professionals with women to normalise their lived experience.**

Since the publication of the NICE guideline for Menopause in 2015 (NCC-WCH 2015) a number of organisational policies have been developed for healthcare, and there has been increased parliamentary awareness with Members of Parliament such as Rachel Maclean raising for the first time, menopause related issues in the workplace at Prime Ministers Question Time (www.parliament.uk 2019). The discussions have not generated any white papers and therefore organisations have been left to develop their individual working strategies. A publication by Brewis et al. (2017) on behalf of the Department for Education exploring the effects of the menopause on women's economic participation in the UK was a key driver for the authors in calling for menopause policies and guidelines (Beck et al. 2019). The University of Leicester was the first UK university to introduce a menopause policy in November 2017 (University of Leicester 2017) having identified that employees experiencing menopause felt invisible, were being stereotyped and experienced gendered ageism. The staff experiences mirror the findings of the study reported in this thesis where participants articulated feeling invisible, "fading away" and being ignored, particularly in the workplace.

The number of policies and guidance have continued to develop across organisations and trade unions, some examples being the Royal College of Nursing (2019), the Wales TUC Cymru (2017) and UNISON (2019) to offer guidance for both union representatives and members. The key focus across these documents are to raise awareness of the menopause, highlight the impact work environments can have on the wellbeing of women and promote best practice for inclusivity. In early 2020 the Welsh TUC launched additional resources including posters, leaflets and a course for union representatives to complement their 2017 policy and to promote wider discussions about menopause within organisations. This is counter to the findings reported in this thesis where participants clearly articulated that the menopause was 'women's business' and their preferences were talking to other similarly aged women with experience of menopause. It is important therefore to consider the impact of promoting conversations amongst people more

generally if the view amongst women is that it is 'women's business' and may have the opposite effect of making women feel exposed rather than empowered. Beck et al. (2019) identified the need for a 'bottom up' approach to meeting the needs of women experiencing menopause ensuring that women themselves are empowered to promote change. The study findings reported in this thesis concur suggesting that women gain support predominantly from friends, work colleagues, family members and health professionals who are female and this should be respected within policies and guidance.

There is a continuing tension in relation to discussions about menopause because if women continue to believe that it is 'women's business' and is part of a "sisterhood" that can only be understood by other women there is a risk menopause will never become an open topic within society. Therefore, there will always be individuals who will only want to have a conversation with another woman but this does not necessarily move discussion of the menopause forward. It is difficult to make a generalised recommendation about how this can be managed but opportunities should be constructed within organisations which makes it easier to have conversations that are individualised, personalised and not considered a routine, tick box exercise to meet organisational objectives.

The NHS offers advice via the NHS Employers website about menopause drawing together guidance from other national organisations that have been working to raise awareness of menopause in the workplace such as ACAS (no date), the Chartered Institute for Personnel and Development (2019a) and the Faculty of Occupational Medicine of the Royal College of Physicians (No date). In 2017 77% of the NHS workforce was reported to be female (NHS Digital) with 54,904 nurses between the ages of 45 and 55 years (NHS Digital 2019), the key age range for women to experience the menopause. As a large employer of women in the UK there has been very little reported in the literature about how the NHS can accommodate the needs of a largely female workforce. Although there has been research exploring menopause at work, such as Hardy et al. (2018b), Beck et al. (2020), Griffiths and Hunter (2015) nursing specific studies tend to focus on the experience of becoming older more generally (see for example: Andrews et al. 2005; Phillips and Miltner 2015; Ryan et al. 2017) and do not include discussions about the menopause. Banks (2019) published her NHS Trust strategy for supporting women experiencing menopause at work to be achieved through the development of guidelines, awareness raising via regular communications, social media and monthly menopause support groups. **A recommendation for future research would be to use IPA to explore and better understand the lived experienced of different groups of professional women and female support staff.** More research using similar

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methodologies would enhance our understanding of the convergence and divergence across different groups of working women, providing a detailed and nuanced analysis of the lived experience of menopause for contemporary women.

The Chartered Institute of Personnel and Development (CIPD), the professional body for human resources in the UK, also have a detailed guide for supporting women through the menopause at work which was launched in March 2019 (Chartered Institute for Personnel and Development 2019b). The aim of the CIPD guide is to promote inclusive work environments in which managers and employees are able to confidently discuss any adjustments that may be needed. The essence throughout is that older women are growing as a significant section of the workforce and by fostering age and gender inclusivity there are opportunities to attract and retain valuable skills. The experiences of participants articulated in this thesis would support the work of the CIPD as they reported they were not listened to by some colleagues as they become older and attributed this to declining fertility and a feeling of invisibility and "fading away".

Because policies exist, it does not necessarily follow that changes in attitudes and behaviours happen automatically. Whilst policies and guidelines should help to begin to acknowledge the challenging experiences of some women Beck et al. (2019) identified that policy is not enough to challenge assumptions and stereotypical views of menopausal women or negate the impact of unconscious bias which was reflected in their menopause survey in 2018 (N=5,399). Managers need excellent interpersonal skills with an interest in their workforce not just from an organisational perspective but at an individual level. The communications skills of employers/managers were one of three themes identified by Hardy et al. (2017) in their qualitative online survey (n=137), with non-verbal skills and empathy being considered most desirable. Moreover this aligns with leadership and change theory in identifying a key component of successful organisational change as being able to understand and validate people as individuals and meet their needs (Hersey et al. 2000; Adair 2003; Bridges 2003).

Inclusivity for women experiencing menopause should be seen as a priority for employers as it can lead to a boost in economic participation rather than a loss of talent within the workforce. Changes in policy that do not lead to action or trigger opportunities for conversations may be considered tokenistic. Policy development is key in raising menopause at an organisational level but those policies need to be operationalised to embed them and effectively support change in the work setting.

6.1.6 Considerations: Organisational Policy Implementation

Organisational policy in and of itself is unlikely to change behaviours and attitudes as successful change requires a range of strategies to maximise engagement (Kotter 1996; Bridges 2003). A range of approaches to implementation some of which are empirically informed, have been used to raise awareness of the menopause.

Of note is that the Police Federations of England and Wales completed a menopause survey in November 2018 (n=6315) finding that 76% of women who had experienced or were currently experiencing menopause found changes impacted their work. This survey led to the generation of national guidance (NPCC Menopause Action Group/PFEW 2019) on how the service should make reasonable adjustments in response to employees experiencing the menopause. Guidance included environmental factors such as the impact of inadequate ventilation, improving access to cold drinking water as well as considering the suitability of uniforms and working with men. The overall aim was to provide advice for employees, managers and occupational health advisors to inform reasonable adjustments to support staff, increase openness, reduce sickness absence and improve productivity of staff.

A range of organisations, including some Universities, Councils and NHS Trusts, are using the Menopause Cafe for staff to access as a means of breaking the silence around menopause and women accessing peer support. A key finding in the research reported in this thesis was that participants considered the menopause 'women's business' preferring to speak with other similarly aged women. It is important therefore that any support provides a space that is respectful to this while acknowledging there is a tension in broadening peoples understanding and normalising the menopause if it is never discussed outside of the "sisterhood". However, in accepting that some women will only want to speak to another woman the Menopause Cafe, a charity founded by Rachel Weiss in 2017 provides an opportunity for organisations to facilitate a space to talk about menopause (Weiss 2017). Although the cafe is not exclusively for women only 2% of attendees identify as male (Weiss 2020). The cafe movement has grown predominantly within the UK and Canada with over one hundred UK Menopause Cafes in the last year (2019/2020) with a presence on social media sites such as Twitter, Facebook and Instagram. The supportive approach has also proved flexible, enabling ongoing support via online cafes during the global COVID19 pandemic that prevented face to face meetings for a significant period of time from March 2020. Even with the challenges of a pandemic the importance of menopause cafes seem to be relevant as they have continued in this format when face to face interactions are

difficult or even legislated against. **Cafes appear to be beneficial because they have continued online but how they benefit the individual would be an important piece of empirical work in the future to understand the component parts that are seen as beneficial and supportive.** Using positivist and naturalist inquiry to identify the positive components and understand how they support women would allow for consideration of the transferability to other organisations while maximising support for women.

Some organisations are using campaigns to raise awareness such as the University of Leicester's 'aware, care and confident to act' initiative (Beck et al. 2019) and the Primary Care Women's Health Forum called 'Rock my Menopause'. In May 2019 BBC Breakfast had a 'wake up to the menopause' campaign to raise awareness aiming to break the taboo by getting people talking through Twitter using the hashtag #BBCMenopause (BBC Menopause 2019). Although this was not exclusively for women it was predominantly women that contributed, aligning with the findings of the research reported in this thesis that women value the knowledge of other women in the "sisterhood" who share their experiences placing the menopause firmly in the realm of 'women's business'. Information from the Internet and social media as well as more traditional sources such as books, journals and magazines are widely available. For an example of websites see <https://healthtalk.org/menopause/overview>, <https://www.menopausematters.co.uk/>, or on Twitter Social media @megsmpause, @Menopause_Cafe or #Menopause for a full range of related Tweets although to date while organisations are using social media it does not appear to be empirically informed and therefore evidence remains anecdotal about the support these offer.

It would be beneficial for future mixed methods research to explore the use of social media amongst women along with the benefits and challenges. The global COVID19 pandemic may have changed the way women access support persuading women who would ordinarily prefer face to face contact to access online modes of support due to the lack of availability of the former. Having empirical evidence about the use and usefulness of different media either as an alternative or an adjunct to face to face support could help organisations more effectively use the resources they have to maximise support and organisational change.

As well as campaigns there are more formalised organisational approaches to raising awareness amongst staff with training and support for managers (Chartered Institute for Personnel and Development 2019b). An internet search for 'menopause training' finds a plethora of businesses offering online and face to face courses to organisations but without necessarily having robust evidence-based evaluation of the impact. Hardy et al. (2019) developed and evaluated a 30 minute web based/online resource to raise awareness of menopause among line managers. The findings based on pre (n=98), immediately post (n=62) and four weeks post (n=61) training suggested increased knowledge and confidence of line managers in talking about menopause.

Empirical evaluation is essential in ensuring that training is effective in facilitating change rather than becoming an organisational tick box exercise.

The contribution of this first study using IPA as a methodology was to challenge preconceived notions of menopause and make visible the lived experiences of the nine women who took part in this study. Implementing the recommendations for developing our knowledge of the journey through menopause, including interactions with healthcare professional, clinical guidance and the implementation of support through organisational policy would acknowledge and validate the voices of women and their lived experience.

6.2 Limitations of this Study

This section discusses the challenges and limitations of the study starting with the challenges to the process of recruitment and the resultant learning. Recruitment to any study is key to ensuring data collection can take place and influences the whole study. Reflecting on the experiences of this study and learning from them is key for the development the recruitment strategies for future research.

6.2.1 Key Challenges to the Research Process

Recruitment:

Setting up recruitment with the GP practice was a significant amount of work. Despite engaging with the stakeholders and service provider from the inception of the study there was a lack of integrated knowledge about their own systems and the data held within them. It was not until recruitment was being operationalised that it became evident that they did not hold the information required regarding mental health diagnoses to invite potential participants to the study. A key learning point from this for the future is to ensure there is a pilot with the service provider to test that the information available aligns with the study recruitment requirements. This could have been completed by the practice manager therefore avoiding any ethical issues before the first submission for ethical approval. This would have saved a significant amount of work and allowed for early identification that an additional recruitment site was required.

In view of the problems in identifying potential participants to recruitment via the GP surgery, and following a review of the literature and discussion with supervisors the decision to explore the lived experiences of the menopause from the perspectives of women and their partners was

agreed as this was a specific gap in the literature. Partner participants, male or female, were included in new recruitment strategies as evidence from the limited available literature suggested that men in the UK perceive that the menopause is a taboo subject (Liao et al. 2015) and evidence reporting that women experiencing the menopause lack partner support (Jurgenson et al. 2014; Mackey et al. 2014). Therefore, a new recruitment strategy was put in place which included partners.

Limitations: recruitment process: use of posters seeking participants and partners

Advertising the study: Posters

In view of the GP surgery not being able to provide an effective recruitment pathway I advertised the study using posters (Appendix D). The posters were placed in the GP reception, waiting area and on the back of the toilet door. Within the university they were placed on the back of the toilet doors in male, female and disabled toilet doors and beside the hand dryers in two of the largest faculties, the main cafe and the bar. Each poster was left in place for two weeks with recruitment taking place over a total period of eight weeks. Reflecting on the recruitment process, and particularly the posters, I would have given them more clarity, for example: clearly stating exactly who I wanted to recruit and the precise timeframe for the FMP rather than a range.

The recruitment posters (Appendices D and H) stated the study was seeking male and female 'partners' and whilst not excluding same sex couples it needed to be clear that I was looking for partners regardless of gender orientation. In line with gendered norms I had written about recruiting male and female participants and due to this specificity potential participants may have been put off coming forward to the study. Ellard-Gray et al. (2015) argue for the use of wide range of labels to help participants identify with the eligibility criteria. Therefore specifically targeting partners who were lesbian, gay, bisexual, transgender, queer, plus other sexual identities (LGBTQ+) or heterosexual may have generated more interest.

The aim of a poster is to appeal to the target group and given the lack of uptake from partners it may have been that partners did not immediately relate to the title 'participants needed for menopause research'. Partner recruitment may have been more successful with a separate poster to specifically appeal to them for example headed with: 'Partner experiencing menopause? If so come and tell us about it'. The change may have assisted the target group to relate to the request, a strategy effectively used by other researchers to appeal to specific potential participants (Grov et al. 2009; Ellard-Gray et al. 2015). The main reason articulated by female participants in the study reported in this thesis as a reason for making an initial enquiry about joining was they made a connection with the poster request and wanted to come and talk about their menopause experiences.

In reviewing this outcome to recruitment my assumption that partners would come forward as a result of being partners of the women interviewed was misplaced. Liao et al. (2015) recruited seven of his eight participants via colleagues, friends and acquaintances with no participants responding to advertisements. Law (2019) also reports that the most effective strategy in recruiting men to her reproduction study was through female informal gatekeepers who were the known to the researcher. Both studies use informal networks which I did not do and given the small sample size recruiting partners through participants was in hindsight an incorrect assumption.

Despite interest being expressed by participant partners, only one male partner made contact in response to a recruitment e-mail sent using a 'snowball technique' using participants already recruited to the study to identify people, in this case partners, who might participate in the study (Creswell 2013). On completion of a very challenging interview with the participant avoiding menopause related questions (moving the conversation to topics such as: football, work and friends) and following a review of the interview by my supervisors, the interview was not included in the analysis. During the interview I spent time summarising the participant's conversation and then trying to return it to the subject of the menopause, for example when talking about watching football in the pub with male friends asking what they discussed about the menopause. The conversation quickly moved onto other topics concurring with the findings of other studies that men are uncomfortable with discussions about menstruation and menopause (Allen et al. 2011; Liao et al. 2015).

The recruitment for phase two was more successful in recruiting women over a more condensed period of time. Posters were used in the same way but principles of snowball recruitment were applied to try to increase the sample size in phase two of the study.

The key learning points from this study and recommendations for other researchers are to:

- Use multiple recruitment strategies.
- Use different posters for recruiting different groups. Potentially, in this study, a poster for women experiencing menopause and a separate poster for recruiting partners.
- Utilise available networks such as colleagues.

Incentives for participants: It is reported that incentives can increase participation in research studies (Head 2009; Kelly et al. 2017; Parkinson et al. 2019). Kelly et al. (2017) in their experimental design study (n=4136) identified that participants were more willing to participate in

Chapter 6

studies offering monetary incentives compared to other incentives. Zutlevics (2016) argues that financial incentives may artificially skew results by attracting participants motivated by self-gain and may discourage participants who take part out of altruism. Evidence suggests that there is no clear convention in deciding to offer financial incentives and ethical research practice means incentives need careful consideration ensuring that they do not result in undue inducements or coercion and must receive ethical approval (Head 2009; Health Research Authority 2014). Incentives were considered but in this PhD project there was no funding available.

Interview options: The posters indicated how long interviews may take, but not the means by which interviews could be undertaken. This may have put off potential participants who may have assumed it would be a face to face interview and preferred not to do this (in view of recruitment being in my place of work). Clearly stating the options for the interview venue or a telephone interview may have generated more participation. The lack of visual cues and emotional distance provided by telephone interviews may have generated more confidence, reduced any potential embarrassment and generated a feeling of anonymity (Trier-Bieniek 2012; Chanakira et al. 2014; Mealer and Jones 2014). Data collection using both face to face and telephone interviewing allows for the elicitation of participants stories and the facilitation of open dialogue which was essential to capture participants lived experiences in this study. A key learning point is to ensure that the available options are made clear and in future research I would also explore the use of other online technologies such as Microsoft Teams and Zoom which have become more widely used by academics and the public since the COVID19 pandemic.

Limitations: outcomes of recruitment

Nine well educated professional women agreed to participate in the study, five in the first round of recruitment (April-June 2017) and four from the second (Sept-Nov 2019). Participants were all either married or in long term relationships with male partners and lived in the south of the UK. Demographically the group were more similar than dissimilar resulting in a homogenous sample which is argued as beneficial in facilitating an in-depth analysis of a phenomenon within a particular context (Smith et al. 2009; Bazeley 2013). While homogeneity allows for the identification of convergence and divergence within the particular context of the group it does not result in the comparisons and generalisations that may be seen in heterogenous studies and larger sample sizes (Ayres 2007; Bazeley 2013). A broader sample may have gained more non-western, cross cultural views or perspectives from different sociodemographic groups but the principles of IPA are to gain a detailed nuanced understanding in a particular context. Therefore further research using the same methodology would be valuable in representing the lived experiences of menopause for women in other contexts.

Seven women were in early postmenopause STRAW+10 stages +1b and +1c and two participants were considered to be in late postmenopause (STRAW+10 stage +2). Of the nine participants two had experienced an early menopause, defined by the NICE Menopause guideline (NCC-WCH 2015) as being between 40 and 45 years old. These experiences had potential to impact on the research as the participants lived experience of early menopause may have been different as younger women but the findings still demonstrated more convergence than divergence with the lived experience of menopause across the group.

The sample size of this study (section 3.5.3) is similar to the sample sizes within other published IPA studies (O'Mullan et al. 2017; Jacobs et al. 2018; Burton 2020). Some may perceive the small sample size as a limitation however Smith et al. (2009) does not because of the ideographic focus in IPA. Smith et al. (2009) argues that larger datasets inhibit the ideographic commitment and can lead to superficial analysis.

As indicated by examiners at submission of thesis and viva, a second round of recruitment was requested due to the small sample size and the variation of the FMP. This second round of data collection and analysis proved beneficial as the 52 themes from the first phase of data collection could be reviewed against new data. This review confirmed that the identified themes were trustworthy and credible and that they were sufficient (Dey 1999) in explaining the sense making of participants as they journey through their menopause.

6.3 Reflexivity

Reflexivity is considered an important part of ensuring quality in interpretative research which is reliant on the subjective interpretation of the researcher (Yardley 2000; Walsh and Downe 2006). It contributes to the principles of transparency and rigour in the Yardley (2000) quality assessment framework (Table 3.2) forming part of the overall audit trail presented in this thesis. Being 'reflexive' is described by Shaw (2010 p.243) as "an explicit evaluation of the self" completed by the researcher to learn about themselves and their impact on the research process. Reflexivity can reveal how the researcher views the world and make explicit their assumptions requiring them make available details about themselves and their background, biases and preconceptions (Mauthner and Doucet 2003; Clancy 2013).

Tools to facilitate reflexivity:

Methodological rigour: Maintaining an idiographic focus (one of the three theoretical foundations of IPA) can assist the researcher in thinking and considering new perspectives drawn from “stepping inside and outside” of the researchers thinking (Goldspink and Engward 2018 p.4). In interpretative research interpretations are influenced by the particular cultural, social and political perspectives of the researcher as well as their gender and socio-economic class and these need to be transparent. Relevant to the context of this research for example, I am married, heterosexual, mid-life, female healthcare professional working in higher education. Having an understanding of these ‘positions’ adds to the methodological rigour providing transparency to situate both the researcher's interpretations and the subsequent writing within a particular stance (Shaw 2010; Berger 2013; Creswell 2013).

Furthermore, the epistemological stance guiding the research will also be influential and therefore needs to be transparent with assumptions articulated. My initial assumption had been that once women experience the cessation of menses that this would be the end of their menopause and that they would perceive menopause negatively in line with the biophysical/symptomology articulated in the literature. I did not initially question my thinking because the literature reinforced this belief which was further informed by the STRAW+10 staging system for reproductive ageing (Harlow et al. 2012) and the NICE Menopause guideline (NCC-WCH 2015). It was only when I was challenged by my research supervisors in the development of the interview guide that I became conscious of my ‘assumptions’ and how they had the potential to lead the interview in a certain direction. A useful method of capturing ‘assumption’ and ‘foreknowledge’ is the use of a reflexive journal.

Reflexive journal: A reflexive journal is a tool used by the researcher to record their thoughts, feelings and ideas to aid in developing their understanding of self (Vicary et al. 2017). There were times when reading through the journal allowed me to see more clearly the negative preconceptions I had in relation to menstruation being an annoyance and menopause being a time of negative experiences. Until challenged by my supervisors, I had not noticed these views around menopause:

“The questions were also portraying a number of underlying assumptions, and in particular my beliefs that the menopause is a negative experience and that women seek help. This in turn may have been reinforcing a medicalised view of a normal stage in a woman’s life cycle, which was something I was trying to avoid. I have not really considered that in asking questions we may already be carrying prejudgment and that this may influence how we hear the answers to our

questions. This is discussed by Moran (2000) as the hermeneutical structure of the question" (Journal excerpt April 2016).

The use of a reflexive journal enabled me to record and revisit thoughts and feelings which helped me realise the influence of my early nursing experiences and the dominance of the medical model at that time. I wanted to view the data through a feminist lens which required me to be mindful of the influence of the dominant biomedical discourse on both participants' and my own interpretation throughout the data analysis. In recognising and acknowledging these it helped me to consider the impact not just in asking and responding to questions during interviews, but the potential influence personal views may have on data analysis.

Reflexive journal and data analysis: Using a journal enabled the articulation of frustrations knowing that they were recorded so that they could be set aside in the moment of data analysis but revisited later to consider the potential impact on the interpretation of the data. Use of the journal facilitated reflection from an insider (emic) and an outsider (etic) perspective. Hayfield and Huxley (2015) argue that the researcher may occupy both an emic and etic stance simultaneously depending on their personal situation, history, training and interest in the topic being researched. Sharing an emic position (I was a similar age to five participants, I am a woman, white and heterosexual) was beneficial in building rapport with participants (Corbin Dwyer and Buckle 2009; Hayfield and Huxley 2015), however as I was perimenopausal rather than having reached menopause, I had an etic stance to the experience being shared with me by participants. I had no personal experience to draw on and so adopted an etic stance in questioning, avoiding assumptions and trying to gain a shared understanding (Corbin Dwyer and Buckle 2009; Hayfield and Huxley 2015).

Being perceived as an 'insider' (due to a shared health and education background) raised benefits and challenges. Benefits included a shared language which appeared to build rapport and allow for relaxed conversations. This led to some participants sharing extremely sensitive stories, an issue identified by authors (Watts 2006; Berger 2013) as a potential area of vulnerability for participants in disclosing more than they intended. During data analysis I noted:

"There are times when I feel sad, angry and relieved as she reveals the situation [details removed] and how she extracted herself from the situation. The participant is very matter of fact about the situation and how this has shaped her as the person she is" (Journal excerpt December 2017).

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Reflexivity is important in facilitating the recognition of not just thoughts but emotions which can influence data analysis if unrecognised (Berger 2013). I felt well prepared for the emotional labour during interviews but I was unprepared to feel the emotional connection when listening to interviews during transcription or when during data analysis. Keeping a record during analysis facilitated the exploration of thoughts, feeling and emotions during research supervision in considering how these may be affecting the data and shaping the findings.

Reflexivity is part of the detailed audit trail and a marker for quality assessment (transparency and coherence) in interpretative research (Yardley 2000). To meet the requirements for transparency, coherence and maintaining an idiographic focus this section has given insight into my worldview as this is argued to affect the perspective by which interpretations are made (Shaw 2010).

Goldspink and Engward (2018) highlight the importance of evidencing that interpretations are “grounded in the participant’s life world” (Goldspink and Engward 2018 p.2), particularly when the data resonates with the researcher’s life. This was an important aspect of maintaining a reflexive journal and discussing journal entries with research supervisors given some of the similarities demonstrated in the insider perspective. In IPA the relationship between the researcher and the participant are integral to the research process along with their assumptions and preconceptions (Clancy 2013; Tuohy et al. 2013).

Personal Journey:

The long duration of this part time research journey which commenced in 2011 resulted in a number of challenges. The supervisory team changed completely during 2015/2016 starting with the loss of my primary supervisor who was subsequently replaced by my secondary supervisor. Within a relatively short period of time the new primary supervisor left the organisation resulting in the recently introduced secondary supervisor stepping into the primary role and a further secondary supervisor joining the team in 2016. The changes took place at a key point when the recruitment strategy with the GP practice was taking place bringing new expectations and views that needed to be negotiated. While in the long term the changes were beneficial at the time they brought about uncertainty and change requiring the building of new relationships.

The overall process of planning, implementing, writing the findings and reflecting on the learning has occurred over the process of several years developing my skills as a qualitative researcher. Completing this thesis has resulted in challenging my views on menstruation, menopause and my attitude to the female body. Along with this has been a consideration of a personal motivation of wanting to make a positive difference to women’s lives by making a contribution to heightening awareness of an invisible part of a woman's reproductive journey.

6.4 Overall Summary

Overall this thesis has provided an in-depth audit trail of my PhD research journey forming an essential record to assess the quality of this IPA study. This has been achieved by providing a detailed record in each chapter.

Chapter One introduced the study phenomenon, the menopause within a historical and contemporary context by considering the discovery of female sex hormones, the impact of the development of hormones to control women's 'normal' reproductive health, along with controversy that has often accompanied these developments. Having situated the study, Chapter One has also presented the research question and objectives.

Chapter Two presented a detailed exploration of the qualitative literature and the extent to which the lived experience of the menopause has been studied in the literature since 2002 using Arksey and O'Malley's (2005) scoping review framework and incorporating the three-step search strategy recommended by The Joanna Briggs Institute (2015). The scoping review identified a global but limited view of what is known about the lived experience of the menopause with no researchers using IPA to explore the phenomena within the context of women's lives.

The chosen methodology, IPA and the research design are presented in Chapter Three articulating the decision-making process followed by a detailed record of data analysis using the six steps suggested by Smith et al. (2009) in Chapter Four. Data analysis is illustrated by one theme, **women's business** to demonstrate the analytical process from inception to the finalisation of the higher order concepts.

Chapter Five presented the three higher order concepts, cross-case super-ordinate themes and a discussion of the findings. The findings represent the double hermeneutic of the researcher's interpretations using exemplar quotes to illustrate the ideographic focus. The discussion considered the Hvas and Gannik (2008b) seven discourses of menopause and the dominance of some discourses over others.

This final chapter has discussed the implications of the key findings, the methodological limitations and what has been learnt from the challenges experienced in the study since the part-time PhD journey commenced in 2011. Chapter Six also provides an account of reflexivity and how it has contributed to the research process, including personal development.

Chapter 6

The aim of this IPA study was to gain an in-depth understanding of the lived experiences of women undergoing a natural menopause, as well as answering the overall research question:

What are women's lived experiences of the transition to natural menopause?

The research objectives have been achieved delivering an IPA study which has generated an in-depth idiographic exploration of the participants experience of the phenomena, natural menopause. By looking at the parts and the whole this thesis has generated three higher order concepts capturing participants lived experiences, ***Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal"*** (Kate:36), ***Liberation: Freedom from "cultural baggage...to feel that you're becoming yourself finally"*** (Kate:486) and ***Women's Business: The "stuff of legend" that only can be experienced and shared by women*** (Rose:278), which are encapsulated by the overarching theme of ***Acceptance of the changing me: "You just get on with it"*** (Rose:347).

The findings reported in this thesis show that while the menopause is experienced universally the menopause is not a universal experience. It was a unique, non-linear individual journey that for the women in this study had no defined beginning or end. In considering the stories of women the findings in this study 'give voice' to their lived experiences of menopause.

Appendices A to R

Appendix A Upgrade Scoping Review Database Search

Upgrade Scoping Review Database Search Using Full Text or Abstract Field Search

Objective	Database	Number of articles AB = Abstract field search TI = Title field search	Number of articles TX = Full text field search TS = Topic field search
To explore the lived experience of women during the menopausal transition.	CINAHL plus with full text:	110 AB	296 TX
	Medline	239 AB	336 TX
	PsycINFO	78 AB	121 TX
	AMED	2 AB	4 TX
	Web of Science	79 TI	461 TS

Appendix B Excluded Scoping Review Studies

Codes: reasons for exclusion:

1. Abstract only: 4
2. Not in English: 4
3. Poor translation: 1
4. Not lived experience: 14
5. Data pre 2002: 14
6. Not enough detail: 2
7. Not menopause transition: 4

Author	Title	Code
Agee (2003)	Menopause and the transmission of women's knowledge: African American and White women's perspectives	4
Alidoosti et al. (2012)	Qualitative inquiry into women's menopause experiences in southeastern Iran	6
Araya et al. (2017)	Menopause, the beginning of aging for Chilean women: A qualitative study	6
Arpanantikul (2003)	Midlife transition: reflection from Thai women living between two cultures	7
Bahri et al. (2018)	In the limbo of fear and hope": How iranian women perceive menopause? an exploratory qualitative study	2
Baird (2004)	Negotiating the maze: the meaning of perimenopause	4
Ballard et al. (2009)	Private and public ageing in the UK: The transition through the menopause	5
Berterö (2003)	What do women think about menopause? A qualitative study of women's expectations, apprehensions and knowledge about the climacteric period	5
Buchanan et al. (2002)	Women, menopause, and (Ms.)Information: Communication about the climacteric	4
Bulbeck (2003)	'Mix and Match': Meanings and Uses of Complementary Medicine at Midlife	5
Busch et al. (2003)	Menopausal transition and psychological development	5
Costa and Gualda (2008)	Menopause knowledge and experience for a group of women	2
Dillaway et al. (2008)	Talking 'among us': how women from different racial-ethnic groups define and discuss menopause	5
Duffy et al. (2009)	Reassessing the impact of the menopause among UK women: Results from a qualitative study	1
Eden et al. (2015)	Attitudes and experiences of menopause amongst Macedonian women in Australia	1

Appendix B

Author	Title	Code
Elliott et al. (2002)	A critical ethnography of Korean Canadian women's menopause experience	5
Field-Springer et al. (2018)	From Menarche to Menopause: Understanding Multigenerational Reproductive Health Milestones	4
Fiskin et al. (2015)	Perceptions and attitudes toward the menopause among climacteric aged women from Turkey	1
George (2002)	The Menopause Experience: A Woman's Perspective	5
Gómez Martínez et al. (2008)	Socio-cultural representations about menopause: Experiences of the process in resident women in Albacete, Spain	2
Hakimi et al. (2014)	Perceived Concerns of Azeri Menopausal Women in Iran	4
Hinchliff et al. (2010)	Sex, Menopause and Social Context	4
Howell and Beth (2002)	Midlife myths and realities: women reflect on their experiences	7
Hsu (2002)	An exploration of Chinese American women's menopause experiences	5
Hvas (2006)	Menopausal women's positive experience of growing older	5
Hyde et al. (2011)	The Ending of Menstruation: Perspectives and Experiences of Lesbian and Heterosexual Women	4
Kagawa-Singer et al. (2002)	Comparison of the menopause and the midlife transition between Japanese-American and Euro-American women	5
Khan and Hallad (2011)	Age at menopause: Differentials and perceptions of women findings from an ethnographic study in rural North Karnataka	4
Komesaroff et al. (2002)	Experiences at menopause of women in a non-English-speaking community: A qualitative study	5
Lewis McCabe (2004)	Morphing the Crone: An Ethnography of Crone Culture, Consciousness and Communities	4
Leyva-Moral (2013)	The menopause and immigrant Equadorian women: A natural experience in the hands of others	2
Manesh and Moghadam (2011)	The experiences of menopause through the lens of Iranian women: Content analysis study	3
Michaud (2010)	The blood journey: A thematic analysis of women's psychospiritual change from menstruation through menopause	7
Morris and Symonds (2004)	'We've been trained to put up with it': real women and the menopause	5
Morrison et al. (2009)	A quantitative and qualitative assessment of attitudes toward menstruation and menopause: The Hilo Women's Health Study	1
Musker (2008)	Life patterns of women transitioning through menopause: a Newman research study	4
Nkwo and Onah (2008)	Positive attitude to menopause and improved quality of life among Igbo women in Nigeria	4

Author	Title	Code
Perz and Ussher (2008)	'The horror of this living decay': women's negotiation and resistance of medical discourses around menopause and midlife	7
Pimenta et al. (2011)	Representations and Perceived Consequences of Menopause by Peri- and Post-Menopausal Portuguese Women: A Qualitative Research	4
Saka et al. (2012)	Behavioral pattern of menopausal Nigeria women	4
Sampselle et al. (2002)	Midlife development and menopause in African American and Caucasian women	5
Stewart (2003)	Menopause in highland Guatemala Mayan women	5
Ussher et al. (2018)	'Age of despair', or 'when life starts': migrant and refugee women negotiate constructions of menopause	4

Appendix C Data Analysis Methods

Data Analysis Method	No. of studies reporting a specific method:
Atlas ti.	3
Constant Comparative Technique	1
Constant Comparison Method	2
Constructive inquiry	1
Critical Discourse Analysis	1
Descriptive Qualitative Analysis	1
Dimensional Analysis	1
Framework Analysis	1
Intuiting, Analysing and Describing (Spiegelberg 1975)	1
Max QDA-10 Thematic Analysis	1
Narrative analysis	1
NVIVO Thematic Analysis	4
Poetic Restructuring and Elements of a True Story	1
QSR NVIVO after 2002	4
SPSS	2
Tesch (1990) Eight Steps of Data Analysis	2
Thematic Analysis	15
Thematic Co-investigation	1

Appendix D Phase One: GP Poster



(Version 2 25/07/2016)

PARTICIPANTS NEEDED FOR MENOPAUSE RESEARCH

I am looking for **male** and **female** volunteers to take part in a study exploring the lived experience of the menopausal transition from a male and female perspective.

Who am I looking for?

- Women who have not had a menstrual period for at least 1 to 2 years due to the menopause.
- Men or Women who have a partner who has experienced a natural menopause within the last 4 years.
- Couples where one person has experienced a natural menopause in the last 4 years.

What would you be asked to do?

You would be asked to take part in an interview lasting approximately 60-90 minutes.

For more information about this study, or to volunteer for this study, please contact:

Yvonne Middlewick
PhD Student
Faculty of Health Sciences

Tel: 023 80597895
Email: ym1c06@soton.ac.uk

This study has been reviewed and approved by: Hampshire B Research Ethics Committee IRAS ID: 132231
& The University of Southampton Ethics & Research Governance Team ERGO ID: 11468

This poster will be taken down by: Thursday 4th May 2017

<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>	<p>Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk</p>
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Appendix E Phase One: GP Invitation Letter

**Dr M. D. Coombe
Dr C Matthews
Dr Z Hirmiz**



**Blendworth Lane, Horndean
Waterlooville, Hants PO8 0AA
Tel: (023) 92592138
Fax: (023) 92571628**

11th April 2017

Study reference: ERGO 11468
Ethics reference: IRAS 132231

Dear Patient

I am writing to invite you to become involved in some research that is being supported by the surgery. The focus is exploring the lived experiences of a woman's menopausal transition from a male and female perspective. This study is of particular interest because it has been suggested in publications that women can experience a number of difficulties at this time and we would like to know more about this. If you have a partner who would be interested in taking part we are also interested in how they perceive this period in a woman's life as there appears to be very little information available in relation to this.

The researcher, Yvonne Middlewick, is a Registered Nurse (Adult & Mental Health) who currently teaches nurses and other healthcare professionals at the University of Southampton. She has an interest in supporting women's health and wellbeing and is completing this research project as part of her PhD study.

If you (and/or your partner) are interested in being involved in the study or just finding out a bit more about it please see the enclosed participant information sheet and 'What will happen to me if I take part?' Yvonne's contact details are on this. Please contact her within 14 days of receiving this letter if you are interested.

Thank you for your consideration of this.

Yours sincerely

Dr Mark Coombe

MBBS FRCGP MFFP DRCOG PGCE

Appendix F Phase One: GP Participant Information Sheet



Participant Information Sheet (Version 13)

Study Title: *A study of the lived experiences of a woman's menopausal transition from a male and female perspective.*

Researcher: Yvonne Middlewick

Ethics number: ERGO ID: 11468
IRAS ID: 132231

Please read this information carefully before deciding whether or not to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research project is exploring the experiences of women in the period of the menopausal transition from the perspective of women and men. I am a nurse and currently work as a lecturer teaching nurses and other healthcare professionals. This research project is part of my PhD study.

Women have expressed that they can experience a number of difficulties at this time that can affect different aspects of their lives. I am interested in this and I am also interested in the similarities and differences between male and female perspectives of this time in a women's life.

Who has reviewed this study?

This study has been reviewed and approved by the Hampshire B Research Ethics Committee & the University of Southampton Ethics & Research Governance Team.

Why have I been invited to take part?

You are being approached to take part as either yourself or your partner potentially has experience of the menopause. If, after reading this information sheet, you are interested in taking part please see the 'What will happen to me if I take part?' document included. I am also interested in the views and experiences of partners and therefore if you have a partner who may be interested in taking part please ask them to have a look at the information you have been sent and contact me as outlined below. If you do not wish to take part then you do not need to do anything; this information has been sent by your GP surgery so that the researcher does not have your details unless you contact her to say you wish to take part.

What will happen to me if I take part?

I will arrange a time convenient to you for us to meet to talk about your experiences in an interview. This interview will be tape recorded and will take approximately 60 to 90 minutes. If you wish to take part then you will be invited to sign a consent form but you have the right to change your mind at any time before, during or after the interview.

Are there any benefits in my taking part?

There will be no direct benefits to you as a participant but through the project I hope to gain a better understanding of people's experiences.

Are there any risks involved?

You are being asked to share your story and there is the possibility that this may raise issues that cause you some distress and that you would like to discuss further. Time will be available after the interview to discuss any issues and information about additional support can be found on page 3 of this document. I will contact you the day after the interview to answer any outstanding questions.

Will my participation be confidential?

All the information that you share will be handled and stored as per guidance provided by the Data Protection Act (1998) and the University data archiving policy. Your recorded interview will be heard only by myself and my research supervisors.

The interview recording will be typed and your name and the names of any other person or organisation will be removed so that it is anonymous. All electronic information is stored on a password protected computer and all other documentation will be stored in a locked filing cabinet within the Faculty of Health Sciences. Quotations from the interview will form part of the final thesis and any publications. All quotations will be fully anonymised.

All data will be stored for 10 years in line with the University data archive policy. After this time data will be destroyed.

When will confidentiality not be guaranteed?

Confidentiality cannot be guaranteed if any disclosures are considered a risk to yourself or others. This will result in appropriate action being taken by the researcher to ensure that yourself and others are protected. If there are concerns about your wellbeing then the researcher will discuss these with you and a decision will be made if it is appropriate to inform your GP.

What happens if I change my mind?

You have the right to withdraw from this research at any time, without giving a reason and without your medical care being affected. You will then be withdrawn from the study and no identifiable information will be used.

What happens if something goes wrong, there is a problem or I have a complaint?

In the unlikely case of concern or complaint about this study, you should contact:

Isla-Kate Morris
Research Governance Office,
University of Southampton,
Building 37,
Highfield,
Southampton,
SO17 1BJ.
Tel: +44 (0)23 8059 5058
Email: rgoinfo@soton.ac.uk .

If you remain unhappy and wish to complain formally, Isla-Kate can provide you with details of the University of Southampton Complaints Procedure.

Where can I get more information?

If you require further information please contact:

Researcher: Yvonne Middlewick
Tel: 023 80597895
Email: ym1c06@soton.ac.uk
By post: University of Southampton

Faculty of Health Sciences
Building 67
Southampton
SO17 1BJ

Participant Additional Support (Version 2)

This page has information about different organisations that may be able to support you:

Your GP Practice:

Your GP will have information about your health and wellbeing and will be able to offer you support if you have any physical or emotional issues related to the menopause, or any other aspect of your health or wellbeing. Your GP may be able to signpost you to other services where you can access free and confidential advice and support.

Many GP practices offer well women and well man clinics and some practices have menopause clinics or access to a menopause specialist.

NHS Choices: <http://www.nhs.uk/conditions/menopause/Pages/Introduction.aspx>

This web-based resource has useful information about the menopause, symptoms and treatments as well advice about contacting your GP. There are also links to external organisations that may be able to offer support.

Healthtalk.org: <http://www.healthtalk.org/peoples-experiences/later-life/menopause/topics>

This website has video clips of women talking to a researcher about the different experiences they have had of the menopause.

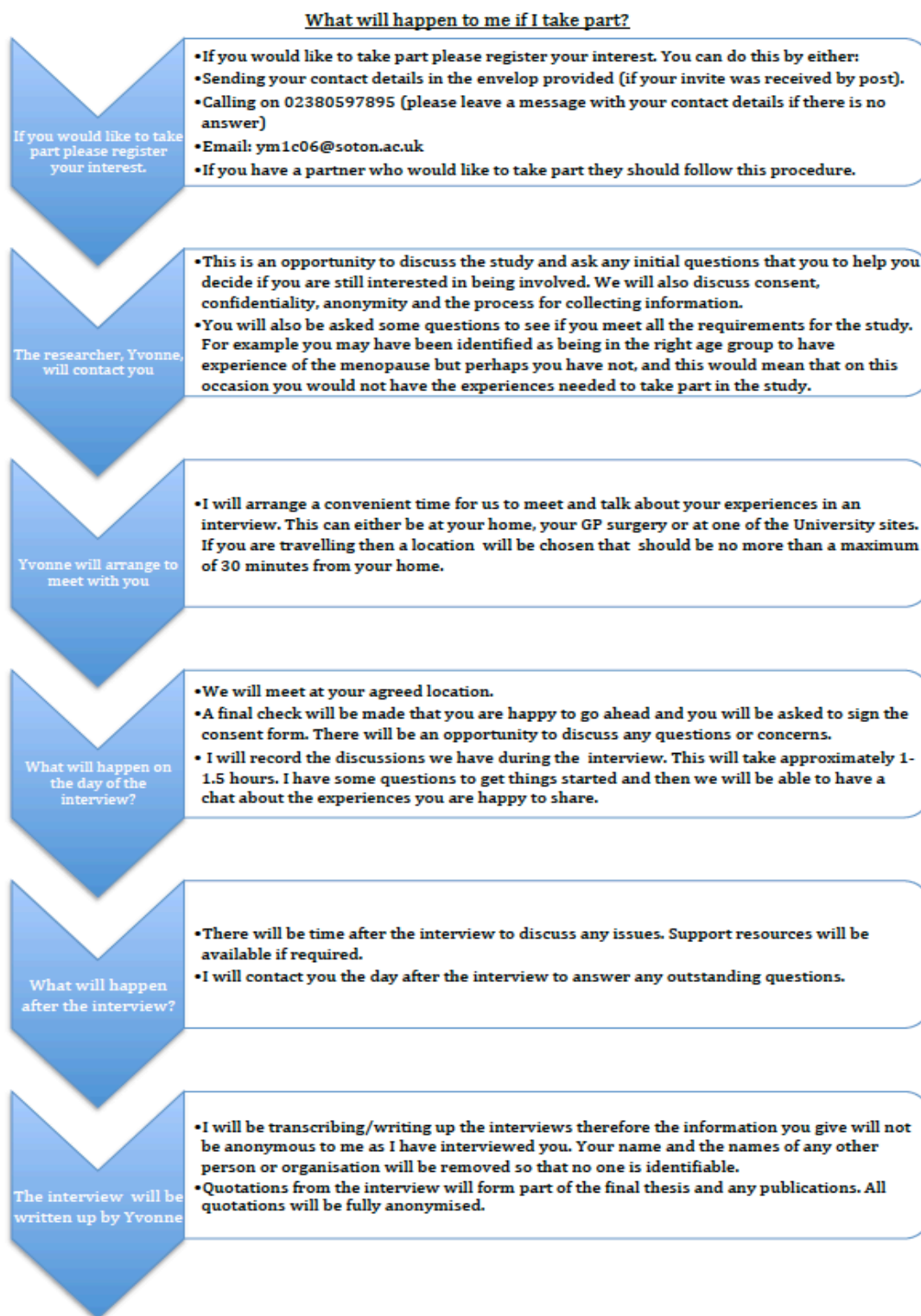
Samaritans:

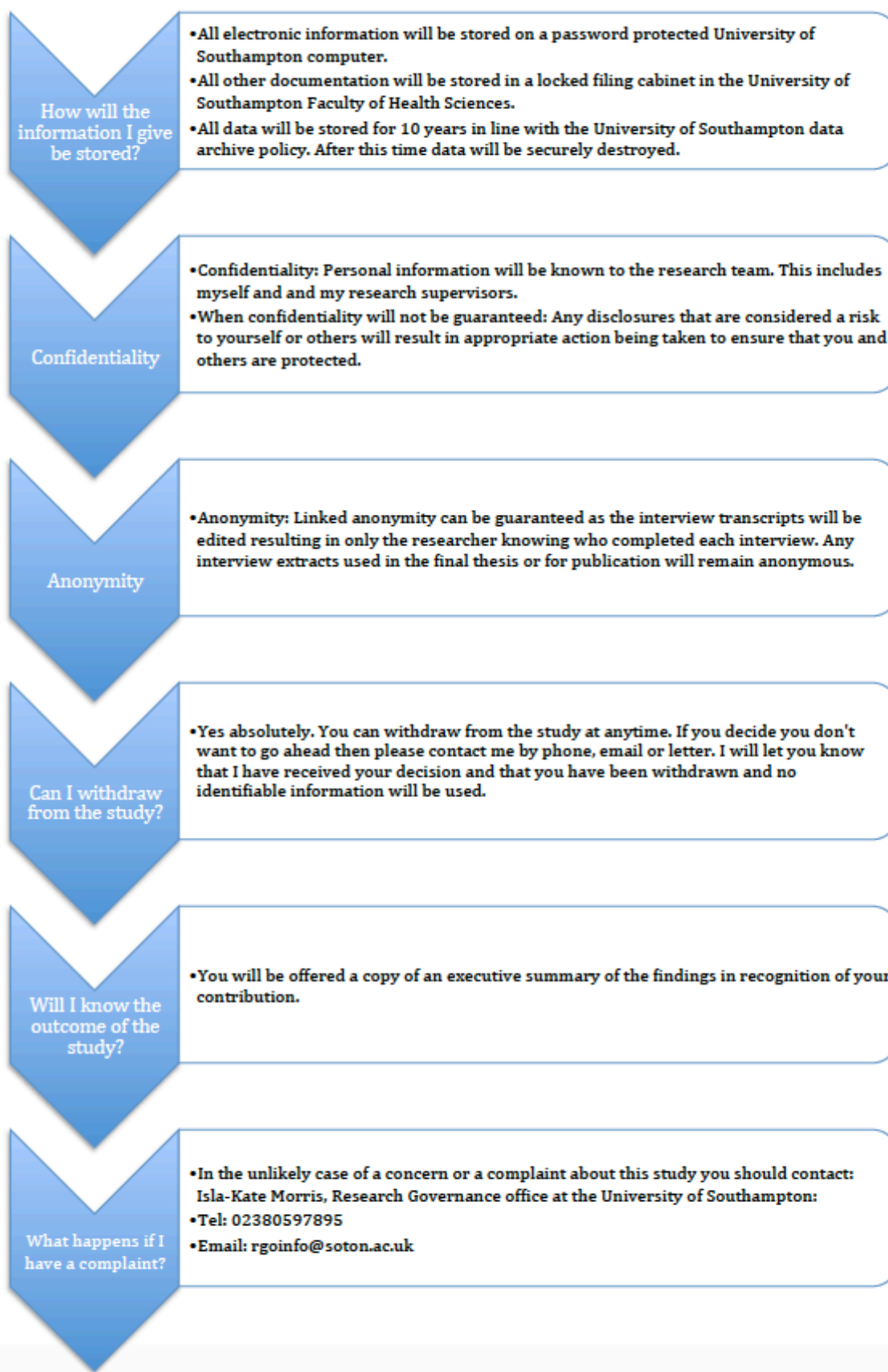
You can contact the Samaritans about anything that is concerning you. Telephone: 116 123 (this number is free to call).

If you require further information please contact:

Researcher: Yvonne Middlewick
Tel: 023 80597895
Email: ym1c06@soton.ac.uk
By post: University of Southampton
Faculty of Health Sciences
Building 67
Southampton
SO17 1BJ

Appendix G Phase One: What Will Happen if I Take Part?





Appendix H Phase One: UoS Recruitment Poster



Version 3 25/07/2016

PARTICIPANTS NEEDED FOR MENOPAUSE RESEARCH

I am looking for **male** and **female** volunteers to take part in a study exploring the lived experience of the menopausal transition from a male and female perspective.

Who am I looking for?

- Women who have not had a menstrual period for 1-2 years due to the menopause.
- Men or Women who have a partner who has experienced a natural menopause within the last 4 years.
- Couples where one person has experienced a natural menopause in the last 4 years.

What would you be asked to do?

You would be asked to take part in an interview lasting approximately 60-90 minutes.

For more information about this study, or to volunteer for this study, please contact:

*Yvonne Middlewick
PhD Student
Faculty of Health Sciences*

Tel: 023 80597895
Email: ym1c06@soton.ac.uk

This study has been reviewed by, and received ethics clearance by ERGO Ref: 11468

This poster will be taken down by: Wednesday 14th June 2017

Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk	Please contact: Yvonne Middlewick Phone: 023 80597895 email: ym1c06@soton.ac.uk
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Appendix I Phase One: UoS Participant Information Sheet



Participant Information Sheet (Version 4)

Study Title: *A study of the lived experiences of a woman's menopausal transition from a male and female perspective.*

Researcher: Yvonne Middlewick

Ethics number: ERGO ID: 11468
IRAS ID: 132231

Please read this information carefully before deciding whether or not to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research project is exploring the experiences of women in the period of the menopausal transition from the perspective of women and men. I am a nurse and currently work as a lecturer teaching nurses and other healthcare professionals. This research project is part of my PhD study.

Women have expressed that they can experience a number of difficulties at this time that can affect different aspects of their lives. I am interested in this and I am also interested in the similarities and differences between male and female perspectives of this time in a women's life.

Who has reviewed this study?

This study has been reviewed and approved by the University of Southampton Ethics & Research Governance Team.

Why have I been invited to take part?

You are being approached to see if either yourself or your partner potentially has experience of the menopause and may be interested in contributing to this study. If, after reading this information sheet, you are interested in taking part please see the 'What will happen to me if I take part?' document included and please contact me using the details in the section below 'Where can I get more information?' I am also interested in the views and experiences of partners therefore if you have a partner who may be interested in taking part then please ask them to have a look at this the information and contact me as outlined below. If you do not wish to take part then you do not need to do anything.

What will happen to me if I take part?

I will arrange a time convenient to you for us to meet to talk about your experiences in an interview. This interview will be tape-recorded and will take approximately 60 to 90 minutes. If you wish to take part then you will be invited to sign a consent form but you have the right to change your mind at any time before, during or after the interview.

Are there any benefits in my taking part?

There will be no direct benefits to you as a participant but through the project I hope to gain a better understanding of people's experiences.

Are there any risks involved?

You are being asked to share your story and there is the possibility that this may raise issues that cause you some distress and that you would like to discuss further. Time will be available after the interview to discuss any issues and information about additional support can be found on page 3 of this document. I will contact you the day after the interview to answer any outstanding questions.

Will my participation be confidential?

All the information that you share will be handled and stored as per guidance provided by the Data Protection Act (1998) and the University data archive policy. Your recorded interviews will be heard only by my research supervisors and myself.

The interview recording will be typed and your name and the names of any other person or organisation will be removed so that it is anonymous. All electronic information is stored on a password protected computer and all other documentation will be stored in a locked filing cabinet within the Faculty of Health Sciences. Quotations from the interview will form part of the final thesis and any publications. All quotations will be fully anonymised.

When will confidentiality not be guaranteed?

Confidentiality cannot be guaranteed if any disclosures are considered a risk to yourself or others. This will result in appropriate action being taken by the researcher to ensure that yourself and others are protected. If there are concerns about your wellbeing then the researcher will discuss these with you and we will consider how best to support you.

All data will be stored for 10 years in line with the University data archive policy. After this time data will be securely destroyed.

What happens if I change my mind?

You have the right to withdraw from this research at any time, without giving a reason. You will then be withdrawn from the study and no identifiable information will be used.

What happens if something goes wrong, there is a problem or I have a complaint?

In the unlikely case of concern or complaint about this study, you should contact:

Isla-Kate Morris
Research Governance Office,
University of Southampton,
Building 37,
Highfield,
Southampton,
SO17 1BJ.
Tel: +44 (0)23 8059 5058
Email: rgoinfo@soton.ac.uk

If you remain unhappy and wish to complain formally, Isla-Kate can provide you with details of the University of Southampton Complaints Procedure.

Where can I get more information?

If you require further information please contact:

Researcher: Yvonne Middlewick
Tel: 023 80597895
Email: ym1c06@soton.ac.uk
By post: University of Southampton

Faculty of Health Sciences
Building 67
Southampton
SO17 1BJ

Participant Additional Support (Version 2)

This page has information about different organisations that may be able to support you:

Your GP Practice:

Your GP will have information about your health and wellbeing and will be able to offer you support if you have any physical or emotional issues related to the menopause, or any other aspect of your health or wellbeing. Your GP may be able to signpost you to other services where you can access free and confidential advice and support.

Many GP practices offer well women and well man clinics and some practices have menopause clinics or access to a menopause specialist.

NHS Choices: <http://www.nhs.uk/conditions/menopause/Pages/Introduction.aspx>

This web-based resource has useful information about the menopause, symptoms and treatments as well advice about contacting your GP. There are also links to external organisations that may be able to offer support.

Healthtalk.org: <http://www.healthtalk.org/peoples-experiences/later-life/menopause/topics>

This website has video clips of women talking to a researcher about the different experiences they have had of the menopause.

Samaritans:

You can contact the Samaritans about anything that is concerning you. Telephone: 116 123 (this number is free to call)

If you require further information please contact:

Researcher: Yvonne Middlewick
Tel: 023 80597895
Email: ym1c06@soton.ac.uk
By post: University of Southampton
Faculty of Health Sciences
Building 67
Southampton
SO17 1BJ

Appendix J Phase Two: Poster Recruitment



PARTICIPANTS NEEDED FOR MENOPAUSE RESEARCH

I am looking for **female** volunteers to take part in a study exploring women's lived experience of the transition to natural menopause

Who am I looking for?

- Women who have not had a menstrual period for between 1 and 5 years due to the natural menopause.
- Women over the age of 45 years when they experienced their last menstrual period.

What would you be asked to do?

You would be asked to take part in an interview lasting approximately 60-90 minutes.

For more information about this study, or to volunteer for this study, please contact:

Yvonne Middlewick
PhD Student
School of Health Sciences

Tel: 023 80597895
Email: ym1c06@soton.ac.uk

This study has been reviewed by, and received ethics clearance by ERGO Ref: 11468.A2

This poster (version 11 28/07/2019) will be taken down by: 29th November 2019]

Please contact:
Yvonne Middlewick
Phone: 023 8059 7895
email: ym1c06@soton.ac.uk

Please contact:
Yvonne Middlewick
Phone: 023 8059 7895
email: ym1c06@soton.ac.uk

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Yvonne Middlewick
Phone: 023 8059 7895
email: ym1c06@soton.ac.uk

Appendix K Phase Two: Participant Information Sheet



Participant Information Sheet (Version 11)

Study Title: *A study of women's lived experience of the transition to natural menopause.*

Researcher: Yvonne Middlewick

Ethics number: 11468.A2

Please read this information carefully before deciding whether or not to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research project is exploring the experiences of women as they transition to menopause. I am a nurse and currently work as a lecturer teaching nurses and other healthcare professionals. This research project is part of my PhD study.

Women have expressed that they can experience a number of changes during the transition to menopause that can affect different aspects of their lives. I am interested in understanding how this period of time impacts of women's lives.

Who has reviewed this study?

This study has been reviewed and approved by the University of Southampton Ethics & Research Governance Team.

Why have I been invited to take part?

You are being invited to take part as you may have experience of menopause and may be interested in contributing to this study. If, after reading this information sheet you are interested in taking part please contact me using the details in the section below 'Where can I get more information?' If you do not wish to take part then you do not need to do anything.

What will happen to me if I take part?

I will arrange a time convenient to you for us to meet to talk about your experiences in an interview. This interview will be audio-recorded and will take approximately 60 to 90 minutes. You will need to sign the consent form but you have the right to change your mind at any time before, during or after the interview.

Are there any benefits in my taking part?

There will be no direct benefits to you as a participant but through the project I hope to gain a better understanding of people's experiences. This knowledge is intended to inform recommendations for future practice developments and policy initiatives. You will be offered a copy of an executive summary of findings in recognition of your contribution.

Are there any risks involved?

Appendix K

You are being asked to share your story and there is the possibility that this may raise issues for you that you would like to discuss further. Time will be available after the interview to discuss any issues and support resources are available. You are welcome to contact me after the interview if you wish to discuss any support you need.

What data will be collected?

As well as the audio recorded interview I will need to collect some personal information to give context to the study. This will include:

Age

Ethnicity

Relationship status

Date/year of your last menstrual period

Profession

If you would like a copy of the executive summary at the end of the study I will also need to collect your name, address/or email address to enable this to be sent to you.

The above information will be collected by myself once you have decided to participate in the study and I will put the information directly into a password protected database on a password protected computer.

You will need to provide your name on the consent form. This will then be kept in a locked filing cabinet until it is scanned and stored in a separate password protected electronic folder.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

The interview recording will be typed (transcribed) and your name and the names of any other person or organisation will be removed so that it is anonymous. At the end of the study the audio recording will be destroyed. All electronic information is stored on a password protected computer and all other documentation will be stored in a locked filing cabinet within the School of Health Sciences. Quotations from the interview will form part of the final thesis and any publications. All quotations will be fully anonymised.

When will confidentiality not be guaranteed?

Confidentiality cannot be guaranteed if any disclosures are considered a risk to yourself or others. This will result in appropriate action being taken by the researcher to ensure that yourself and others are protected. If there are concerns about your wellbeing then the researcher will discuss these with you and we will consider how best to support you.

What happens if I change my mind?

You have the right to withdraw from this research at any time, without giving a reason. You will then be withdrawn from the study and no identifiable information will be used.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

What happens if there is a problem?

If you have a concern about any aspect of this study, you please speak to me and I will do my best to answer your questions.

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at <http://www.southampton.ac.uk/assets/sharepoint/intranet/Is/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf>

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

Appendix K

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.

Thank you for taking the time to read the information sheet and considering taking part in the research.

Where can I get more information?

If you require further information please contact:

Researcher: Yvonne Middlewick

Tel: 023 80597895

Email: ym1c06@soton.ac.uk

By post: University of Southampton

School of Health Sciences

Building 67

Southampton

SO17 1BJ

Additional Support:

This page has information about different organisations that may be able to support you:

Your GP Practice:

Your GP will have information about your health and wellbeing and will be able to offer you support if you have any physical or emotional issues related to the menopause, or any other aspect of your health or wellbeing. Your GP may be able to signpost you to other services where you can access free and confidential advice and support.

Many GP practices offer well women and well man clinics and some practices have menopause clinics or access to a menopause specialist.

NHS Choices: <http://www.nhs.uk/conditions/menopause/Pages/Introduction.aspx>

This web-based resource has useful information about the menopause, symptoms and treatments as well advice about contacting your GP. There are also links to external organisations that may be able to offer support.

Healthtalk.org: <http://www.healthtalk.org/peoples-experiences/late-life/menopause/topics>

This website has video clips of women talking to a researcher about the different experiences they have had of the menopause.

Samaritans:

You can contact the Samaritans about anything that is concerning you. Telephone: 116 123 (this number is free to call)

If you require further information about support please contact:

Researcher: Yvonne Middlewick

Tel: 023 80597895

Email: ym1c06@soton.ac.uk

By post: University of Southampton

School of Health Sciences

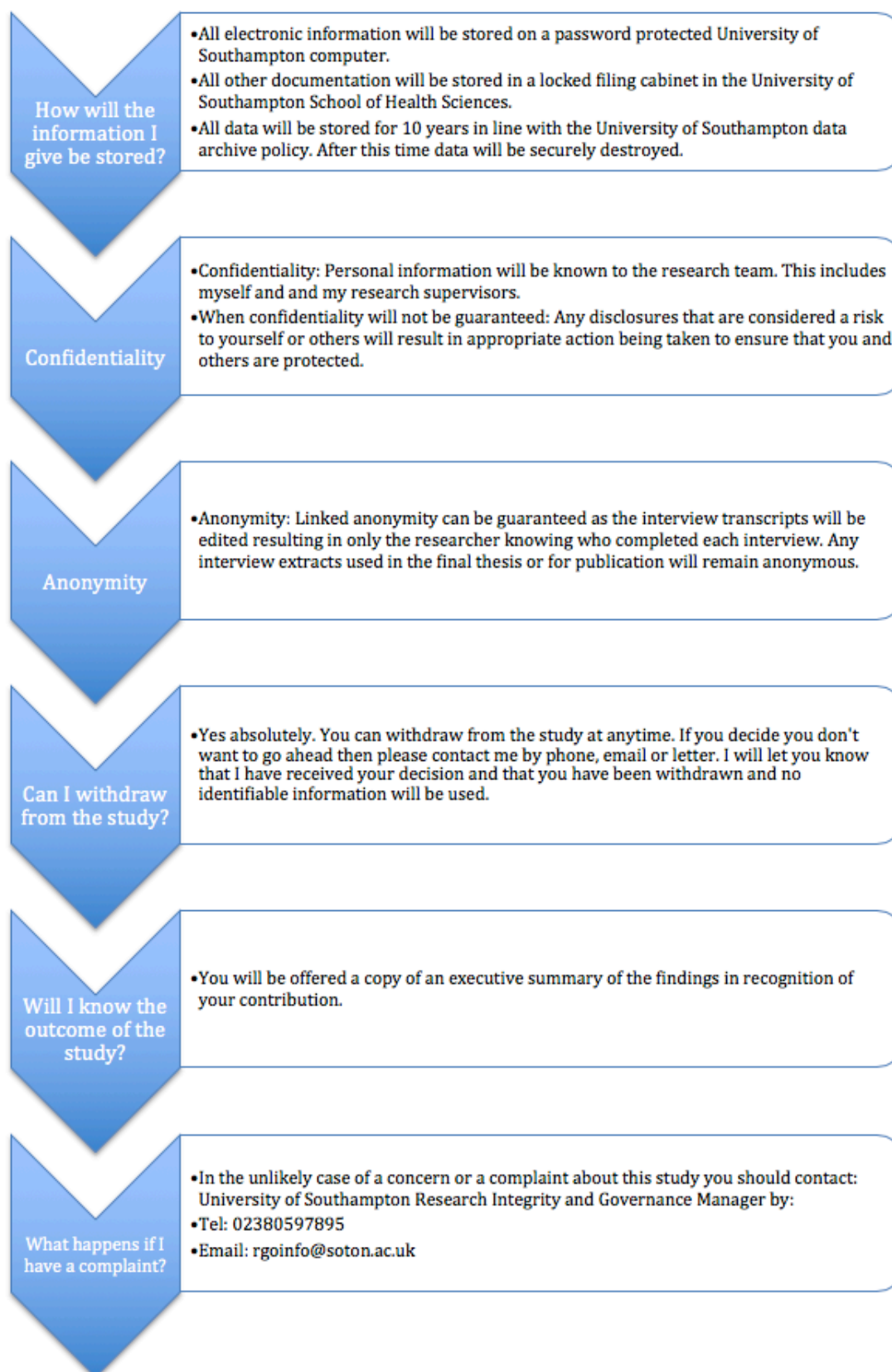
Building 67

Southampton

SO17 1BJ

Appendix L Phase Two: What Will Happen If I Take Part





Appendix M Phase One: GP Consent Form

UNIVERSITY OF
Southampton

CONSENT FORM (Version 9)

Study title: A study of the lived experiences of a woman's menopausal transition from a male and female perspective

Researcher name: Yvonne Middlewick

Study reference: ERGO 11468

Ethics reference: IRAS 132231

Please initial the box(es) if you agree with the statement(s):

I have read and understood the participant information sheet (04/08/16 /version no. 13) and have had the opportunity to ask questions about the study.

I understand my participation is voluntary and I may withdraw at any time, without giving a reason, and without my medical care or legal rights being affected.

I am happy to be contacted regarding other unspecified research projects. I therefore consent to the University retaining my contact details on a database, kept separately from the research data detailed above. The 'validity' of my consent is conditional upon the University complying with the Data Protection Act (1998) and I understand that I can request my details be removed from this database at any time.

Yes [] No []

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

I understand that relevant sections of my notes and data collected during the study may be looked at by individuals from regulatory authorities, Southampton University or from the CCG, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I agree to the use of anonymised quotes in the research reports.

I agree to the interview being audio recorded and for my data to be used for the purposes of this study.

Name of participant (print name).....

Signature of participant.....

Date.....

Appendix N Phase One: UoS Consent Form

UNIVERSITY OF
Southampton

CONSENT FORM (Version 9)

Study title: A study of the lived experiences of a woman's menopausal transition from a male and female perspective

Researcher name: Yvonne Middlewick

Study reference: ERGO 11468

Ethics reference: IRAS 132231

Please initial the box(es) if you agree with the statement(s):

I have read and understood the participant information sheet (04/08/16 /version no. 4) and have had the opportunity to ask questions about the study.

I understand my participation is voluntary and I may withdraw at any time, without giving a reason, and without my medical care or legal rights being affected.

I am happy to be contacted regarding other unspecified research projects. I therefore consent to the University retaining my contact details on a database, kept separately from the research data detailed above. The 'validity' of my consent is conditional upon the University complying with the Data Protection Act (1998) and I understand that I can request my details be removed from this database at any time.

Yes [] No []

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

I understand that relevant sections of my notes and data collected during the study may be looked at by individuals from regulatory authorities, Southampton University or from the CCG, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I agree to the use of anonymised quotes in the research reports.

I agree to the interview being audio recorded and for my data to be used for the purposes of this study.

Name of participant (print name).....

Signature of participant.....

Date.....

Appendix O Phase Two: Consent Form



CONSENT FORM

Study title: *A study of women's lived experience of the transition to natural menopause.*

Researcher name: Yvonne Middlewick

ERGO number: 11468.A2

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (28/07/2019 /version no. 11 of participant information sheet) and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand my participation is voluntary and I may withdraw (at any time) for any reason without my participation rights being affected.	

Name of participant (print name).....

Signature of participant.....

Date.....

Name of researcher (print name).....

Signature of researcher

Date|.....

Appendix P Initial Code Book Example

In vivo codes= "Blue Bold"

Codes = Blue Bold

Codes:	Description:	Example:
"Stuff of legend"	When older women share their experiences/stories with other women who have started to experience the menopause.	Rose:311 "it's from talking to women and older women, that sort of stuff is sort of the stuff of legend isn't it"
"Sisterhood"	The support between women of a similar age who are experiencing or have experienced the menopause.	Rose:471 "I think there's, I think there's a sort of a sisterhood around it you know it's a shared experience"
A shared experience	The sharing of the experience with other women who are experiencing the menopause.	Emma:853 "we [sister] started talking about stuff and she went "Oh yeah, yeah I get that and I get that" and then it was "so what do you do about it?"
Humour	Participant's state that they use of humour when talking to other women about bodily changes.	Rose:472 "it's certainly something that when I'm with my girlfriends we have a good giggle about"
Knowledge from Mum	Knowledge is shared from mother to daughter.	Sophie:378 "I knew that my mother was going through the menopause because it was talked about, it was talked, it was talked about yeah"
Like mother like daughter	Women describe their experience as being the same or very similar to their mother's experience of menopause.	Lisa:21 "that's the same age as my mum and my sister"
Secret society	The experience is treated in a way that means you have to experience the menopause to become part of the club: like belonging to a secret society.	Rose:409 "when you talk to women I think there always that 'you wait till you get there' sort of thing"
Woman to woman	Only women can understand the experience of other women.	Lisa:119 "She's [GP] more compassionate, she listens more and actually she's really focused on women and their needs so a lot of women that I know go to her".
Women's business	It is not the business of men because they do not experience menopause.	Rose:505 "You know this is ours, this is something that happens to us, nothing to do with you, you don't experience it".

Appendix Q Potential Super-Ordinate and Emergent Themes

Potential Super-Ordinate Themes	Emergent Themes
Beliefs	<ul style="list-style-type: none"> • Becoming invisible is due to increased age and reduced fertility • Common in 50s to have a reduced working memory • First realisation of getting older • It will only last a year or two • Menopause is 'in your face', can't ignore it • Positive attitude = positive impact • Sweating during a chilly day must look weird • That you would be affected by alcohol in the same way • Thought hot flushes were just being warm & red • Thought sweats only happened at night • Thought you'd get back to normal afterwards • You need less sleep in your 50s
Coping strategies	<ul style="list-style-type: none"> • Becoming invisible is due to increased age and reduced fertility • Being fit/getting fit • Being in control • Commitment to being in/taking control • Common in 50s to have a reduced working memory • Get on with it • Positive approach • Positive outlook • Trying to take control • You need less sleep in your 50s
Gains	<ul style="list-style-type: none"> • Positive change in relationship with partner • A time for yourself • An excuse to be "shitty" • Argumentative streak (gain) • Becoming yourself • Better at coping with stress • Better sleep • Boyfriend adjusted behaviour • Confidence • Don' worry so much about upsetting people • Empathy for mum now • Focus on self • Freedom from contraception • Freedom from repression • Freedom from unintended pregnancy • Getting away with things • Happy with self • Haven't got expectations of self

Potential Super-Ordinate Themes	Emergent Themes
	<ul style="list-style-type: none"> • Increased self-awareness • Less self-conscious • No longer a worrier • No more menstruating • Not bothered with "shit/incidentals" • Not hemmed in by expectations • Right to say how she feels • The real me • Want to make everything count
Knowledge	<ul style="list-style-type: none"> • Common in 50s to have a reduced working memory • Electronic/internet knowledge • Experience is believing • Hindsight • Knowledge from female GP • Knowledge from husband • Knowledge from Mum • Knowledge from Mum's experience • Knowledge from other women • Knowledge from others talking • Knowledge of self • Knowledge through experience is powerful • Lack of knowledge • Lack of trust in medical knowledge • Like mother like daughter • Observational knowledge • Own professional knowledge • Personal knowledge through reading • Professional knowledge • Seeking own knowledge • Shared knowledge • Sharing = being prepared • Specialist female professional knowledge valued • Women's knowledge • You need less sleep in your 50s
Losses	<ul style="list-style-type: none"> • Increased emotions • Increased vaginal secretions (loss) • Loss of bladder responsiveness • Loss of body shape • Loss of confidence • Loss of control over body • Loss of energy: "not firing on all cylinders" • Loss of femininity • Loss of fertility • Loss of health • Loss of humour • Loss of memory • Loss of moisture • Loss of physical strength • Loss of rationale • Loss of sexual relationship/libido • Loss of skin condition • Loss of sleep

Potential Super-Ordinate Themes	Emergent Themes
	<ul style="list-style-type: none"> • Loss of temper (waiting to erupt) • Loss of tolerance • Loss of visibility • Loss of youth • Mood swings with boyfriend • No longer feeling glowing & healthful • Reduced self confidence • Sadness
Maturity/self-actualisation	<ul style="list-style-type: none"> • An excuse to be "shitty" • Becoming yourself • Comfier with self • Comfortable with body changing now • Confidence • Don't worry so much about upsetting people • Focus on self • Happy with self • Knowledge of self • Less self-conscious • Not hemmed in by expectations • Right to say how she feels • Sharing = being prepared • The real me
"Sisterhood"	<ul style="list-style-type: none"> • A girl's club • A shared experience • Connecting with each other (women) • Knowledge from Mum • Knowledge from Mum's experience • Knowledge from other women • Like mother like daughter • More empathy with Mum & older women • Ours (women's) to own • Secret society • Shared experience with Mum & sister • Shared experience with other women • Sharing = being prepared • Sharing knowledge with other women • "Sisterhood" • Woman to woman
Thinking about your body differently	<ul style="list-style-type: none"> • Being fit • Being in control of body • "Boiling alive" • Breast tenderness • Change in vaginal odour/discharge • Comfortable with body changing now • Commitment to being in/taking control • First realisation of getting older • Freedom from contraception • Freedom from unintended pregnancy • Get on with it • Getting to know your body • Increased vaginal secretions (loss)

Potential Super-Ordinate Themes	Emergent Themes
	<ul style="list-style-type: none"> • Intermittent vaginal dryness • Knowledge of self • Loss of bladder responsiveness • Loss of body shape • Loss of confidence • Loss of control over body • Loss of energy: "not firing on all cylinders" • Loss of femininity • Loss of fertility • Loss of health • Loss of humour • Loss of memory • Loss of moisture • Loss of physical strength • Loss of rationale • Loss of sexual relationship/libido • Loss of skin condition • Loss of sleep • Loss of temper • Loss of tolerance • Loss of visibility • Loss of youth • Menopause is 'in your face', can't ignore it • No longer feeling glowing & healthful • No more menstruating • Positive attitude = positive impact • Skin changes • Stay in control of body • Sweating in the day was just another irritation • Sweaty & greasy skin • That you would be affected by alcohol • Trying to take control • Vaginal prolapse
<p>Unanticipated things</p>	<ul style="list-style-type: none"> • "Boiling alive" • Loss of femininity • Reduced self confidence • That you would be affected by alcohol • Thinking everything would get back to normal afterwards • Vaginal prolapse
<p>Women's business</p>	<ul style="list-style-type: none"> • A girl's club • A shared experience • Connecting with each other (women) • Knowledge from mother to daughter • Knowledge from other women • Knowledge through experience • Male avoidance • Not for men • Ours (women's) to own • Shared knowledge • Sharing knowledge with other women • Woman to woman • Women's knowledge

Appendix R Super-Ordinate Themes and *Higher Order Concept Development*

Super-ordinate Themes: version 1
• Beliefs
• Coping strategies
• Gains
• Knowledge
• Losses
• Maturity/self-actualisation
• "Sisterhood"
• Thinking about your body differently
• Unanticipated things
• Women's business

<i>Higher order concepts</i> and super-ordinate themes: version 2
<ul style="list-style-type: none"> • <i>Women's business</i> <ul style="list-style-type: none"> ▪ Not for men ▪ Shared experience with women/ "sisterhood" ▪ ? Women's knowledge
<ul style="list-style-type: none"> • <i>Liberation</i> <ul style="list-style-type: none"> ▪ Physical ▪ Emotional ▪ Social

Higher order concepts and super-ordinate themes: version 2

- **Changing me:**
 - **Losses: A changing body**
 - **Loss of biological/social identity**
 - **Physical losses**
 - **Emotional losses**
 - **Getting to know my body differently**
 - **Physical**
 - **Emotional**
 - **Control of self**
 - **Forming a new identity**

- **Knowledge:**
 - **Intergenerational knowledge**
 - **Women's knowledge**
 - **Personal knowledge**
 - **Lack of knowledge**

- **Coping strategies:**
 - **Cognitive (things we tell ourselves)**
 - **Behavioural (things we do)**

Professional knowledge has been removed as it is not necessarily trusted knowledge. Although nearly all participants sought GP advice they did not necessarily trust it, particularly from male GPs. Advice from women who have experienced menopause or female GPs appears to be trusted more.

Maturity/self-actualisation has been removed as the themes were similar to gains and gains seemed to capture what the participants were referring to i.e. there are some pros and some cons.

Higher order concepts and super-ordinate themes: version 3
<ul style="list-style-type: none"> • <i>Liberation: Freedom to become the real me:</i> <ul style="list-style-type: none"> ▪ Physical ▪ Emotional ▪ Social
<ul style="list-style-type: none"> • <i>Losses: I thought I'd get "back to normal afterwards"(Kate:36):</i> <ul style="list-style-type: none"> ▪ Physical losses ▪ Emotional losses ▪ ?Loss of biological/social identity
<ul style="list-style-type: none"> • <i>Knowledge: Empowerment through knowledge:</i> <ul style="list-style-type: none"> ▪ Intergenerational knowledge ▪ Women's knowledge ▪ Tacit knowledge ▪ Lack of knowledge/the impact of lack of knowledge
<ul style="list-style-type: none"> • <i>Women's business: The "Stuff of legend" that can only be experienced by women (Rose:278).</i> <ul style="list-style-type: none"> ▪ Not for men ▪ Shared experience with women/ "sisterhood" ▪ ? Women's knowledge
<ul style="list-style-type: none"> • <i>Coping strategies:</i> <ul style="list-style-type: none"> ▪ Cognitive (things we tell ourselves) ▪ Behavioural (things we do)
<p>Getting to know my body differently has been removed as the codes were almost identical to the losses. This became apparent when I split them into physical and emotional themes.</p>

Higher order concepts and super-ordinate themes: version 4
<ul style="list-style-type: none"> • <i>Liberation: Freedom "to feel that you're becoming yourself finally" (Kate: 519):</i> <ul style="list-style-type: none"> ▪ Liberation from biological restrictions ▪ Liberation from social expectations ▪ Liberation from self-expectations
<ul style="list-style-type: none"> • <i>Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate: 36):</i> <ul style="list-style-type: none"> ▪ Physical losses ▪ Emotional losses ▪ ?Loss of biological/social identity (not sure about this as a title) ▪ Lack of knowledge/the impact of lack of knowledge (? to be removed. ?adequately covered in cognitive section of coping strategies).
<ul style="list-style-type: none"> • <i>Women's business: The "stuff of legend" that can only be experienced by women (Rose 278).</i> <ul style="list-style-type: none"> ▪ "Sisterhood": A shared female experience ▪ Intergenerational knowledge ▪ Women's knowledge ▪ Tacit knowledge
<ul style="list-style-type: none"> • <i>Coping strategies: "You just get on with it" (Rose: 347)</i> <ul style="list-style-type: none"> ▪ Cognitive (things women tell themselves) ▪ Behavioural (things women do)
<p>'Getting to know my body differently' has been removed as the codes were almost identical to the losses. This became apparent when I split them into physical and emotional themes.</p>
<p>Knowledge has been incorporated into women's business and I had put lack of knowledge in losses, however I am not sure if lack of knowledge belongs here and I think it could be removed. The codes seem to be covered in the cognitive section of coping strategies and I wonder if this will lead to a discussion about the impact of a lack of knowledge on coping.</p>

Higher order concepts and super-ordinate themes: version 5
<ul style="list-style-type: none"> • <i>Liberation: Freedom "to feel that you're becoming yourself finally" (Kate: 519):</i> <ul style="list-style-type: none"> ▪ Liberation from biological restrictions ▪ Liberation from social expectations ▪ Liberation from self-expectations
<ul style="list-style-type: none"> • <i>Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate:36):</i> <ul style="list-style-type: none"> ▪ Physical losses ▪ Emotional losses ▪ ?Loss of biological/social identity (not sure about this as a title)/ loss of youth identity
<ul style="list-style-type: none"> • <i>Women's business: The "stuff of legend" that can only be experienced by women (Rose 278).</i> <ul style="list-style-type: none"> ▪ "Sisterhood": A shared female experience ▪ Intergenerational knowledge ▪ Women's knowledge ▪ Tacit knowledge
<ul style="list-style-type: none"> • <i>Coping strategies: "You just get on with it" (Rose: 347)</i> <ul style="list-style-type: none"> ▪ Cognitive (things women tell themselves) ▪ Behavioural (things women do)

Higher order concepts and super-ordinate themes: version 6
<ul style="list-style-type: none"> • Liberation: Freedom "to feel that you're becoming yourself finally" (Kate: 519): <ul style="list-style-type: none"> ▪ Liberation from biological restrictions ▪ Liberation from social expectations ▪ Liberation from self-expectations
<ul style="list-style-type: none"> • Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate: 36): <ul style="list-style-type: none"> ▪ Physical losses ▪ Emotional losses ▪ ?Loss of biological/social identity (not sure about this as a title)/ loss of youthful identity. I think loss of youthful identity is my preferred emergent theme and this captures what is being described by participants about not being viewed by others as young anymore.
<ul style="list-style-type: none"> • Women's business: The "stuff of legend" that can only be experienced and shared by women (Rose 278). <ul style="list-style-type: none"> ▪ "Sisterhood": A shared female experience. ▪ Intergenerational knowledge\making comparisons with other women ▪ Women's knowledge ▪ Tacit knowledge
<ul style="list-style-type: none"> • Coping strategies: "You just get on with it" (Rose: 347). <ul style="list-style-type: none"> ▪ Cognitive (things women tell themselves) ▪ Behavioural (things women do)

Higher order concepts and super-ordinate themes across the group: Version 7	
<ul style="list-style-type: none"> • Liberation: Freedom "to feel that you're becoming yourself finally" (Kate: 519): <ul style="list-style-type: none"> ▪ Liberation from biological restrictions ▪ Liberation from social expectations ▪ Liberation from self-expectations 	
Liberation from social and self-expectations appear to be inextricably linked therefore these emergent themes will be merged.	
<ul style="list-style-type: none"> • Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate: 36): <ul style="list-style-type: none"> ▪ Physical losses ▪ Emotional losses ▪ Loss of social identity 	
<ul style="list-style-type: none"> • Women's business: The "stuff of legend" that can only be experienced and shared by women (Rose 278). <ul style="list-style-type: none"> ▪ "Sisterhood": A shared female experience. ▪ Making comparisons with other women ▪ Women's knowledge ▪ Tacit knowledge 	
Tacit knowledge has been incorporated into making comparisons with other women and women's knowledge	
<ul style="list-style-type: none"> • Coping strategies: "You just get on with it" (Rose: 347). <ul style="list-style-type: none"> ▪ Cognitive (things women tell themselves) ▪ Behavioural (things women do) 	
Coping strategies to become: Acceptance of the changing me	

Higher order concepts and super-ordinate themes across the group: Version 8	
<ul style="list-style-type: none"> • <i>Liberation: Freedom from "cultural baggage...to feel that you're becoming yourself finally" (Kate: 519):</i> <ul style="list-style-type: none"> ▪ Liberation from biological restrictions ▪ Liberation from social expectations ▪ Liberation from self-expectations 	
<p>"Cultural baggage" has been added to the higher order concept as this in vivo code, used by Kate, represents negative views of midlife and older women.</p>	
<ul style="list-style-type: none"> • <i>Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate: 36):</i> <ul style="list-style-type: none"> ▪ Physical losses ▪ Emotional losses ▪ Loss of social identity 	
<ul style="list-style-type: none"> • <i>Women's business: The "stuff of legend" that can only be experienced and shared by women (Rose 278).</i> <ul style="list-style-type: none"> ▪ "Sisterhood": A shared female experience. ▪ Making comparisons with other women ▪ Women's knowledge ▪ Tacit knowledge 	
<ul style="list-style-type: none"> • <i>Acceptance of the changing me: "You just get on with it" (Rose: 347).</i> <ul style="list-style-type: none"> ▪ Cognitive (things women tell themselves) ▪ Behavioural (things women do) 	
<p>Acceptance of the changing me to be removed as a higher order concept as it is the the outcome of the three higher order concepts.</p>	

Higher order concepts and super-ordinate themes across the group: Final version

- ***Liberation: Freedom from "cultural baggage...to feel that you're becoming yourself finally" (Kate: 519):***
 - Liberation from biological restrictions
 - Liberation from social expectations
- ***Losses: "I kind of assumed that it was something that lasted for a year or two and then it went and you went back to normal" (Kate: 36):***
 - Physical losses
 - Emotional losses
 - Loss of social identity
- ***Women's business: The "stuff of legend" that can only be experienced and shared by women (Rose 278).***
 - "Sisterhood": A shared female experience.
 - Making comparisons with other women
 - Women's knowledge
 - Tacit knowledge

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