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A Postmodern Discourse on Distress during the Menopause Transition

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A Postmodern Feminist Discourse on Distress during the Menopause Transition

by

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DISSERTATION

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Dedication

I dedicate this to three particular women of my family—my mother, who, although born in the United States, never had the opportunity to continue school beyond the eight grade; my sister, Teresa who, although confined to a wheelchair for most of her adult life, lived with courage, character, and humor, and died before even having the opportunity to experience menopause; and my 24 year old daughter, Crystal, who lived twenty years of her life through the unceasing endeavors of her mother's educational pursuits. Without the inspiration of these women, I would not have arrived here.

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My advisor, Dr. Holly P. Kennedy has taught me a new meaning for midwifery. She has spent hundreds of hours coaching me through the birth of this from conception to expulsion. I will forever be grateful. My committee member, Dr. Maria Gudmundsdottir has lived the role of the doula, sustaining her position at my side as she endured the special challenges of transition and crowning. I extend my thanks to my two other committee members, Dr. Kathryn A. Lee and Dr. Margaret Wallhagen. I have much gratitude for their expertise and patience as they belabored my 300 page first draft.

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And last but certainly not least, I thank the participants of this study who shared their pain, sorrow, joys, and journeys with me. May they continue to be acknowledged for the amazing women they are. And may all women transitioning through menopause find the support and validation they need and deserve.

Abstract

A POSTMODERN DISCOURSE ON DISTRESS DURING THE MENOPAUSE TRANSITION

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Some women experience symptoms during the menopause transition that cause distress. Due to the heterogeneity of experiences, distress has been difficult to measure. Researchers have examined risk factors such as personality traits, stress, coping, lifecourse, and hormonal sensitivities to explain distress during menopause. The purpose of this narrative analysis study was to explore the experiences of distress for women during the menopause transition, and to examine the experiences of aging.

A postmodern feminist framework allowed for individual experiences of distress to unfold within the stories and to view how women adopt positions in prevailing discourses. Narrative analysis methodology facilitated the understanding of individually defined distress and how it reflected shared meanings embedded in Western society.

Fifteen women were interviewed in person using open interview techniques and were digitally voice recorded. Interviews were transcribed verbatim to examine use of language such as utterances, tone of voice, and pauses. Data were re-transcribed after the identification of narratives and poetic structures. Themes were analyzed within and across interviews. Coding was conducted to aid in the noting of themes.

The women described hot flashes, night sweats, menstrual changes, decreased libido, vaginal dryness, sleep disruption, and others within the context of their lives. The women demonstrated ways of adopting social discourses on menopause and aging that aided or dampened positions of power. Themes identified were of silence, shame, and stigma related to aging and menopause. Some women experienced social withdrawal and alienation. Narratives of chaos, restitution, and quest were analyzed. Loss of control was experienced to be most distressful for some of the women.

It is a historical time with many babyboomers reaching the age of menopause and studies cautioning against the liberal use of hormone therapy. Nurses need to understand the contextual meaning embedded in the women's experiences. Alternative models to provide care and reduce alienation, such as group care, is worthy of research. Women need to be advised in how the adoption of social discourse may influence experiences of distress. Further exploration of the meaning of control in women's lives needs to be conducted.

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CHAPTER ONE: THE STUDY PROBLEM

Distress during the Menopause Transition: A Complex Phenomenon

Currently in the United States there are more than 20 million women of menopausal age (45-54 years), and an additional 22 million will enter menopause over the next 10-15 years (Projections of United States Census Bureau: 2001-2005, 1999). The most frequent reason women of this age group visit their healthcare provider is because of the inability to cope with conditions related to menopause, especially hot flashes (Guthrie, Dennerstein, Taffe, Lehert, & Burger, 2004; Kronenburg, 1994). Most women (87%) between 40-60 years of age experience hot flashes daily, with 30% reporting 10 or more per day (Kronenburg, 1990). Additionally, among women experiencing menopause, 75-80% experience physiological or psychological changes that may be perceived as bothersome (Kronenburg, 1990). Although large population studies have demonstrated that most women transition through menopause without much discomfort (Avis & McKinlay, 1995), others experience distress (Avis et al., 2003; Bloch, 2001; Bromberger et al., 2003; Bromberger & Matthews, 1996; Dennerstein, Dudley, Hopper, Guthrie, & Burger, 2000; Finset, Overlie, & Holie, 2004; Gold et al., 2004; Joffe et al., 2002; Keenan et al., 2003; Kuh, Hardy, Rodgers, & Wadsworth, 2002; Nedstrand, Wijma, Kindgren, & Hammer,1998; Reynolds, 2000; Steiner, Dunn, & Born, 2003; Woods & Mitchell, 2005).

The inscrutability of distress as a concept precludes the ease by which it can be defined and understood (Massé, 2000). A major problem in the study of distress during the menopause transition is that distress may mean different things to different people, including women and scientists. Generally, research foci tend to reflect three aspects of

distress during menopause: 1) the primary experience of distress—anxiety, irritability, angst, depression—often attributed to potential neuroendocrine changes in the brain (Desoto, 2003; Joffe et al., 2002; Rubinow & Schmidt, 2003; Steiner et al., 2003); 2) a secondary response to the intensity and impact of empirically supported symptoms related to menopause, such as hot flashes, night sweats, and vaginal dryness (Avis, Crawford, Stellato, & Longcope, 2001a; Guthrie, et al., 2004); or 3) psychological states resulting from the emotional responses to menopause or aging (Bannister, 1999; Bloch, 2001), inablility to cope with stressors (Bosworth, Bastian, Rimer, & Siegler, 2003; Bromberger & Matthews, 1996; Nedstrand et al., 1998), difficult life trajectories (Kuh et al., 2002), or innate personality traits that cause excessive stress reactions to midlife challenges (Bosworth et al., 2003; Bromberger & Matthews, 1996; Kuh, et al., 2002). For the woman experiencing distress, the contextual background of her life will shape her experience; yet this is nearly impossible to quantify through the use of instrumentation (Massé, 2000). The scope of her experience is beyond a questionnaire. Nonetheless, attempts have been made in an effort to identify the roots of the problem.

Conflicting results from previous research impart further questions regarding the etiology of distress for a woman at this time of her life. Often, experiences are interconnected and dependent upon one another. For example, frequent night sweats may disrupt sleep and can cause depression or irritability during the day (Avis et al., 2001a). Because of the complexity of a midlife woman's life and the variation of the manifested symptoms of menopause, much remains inconclusive regarding the experience of distress during the menopause transition.

Distress during the menopause transition is laden with conceptual challenges, including distress, symptom, and aging, and menopause itself. Each of these concepts has multiple meanings to different people, cultures, subcultures, contexts, and historical periods. They are also simultaneously reflective of societal discourses that draw common threads through individual interpretations. The multiple social discourses that prevail and inform women through various sources such as the media, healthcare providers, and other women influence their understanding and experience of the menopause transition (Bannister, 1999; Ogle & Damhorst, 2005). Women who are experiencing distress may be viewed as silent actors (Clarke, 2005) caught between those who assert their agendas that menopause is either a disease or simply a natural occurring stage in women's lives (Friedan, 1993). Granville (2000) stated, "…the feminists' 'the normal body' and the patriarchs' 'medicalized body' are equally constructed forms of the same discourse" (p. 79). Additionally, meanings, both fluid and dynamic, fluctuate within the individual, thus varying interpretations exist at any given time. Menopause is a time of change and subsequent uncertainty (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). For multiple reasons, women may experience distress during this reproductive transition. The manifold expression of this distress creates immense difficulty in the ability to comprehend the impact it may have on affected women.

Problem Statement and Purpose of Study

Distress during the menopause transition is a multifaceted phenomenon that can manifest for midlife women and create difficult challenges for their healthcare providers. In order to gain a fuller understanding of the phenomenon, the purpose of this study was to explore the experiences of distress for women during this menopausal transition.

Significance

Midlife is a time of transition and brings its share of stressors (Meleis et al., 2000; Walters & Denton, 1994). Challenges prevail: family concerns such as raising adolescents or grown children leaving the house, dealing with aging parents' needs, and possible divorce; financial hardships such as job lay-offs, concerns for future retirement, and children's college education; and physical trials and tribulations such as illness or the myriad effects of the aging process (Norton, Gupta, Stephens, Martire, & Townsend, 2005; Phillips, 2000; Quadagna, 1988; Skucha & Bernard, 2000). In addition, women must deal with the changes that occur with menopause. For others, menopause passes without much notice (Avis & McKinlay, 1995; Ogle & Damhorst, 2005).

For women whose lives have become disrupted, the medical community becomes a source of support as they seek explanations and assistance for their concerns (Guthrie et al., 2003; Kronenburg, 1994). However, when women present with symptoms attributed to menopause, there exists only few options. Moreover, health practitioners frequently do not have the opportunity to fully understand the extent of the problems women have (Utian, 2005; Woods & Mitchell, 2005).

For many women, a decreased quality of life is an unfortunate consequence of distressful symptoms during the menopause transition (Avis et al., 2003). Healthcare

costs for midlife women can be attributed to healthcare visits for menopausal complaints (Guthrie et al., 2003; Kronenburg, 1994). Women may experience loss of work days for complications of this disruption. Historically, women who suffer during the menopause transition have been ridiculed and their conditions not seriously considered. Twentieth century "neuroticism" (Bromberger & Matthews, 1996) has now replaced 19th century "hysteria" (Stolberg, 1999). A feminist approach that examines the sociocultural influences of distress is needed to eliminate negative stereotypes of menopausal women.

Treatment for women during the menopausal transition, specifically hormone therapy (HT) has recently raised concerns for health practitioners and women because researchers have discovered that instead of preventing illness such as cardiovascular disease, risk is increased (Writing Group for the Women's Health Initiative (WHI), 2002). Additionally, epidemiological reports from 2006 have demonstrated a significant decrease in the incidence of breast cancer, which has been directly attributed to the decreased consumption of hormone therapy since the WHI study (Breast Cancer Research and Treatment, 2006). More than ever before, women seek alternatives such as herbs, soy products, and natural hormones (Newton, Buist, Keean, Anderson, & LaCroix, 2002), but the evidence does not consistently support the efficacy and safety of such treatments (Boothby, Doering, & Kipersztok, 2004; Huntley & Ernst, 2003; St. Germain, Peterson, Robinson, & Alekel, 2001).

Women are increasingly uncertain as to how to manage their symptoms during the menopause transition (Haskell, 2004; Stephens, Carryer, & Budge, 2004; Theroux & Taylor, 2003). The uncertainty may be the result of a conflict of symptoms' etiologies, the controversy regarding treatment, and/or women's complex lives during the

menopausal years. The uncertainty contributes to the distress and confusion women experience. This study will help to understand the menopausal concerns of midlife women and aims to find effective ways to better support them.

Evidence about the distress midlife women experience is conflicting and inconclusive. Although the final menstrual period is a one point in time, most women experience menopause as a transition that generally lasts for years (Avis & McKinlay, 1995). After a review of recent studies on menopause, Utian (2005), executive director and honorary founding president of the North American Menopause Society (NAMS), stated there is strong evidence to support that only vasomotor symptoms and vaginal dryness can be directly attributed to the endocrinological changes occurring during the menopausal transition. However, he also emphasized that social, cultural, psychological, and environmental factors can influence the variety of responses women have and that there is a "need to understand the factors that determine this variation in response" (p.8). In addition, Woods and Mitchell (2005) raised the concern that "…clinicians do not have access to data about the meaning women assign to their experiences" (p. 155).

A midlife woman's life is complex; she is situated—physically, hormonally, emotionally—in her changing body. She also resides within her social, cultural, and economic environment and has confronted many stressors. Although she has been the focus of a multitude of studies, the factors examined cannot wholly explain the transitional period encompassing menopause in her life. As a result, this study has used narrative analysis to explore how women experience distress during the menopause transition. Women's stories have given insight into their experiences. These stories will

aid clinicians, researchers, and policy makers in the exploration of interventions that may safely and effectively alleviate women's discomforts and improve their quality of life.

The subsequent chapters will be a presentation of the study of distress during the menopause transition. Chapter two includes an overview of relevant literature with an identification of the gap in knowledge, and the conceptual framework used to inform the study. Also in chapter two, assumptions brought into the study will be presented, as well as, the research questions and pertinent conceptual definitions. The methodology used for the study will be discussed in detail in chapter three. Chapters four and five will include sample characteristics, narratives, and thematic representations of the study. The concluding chapter—a thorough discussion of the findings, the implications for nursing, and suggestions for future research—will follow.

CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter is divided into five parts. Part one is the overview of relevant literature on menopause and aging. Part two is a discussion of the conceptual framework chosen to study distress during the menopause transition. Part three is a list of assumptions of menopause and aging. Part four is a presentation of the research questions. The final part is a brief definition of terms.

Overview of Relevant Research

Difficulty in grouping studies on menopause reflects the complexity of the topic. Most researchers, in their attempt to ascertain the etiology of symptoms, compare various endocrinological and psychosocial predictors to establish results based on these comparisons. Much is written on the topic of menopause, so a limited review of the literature has been conducted to expose the various angles researchers have taken in the pursuit of understanding the phenomenon. The approach to the literature search on menopausal symptoms and distress and treatment was multilayered and used the PubMed, CINAHL, and Psych Info databases. On PubMed alone if the word menopause is entered without any modifiers, more than 33,000 articles can be located. Since this study was on the experience of distress during the menopause transition, the key words or modifiers used with menopause were distress, depression, mood alterations, hormones, hot flashes, symptoms, quality of life, and aging. To include a range of predictors, other modifiers were incorporated including attitudes, stress, premenstrual syndrome, and coping. In order to specifically retrieve qualitative studies, the word ‘qualitative’ with menopause was applied. Citations found in articles previously retrieved were also explored. Randomized controlled trials were reviewed whenever possible. A range of

quantitative studies that used various predictors to examine the phenomenon of distress during menopause, as well as a representation of qualitative studies that explored experiences of menopause including the effects and interaction with aging were chosen for the critical review of the literature on distress during the menopause transition. To evaluate hormone therapy (HT) research, the historically famous Women's Health Initiative (WHI) (Writing Group, 2002), as well as studies related to decision making, and hormone therapy use were included. The following section is a short presentation of population studies that examined symptoms midlife women experience during menopause.

Summary of Epidemiological Studies

The median age for natural menopause is around 51 years of age, (Avis & McKinlay, 1995). Avis and McKinley (1995) found that frequency of hot flashes peak just prior to the final menstrual period (FMP) and steadily decrease thereafter. They also found that the rate of depression increased as women moved from pre to perimenopause and was higher in women with longer transitions (at least 27 months). In their sample of 16,065 women aged 40–55 years, Gold and colleagues (2000) discovered that women reported difficulty sleeping, night sweats, headaches, hot flushes or flashes, forgetfulness, vaginal dryness, leaking urine, feeling tense or nervous, feeling blue or depressed, and irritability or grouchiness. In addition, symptoms such as stiffness or soreness in joints, neck or shoulders, and heart pounding or racing were also identified. Adjusted analysis demonstrated that all symptoms were more prevalent in women who were peri or post menopausal versus premenopausal. All symptoms were not only higher among women who had difficulty paying for basics, but increased as economic hardship increased. Both

past and current smoking were related to most symptoms except for vaginal dryness and forgetfulness. High body mass index (BMI) (> 27 vs. 19-26) was related to the prevalence of vasomotor symptoms, but not among women in late perimenopause or postmenopausal women. Those with higher levels of physical activity reported less symptoms overall.

In a 9-year prospective population-based study, Guthrie and colleagues (2004) noted that hot flashes were found to increase 2 years prior to the FMP to a gradual decrease 6 years post FMP. Seventy-five percent of the women reported bothersome hot flashes, and 86% had visited a healthcare provider during the menopause transition. Furthermore, repeated measures of mood scores demonstrated that negative mood decreased significantly over time and was not related to menopause status, hormone levels, age, or education, but was positively associated with baseline reporting of premenstrual complaints, negative attitudes to aging and menopause, and parity of one. Decreasing symptoms, improving heath, positive feelings for partner, gaining a partner, and reducing stress reduced negative mood.

Guthrie, Dennerstein, Taffe, Lehert, & Burger (2005) also studied risk factors for hot flashes during the menopause transition. Eighty three percent (83%) of women reported hot flashes, and 20% reported them to be bothersome. Those who reported bothersome hot flushes were, at baseline, more likely to have negative mood, not be in full or part-time paid work, smoke, and not report exercising every day. Over the 9 years of follow up, those who reported bothersome hot flushes were relatively young in age, had low exercise levels, low estradiol levels, high follicle-stimulating hormone levels, smoked, and were in the late menopause transition, or being postmenopausal.

Dennerstein and colleagues (2000) found that trouble sleeping, vaginal dryness, night sweats, and hot flushes were all increased in late perimenopause and postmenopause. The only symptoms attributed to endocrine changes were vasomotor symptoms, breast tenderness, and vaginal dryness. As women advanced through menopause, a five fold increase in the prevalence of vaginal dryness was noted but was not significantly associated with hormone levels. It was found to increase exponentially from late menopause transition on, indicating it was a later developing symptom. Hot flushes had the highest odd ratio at the middle level of estradiol found in late menopause transition. This was attributed to the possibility that women were sensitive to the changing hormone levels more so than the level itself.

These findings were based on large population studies, either cross sectional or longitudinal. Some studies were multi-site and included multi-ethnicities. The rigor of these investigations adds to the epidemiologic description of menopause and its associated experiences.

Hormone Therapy

Women's distress can be indirectly related to the fear of taking hormone therapy. An under-treatment of severe vasomotor symptoms can occur causing a significant reduction in quality of life. A myriad of studies on hormone therapy and a literature review can focus on this topic alone. The historical Women's Health Initiative (WHI, 2002) will be discussed, since its results changed the liberal use of HT for a majority of women. In addition to a brief summation of the WHI, articles related to women's decision making regarding the use of hormone therapy will be presented in order to gain insight into the effects of post-WHI on menopausal women.

The Women's Health Initiative

Prior to the WHI, all studies on the benefits of hormone use were case/control or clinical observation studies. The Women's Health Initiative (2002) was the first randomized clinical trial with an aim to assess the major health benefits and risks of the most popular combination hormone replacement therapy (Prempro) at that time. The WHI evaluated 16,608 healthy postmenopausal women between the ages of 50 and 79. The main branch of the study examined combined therapy, and participants either received combined hormone therapy or placebo. The primary outcome was coronary heart disease (CHD) incidence including nonfatal myocardial infarction and CHD death. Invasive breast cancer incidence was the primary safety outcome.

As the data and safety monitoring board decided health risks exceeded benefits, the combined therapy branch of the study ended abruptly after an average of 5.2 years of follow-up. Results demonstrated increased risk of CHD, breast cancer, stroke, and pulmonary emboli, with a decreased risk of endometrial cancer, hip fractures, and colorectal cancer. Since the study was looking at CHD protection, they included mostly older women with a mean age of 63. Consequently, the benefit of examining a younger cohort using HT for symptom treatment instead of disease prevention was missed (Grimes & Lobo, 2002; Wehrmacher & Messmore, 2005). Concerns were also raised about the drug regimen used (Grimes & Lobo, 2002). Whether or not the findings could be extrapolated to other regimens, which may vary in the dosage of the hormones, the specific type of hormone, the route of administration, or whether taken continuously or cyclically, was also questioned (Grimes & Lobo, 2002).

A major criticism is the possibility that many of the women in the trial may have already had substantial arteriosclerosis, placing them at risk before they had the treatment. Therefore, for many in the WHI study, the HRT intervention was believed to be tested more as a secondary rather than primary prevention (Grimes and Lobo, 2002). However, the news of this trial swept through the medical profession and popular women's health magazines, created a frenzy, and essentially halted the liberal use of hormone replacement therapy, especially as a preventative treatment.

Decision Making and Hormone Therapy

The historic positioning of hormone therapy post WHI may impact the experience of menopause for many women. The newly exposed risks versus known benefits of HT make it difficult for women with severe menopausal symptoms to decide the best treatment (Haskell, 2004; Murtagh & Hepworth, 2003; Stephens, et al., 2004). This decision making process can increase a woman's distress. Furthermore, women differ in their opinions about the use, safety, and efficacy of HT (Stephens, et al., 2004). Women fear the consequences of taking and not taking hormone therapy. Once they begin hormone therapy, women have concerns about when and how to stop (Haskell, 2004). As a result, women have explored alternatives to HT such as 'bio-identical' or 'natural' hormones with the hope that they may be safer (Adams & Cannell, 2001; Francisco, 2003; Watt, Hughes, Rettew, & Adams, 2003). However, due to the inability to control doses, some researchers believe alternative forms of hormones carry even more danger than HT (Boothby, et al., 2004)

The objective for this part of the chapter is to review literature on women's attitudes, concerns, and thoughts about the consumption of hormone therapy. This

information is needed to further understand the distress related to symptom management and disease prevention for conditions related to menopause.

The WHI revealed adverse effects of HT use. Women feared these effects and abruptly or gradually stopped HT use. Haskell (2004) determined the proportion of women who discontinued the use of HT and compared the effects of discontinuing abruptly or tapering off slowly. Those who used HT for chronic disease prevention were sent recommendations to discontinue use. While those who used HT for menopausal symptoms or osteoporosis were told to consult a physician. Several months later, these women received questionnaires asking if and how they had discontinued use, what factors influenced their decision, and whether or not symptoms had returned.

Forty-eight out of seventy-three women responded, and 37 (77%) had stopped the use of exogenous hormone therapy. The women's mean age was 62 years with a range of 43 to 88 years. Forty-percent (n = 8) of the 20 women who had stopped abruptly versus 71% (n = 12) of the women who tapered off had experienced a recurrence of menopausal symptoms (NS). Of those who discontinued, the mean age was 64 versus 59 for those who decided to continue. The study demonstrates women's concern about the safe use of HT. It also emphasizes the importance of exploring appropriate and most effective approaches for women who choose to discontinue HT.

Stephens, Carryer, and Budge (2004) conducted seven focus group discussions with 48 women in New Zealand to explore contradictions observed in women's attitudes toward hormone therapy. They used a social constructionist framework to analyze discursive practices believed to carry social functions. Incorporating discourse and positioning theories, the authors analyzed talk in action

Six ‘interpretative repertoires’ (constructs of menopause) were identified. *Threatening change* constructed menopause as a time of unwarranted change and women who used this repertoire experienced a loss of control by which HRT was constructed as something essential to come to the rescue. The classic construct of menopause was the *biomedical* repertoire. In this case, menopause was a depletion of hormones. The *drug* repertoire referred to an opposition to HRT and compared its use to illicit drug consumption. Women viewed HRT use as a weakness. The *natural* repertoire challenged the notion of menopause as a deficiency condition, contested the use of HRT and supported alternative treatments. Terms such as ‘life stage’ and ‘growing old gracefully’ denoted this opposition. Women using HRT as a responsibility to maintain their family relationships created the *marriage* repertoire. *Feminist* repertoires were used by women not trusting of the biomedical world including doctors and pharmaceuticals companies. Subject positions (the women positioning themselves) invested in the various repertoires either singularly or in combination. Situations arose in conversation that exposed contradictions in women’s positions, such as a woman who represented the *drug* repertoire as she was concerned about pill popping yet in support of consuming natural pills.

This study established a provocative argument for the socially constructed discursive influences in the use of hormone therapy during the menopause transition. The use of participants’ quotes, especially in conversation, supported this argument. No other demographic data were provided other than employment status and a description of the women as mainly middle class. The authors do not mention analytic descriptions or procedures to support methodological rigor. Both the fluidity and internalization of

subject positioning demonstrates the way women negotiate and defend their stances on hormone therapy use.

Summary of Hormone Therapy

The historical WHI affected the liberal use of hormone therapy for the treatment of menopausal symptoms and disease prevention. Women have felt the effects of this study as fear of hormone therapy use conflicts with the desire to find relief of symptoms. Haskell (2004) found no difference between abrupt or tapering of supplementation, but the small sample prevented sufficient evidence. Social discourse on HT has been demonstrated to influence women's trust and attitudes toward hormone use (Stephens et al., 2004). Social constructionist researchers have demonstrated the fluidity of women's positions toward HT (Stephens et al., 2004). Decision making in HT use may add to women's distress. Though the North American Menopause Society (NAMS) condones the use of hormone therapy for low risk women with severe vasomotor symptoms, the potential harmful side effects demands a more restricted use (NAMS Position Statement, 2007).

Quantitative Studies Related to Distress during Menopause

Researchers have explored possible neuroendocrine etiologies of emotional symptoms during the menopause transition such as depression, anxiety, and/or irritability. Additionally, researchers suggested during the menopause transition, emotional symptoms stem from other factors such as personality traits, stress, attitudes, and life trajectories (Bromberger & Matthews, 1996; Kuh, et al., 2002; Nedstrand, 1998). The following studies, based on physiological or psychosocial theories, examined a range of

possible causes of distress for midlife women. Refer to Appendix B for details of each study including instruments used and statistical analyses.

In a longitudinal study, Avis and colleagues (2001a) investigated whether decreasing estradiol levels were associated with increased rates of depression in women transitioning through menopause. As part of a large population sample of 8050 women, women ages 43 to 53 years (N = 309) were interviewed an average of 2.4 times over a period of three years. They also had two blood samples drawn 30 minutes apart in the morning between days 5-7 of their cycles annually. In the unadjusted analysis, the authors found a negative association between depression and estradiol levels. However, after adjusting for the presence of hot flashes or night sweats, the association was not significant. Hot flashes or night sweats and difficulty sleeping were associated with depression. Therefore, they concluded their data supported a "domino" hypothesis—women who suffer from hot flashes or night sweats may also experience sleep deprivation, which may subsequently result in depression.

Other studies have challenged the 'domino' hypothesis by investigating direct endocrine links between menopause status and depression. For example, Joffe and colleagues (2002) studied the relationship between vasomotor symptoms and depression in perimenopausal women in comparison to postmenopausal and late premenopausal women. They hypothesized depression and hot flashes were both markers of a sensitivity to the effects of fluctuating estradiol levels on neurotransmitters. Data were collected from women aged 40 to 60 years (N = 476) who attended routine care at a women's clinic. Depression history was adjusted for. Results demonstrated women in perimenopause with vasomotor symptoms were 4.27 times more likely to be depressed

than those without vasomotor symptoms. However, no association with depression was found in premenopause or postmenopause women with vasomotor symptoms. The results support previous studies that found no increase in depression, or even decreases of depression in women postmenopause (Avis & McKinlay, 1995). This suggests that women may struggle the more during the menopausal transition than post menopause. Although the authors conclude that a neuroendocrine etiology for depression may be possible, the association can only be suggestive.

Finset and colleagues (2004) aimed to investigate the bidirectional relationship between psychological distress and various sex hormones and prolactin, during the menopause transition. The sample included 57 regularly menstruating women with a mean age of 51 years who were followed for five years. No significant changes in distress occurred during the menopausal transition. Distress was inversely associated with DHEA-S level, but inconsistently at different time points. Significant relationships were found between prolactin at T1 and T2 and distress at all three time points. However, no association between prolactin at T3 and distress was discovered. Prolactin dropped during the menopause transition, especially for those who were distressed. No associations were found between other sex hormones, such as estradiol and distress at any time point. Associations between prolactin and distress, although inconsistent, suggest another possible endocrinological cause for distress during the menopausal transition.

Women have reported changes in their sexuality during midlife. Studies have struggled to find whether symptoms are due to neuroendocrinological changes (therefore directly related to menopause), as part of the aging process itself, or psychosocial issues such as those related to relationships, stress, and self esteem. As part of the larger

SWAN study, Cain and associates (2003) investigated the sexual functioning and practices of 2,466 multi-ethnic, midlife women. Seventy-nine percent of women had engaged in heterosexual sex with a partner in the previous 6 months; 23% reported that sex was not important or not very important; 44% said it was moderately important; and 32% reported that sex was quite or extremely important in their lives. Menopause status was not a predictor of the importance of sex, having sex in the last 6 months, frequency of intercourse, touching or oral sex.

Among the 676 women who did not engage in sex for the last 6 months, the most common reason given by all ethnicities except for Japanese was not having a partner (67%). About 20% of women reported that they sometimes or always experienced vaginal or pelvic pain during intercourse and perimenopausal women were more likely than premenopausal women to have experienced frequent pain with intercourse. These findings contribute valuable information regarding the role that sexuality plays in women's lives at this age.

Women who experience premenstrual syndrome (PMS) may also be at risk for experiencing distress during menopause (Dennerstein et al., 2000; Steiner et al., 2003; Woods, Lentz, Mitchell, Heitkember, & Shaver, 1997). Women may be more sensitive to the hormonal fluctuations during the menstrual cycle, and may also be sensitive to fluctuations during the menopause transition (Rubinow & Schmidt, 2003; Steiner et al., 2003). Furthermore, persistence, and/or an increase in severity of PMS may occur in women as they approach the transition of menopause. Woods and colleagues (1997) examined a sample of 21 women over 40 and compared those with PMS to those with a low-severity symptom pattern on physiologic indicators of stress such as arousal and

response, stress hormone arousal, stressful life circumstances, anger, self and social control, and interpersonal sensitivity. Thirteen women had a low severity pattern and 10 women had a PMS pattern. No significant differences between groups or across cycle phases for epinephrine, norepinephrine, or cortisol occurred, but there was a trend toward higher norepinephrine levels premenses in the PMS group. Women with PMS experienced more negative life events in the past year, increased hostility, interpersonal sensitivity, and more concerns about social control during premenses phase than women with low severity pattern.

Researchers have also conducted various studies to ascertain if psychological symptoms during menopause are related to endocrinological changes or psychosocial factors. Nedstrand and colleagues (1998) investigated whether women with vasomotor symptoms had a lower stress-coping than those without symptoms. Stress-coping was measured by the Stress Coping Inventory, an instrument used to measure an individual's self perception of coping with stressful situations. They also assessed whether stress coping changed after the reduction of vasomotor symptoms with hormone therapy. Furthermore, they examined whether women who were effectively treated for their symptoms scored higher on a neuroticism scale. A self selected sample of 33 women recruited at a gynecological outpatient clinic was placed into two groups: intervention—those who were symptomatic and who received estrogen replacement (n = 16) and a control group of asymptomatic women (n = 17).

Women in the treatment group had significantly lower stress-coping than controls at baseline. Stress-coping did not change in the treatment group even after symptoms were abated, and they scored higher on the neuroticism scale than the asymptomatic

controls. Physicians and subjective reporting of the women noted a change in symptoms in the treatment group. However, the physicians noted a larger reduction of symptoms than the women reported. The researchers concluded with the statement, "neuroticism may play a role on how people report symptoms in general, and the propensity to report significant vasomotor symptoms may differ between women with different personality" (p. 33). The small sample size and lack of placebo adds sufficient bias to weaken results. Theoretically, stress-coping is an important aspect to a woman's subjective response to her symptoms; however, the use of personality trait, specifically neuroticism depicts a negative view of women who are struggling with the menopause experience.

As part of the SWAN study, Avis and colleagues (2003) conducted a study on health-related quality of life (HRQOL) of multiethnicities. They adjusted for menopause related symptoms and sought to determine whether early perimenopause was associated with HRQOL and if they could detect ethnic variation. Forty-six percent of the women were in early perimenopause and 54% were premenopause. In the unadjusted models, women in premenopause had better HRQOL than did those who were in perimenopause. Japanese women consistently scored higher on all subscales, whereas Hispanic women generally scored lower. After controlling for socioeconomic and demographic status, education and financial strain explained the differences in physical and emotional domains and vitality (variables examined to determine quality of life). When examining the role of menopausal symptoms on HRQOL, they found menopausal symptoms did explain impaired functioning in the physical, bodily pain, vitality, and social function domains, but not in the emotional domain. The findings suggest that symptoms

menopausal women experience have an important role in the health-related quality of life.

Adverse lifetime events have been hypothesized as potential predictors of depression in midlife women. Schmidt and colleagues (2004) compared the number and quality of life events reported by depressed and non depressed perimenopausal women. They recruited 50 depressed women with an onset of depression occurring near to the onset of menstrual irregularity, matched with 50 healthy, clinically non-depressed women of the same age, menstrual stage, education, employment status, and ethnicity. Results demonstrated no difference between past major and minor depressive episodes or marital status. The depressed women reported significantly lower marital satisfaction, more undesirable life events, and greater life events that decreased their self esteem. However, marital satisfaction as a sole measurement of social support weakens the study. The authors found the presence of hot flashes did not moderate the effect between life events and depression. The researchers recommended efforts to increase social support and feelings of self efficacy and reduce life stress to decrease depression among perimenopausal women.

Kuh and colleagues (2002) also examined lifetime risk factors for women's psychological distress in midlife. The sample was drawn from a large national prospective cohort of 2547 women. Each year women's reports of psychological symptoms such as anxiety, depression, irritability, tearfulness, and feeling of panic assessed their distress. After taking into account recent life stresses, they found women with high levels of distress between ages 47 and 52 had different life trajectories than those without distress. Women with distress were more likely to have divorced parents,

score higher on the neuroticism scale or exhibit antisocial behaviors as an adolescent, have prior psychological or health problems as an adult, or have current family and work stress. Having teens or younger children contributed to higher symptom scores as did having higher or lower than normal body weight. They found little or no association between menopause status and distress.

Walters and Denton (1994) investigated the social production of women's health to investigate if women's health concerns were mainly reproductive in nature or were centered around their work or other aspects of their lives. Women's experiences of stress, anxiety, depression, and tiredness were most commonly reported. Reproductive issues were not among the health concerns most frequently reported. Stress was most often declared as bothersome. In order of importance, road accidents, breast cancer, being overweight, stress, and arthritis were health and social issues of most concern. The health problems most frequently experienced in the previous 6 months were tiredness, stress, disturbed sleep, being overweight, and finding time for themselves. The main statistical predictors for stress were hours worked, not having a white collar job, and having problems with other family members or money. For tiredness, working outside the home and problems with money were associated; for depression, the most important predictor was loneliness. In conclusion, the researchers raised an argument for the need to further explore the social construction of illness. This study demonstrates provocative results regarding the concerns of midlife women.

Bloch (2001) conducted a cross-sectional study to examine the effects of body image and self esteem on menopausal symptoms and attitudes toward aging and menopause among menopausal women. The researcher also measured the influence of

HRT and postmenopausal estrogen levels on specific complaints such as vasomotor symptoms. Of those reporting symptoms, 51% reported hot flashes, and 61% had complaints of being tired and weak. Women who regarded menopause negatively reported significantly more symptoms such as sleeping disorders and depression than those with a positive attitude. Additionally, those who described the losses of menopause, rather than the reliefs, reported significantly more symptoms such as sleeping disorders, nervousness, tiredness, and hot flashes.

The findings stimulate an interest in the connection between attitude and emotional well-being in women's experience of menopause; however, Bloch (2001) repeatedly drew cause and effect conclusions throughout the paper. Limitations included a small sample size, cross sectional design, and 82% of the women were postmenopause during the study. The study creates an awareness of the vast emotions possibly accompanying the transition but the limitations prevent applicability to practice.

Bromberger and Matthews (1996) conducted a longitudinal study to examine the effects of pessimism, neuroticism, and life stress on depressive symptoms in middle-aged women. They explored whether stress moderated the effect of optimism on depressive symptoms. They described neuroticism as negative affectivity and referred to as a "…personality consisting of chronic negative emotions including sadness, anxiety, guilt, and anger, as well as…low self-esteem and self preoccupation" (1996, p. 208). Women who were pessimistic, had on-going stressful problems, or had experienced a prior stressful life event reported more depressive symptoms. Although women who scored higher on trait anxiety had more depressive symptoms, there were no specific interactions between trait anxiety and stress on menopausal status. The researchers suggested people

with a negative affect may be vulnerable to depression exclusive of stressful events. They make a bold conclusion stating "…clearly, the menopause is not a time of psychological vulnerability to stress" (p. 212). The STAI is a well-validated instrument, but its use as a proxy to measure 'neuroticism' in menopausal women may create a negative picture and possibly blame women for their distress.

Using a different approach, Reynolds (2000) adapted a questionnaire from chronic pain research based on the concept of 'catastrophising.' Catastrophising thoughts are negative appraisals of experiences believed to "…involve despairing anticipations about the future, dwelling on worst-case scenarios or berating the self for failing to control the current situation" (2000, p. 114). Catastrophic thoughts and distress related to hot flushes declined over time. Catastrophic thoughts were found to be related to increased distress at different time points. Catastrophic thoughts were also significantly related to "weak beliefs in control over their physical or psychological effects" (p. 118). A positive association with frequency of flushes and catastrophic thoughts was found at Time 1 but not at 12 months. Reynold's instrument may be able to identify women who could benefit from this self knowledge.

Summary

The studies reviewed above explored a range of factors possibly associated with distress during the menopause transition. Hormonal influences, attitudes, stress, both current and past, personality traits, coping abilities, lifetime events, social support, and experiences with symptoms have demonstrated an influence upon women's menopause experience. Conflicting evidence surfaced regarding endocrinological etiologies of psychological symptoms. Researchers suggest personality traits or learned behaviors as a

cause of women's distress during menopause. However, inconsistent results can be attributed to variations of menopause status classification, insufficient sample size, lack of controls, or the use of non-validated or unreliable instruments.

The drive to focus on individual deviations in this body of literature may stem from the endocrinological studies' inconsistent results or the difficulty in scrutinizing the socio-cultural contributions to distress in midlife women. However, distress is difficult to measure. The use of proxy measures for distress may produce a limited and fractioned understanding of the phenomenon. The following studies incorporated the use of qualitative methodologies to examine the experience of menopause.

Qualitative Studies on Menopause and Aging

The difficulty in capturing the essence of distress during the menopause transition warrants a contextual account of the experience. Qualitative studies have the ability to explore the individual experiences of menopause. This technique weaves the societal influences and shared values regarding the phenomenon and may also expand the experience. The following section includes studies that employ a range of qualitative methodologies to explore aspects of midlife women, including menopause and the process of aging.

George (2001) employed phenomenological methods to examine and interpret the experience of 15 women between the ages of 48 to 62 who experienced a natural menopause. Thematic analysis of the data identified three main themes: 1) expectations and realizations, 2) sorting things out, and 3) a new life phase. George used one quote to describe the confusion of stress during menopause versus the challenges of being a mid-life woman, "…I was in stress; my mother was sick; I was caring for her and there was a

lot going on" (2001, p. 82). Most women had positive responses to the menopausal transition, which was a new beginning free of menstrual periods and the need for birth control methods. The reporting of an audit trail and member checking enhanced credibility and sufficient quotes were given to support the analyses. However, philosophical concepts could have been described in more detail. Overall, the study contributes to knowledge of the menopausal experience of those who had a mild or nondistressful transition.

Menopause and aging are interchangeable. Conditions that may be a result of aging are frequently attributed to menopause since both occur at the same time. Additionally, many physical changes occur during this time that may cause distress for women. Bannister (1999) conducted an ethnographic account of 11 midlife women aged 40 to 53 regarding their perceptions of their changing bodies within a Western cultural context. She discovered the women's experiences were laden with contradiction and included themes of loss, cultural influences that perpetuated ageism and sexism, a lack of consistent information about menopause, redefining self, and issues of self care. One woman addressed experiences related to "…misogynist attitudes amongst men" (p. 527). Bannister had found the most useful method for treating health complaints was dialoguing with other women "…in which midlife myths and misconceptions were balanced by personal accounts of their changing bodies…" (p. 529). Women's struggle with aging in a Western culture was raised with inferences to sexism.

The strengths of this study included an introduction describing theoretical frameworks related to ageism and sexism, as well as, efforts used to assure methodological rigor. Methods to assess credibility, transferability, dependability, and

confirmability were well described. The author used robust excerpts from interviews to support various findings. Groups were incorporated to include the participants in further dialogue regarding the data and to participate in the analysis. This study was a rigorous ethnographic account of women transitioning through midlife.

Following along this theme, Ogle and Damhorst (2005) aimed to explore how women transitioning into their middle years experienced and thought about their changing bodies and various related societal discourses. Interviews were conducted with 20 women between the ages of 37 and 47. Grounded theory methods were employed including open, axial, and selective coding. They found women were distressed about their changing bodies but most "came to terms with" the changes (p. 6). The authors noted conceptual shift in ways the women thought about their bodies. Two "ideological adjustments" were identified: 1) the shift from an emphasis upon external to internal aspects of self and 2) the questioning of dominant discourses about the female body. In conclusion, Ogle and Damhorst acknowledged the challenges women faced as they age in modern Western society, but they found "…participants were able to arrive at a relatively comfortable acceptance of their newly middle-aging bodies" (p.14). They attributed this ability to transform beyond the pressures of societal discourses to the fact that these women were babyboomers and were raised during a historical time when "a feminist self view" was more readily adopted (p. 14). Philosophical concepts regarding the method were woven throughout the article establishing a sound foundation to understand the analyses. Measures to meet methodological rigor were stated. A more diverse study population, including ethnicity, socio-economic, and different relationship status, could

have added to the richness of the data. The researchers revealed valuable information regarding midlife women's awareness of aging discourses.

Menopause has also been suggested to play a role as a developmental stage in women's lives. Busch, Barth-Olofsson, Rosenhagen, & Collins (2003) conducted a longitudinal population based study using Grounded Theory and quantitative statistical analysis. They investigated the relationship between women's appraisal of menopause and reporting symptoms during menopause. Annual interviews were conducted and general health screenings were performed over five years. A total of 130 (N = 150 at baseline) women completed the study. Information from the qualitative interviews were coded and tested quantitatively. The categorizations were as follows: predictors—optimist, pessimist, and pessimistic-positive (pessimists that reassessed as optimist when re-evaluated later in study). At baseline, 56% of women had neutral expectations of menopause, 31% were pessimistic, and 13% were optimistic. At the end of the study, 16% were neutral, 17% pessimistic and 67% positive. Both pessimistic and pessimistic-positive scored significantly higher in depression, anxiety, and interpersonal sensitivity, hostility, and somatization. At Time 1 and Time 3, the negative groups scored significantly higher in negative mood, memory difficulties, and joint pain. At Time 2, the pessimistic group also scored higher in vasomotor and urogenital symptoms. Even though the attitude had changed in the pessimistic group, they continued to score higher on symptom scales.

The researchers' prolonged engagement over a 5 year period and their efforts to use the same interviewer to maintain consistency enhance the study's credibility. The sample was purposive. The recruitment of only 48-year-old women, however, may have

prevented the ability of women who may have already been in the menopause transition to pre-assess their expectations. The study creatively examined menopause as a process, providing a view of how postmenopausal women reassess their predetermined attitudes toward menopause. This study can help women better understand menopause and facilitate passage through this transition.

Summary

The qualitative studies presented reflect the range of experiences among women transitioning through menopause. Women may transition smoothly and welcome the change menopause brings whereas others have reflected upon the influences of socially embedded discourses on women and aging. Lack of clear information about the process of menopause was disturbing for women. Other women may feel differently as symptoms subside, menopause ends, and they settle into their new stages of life. Women may initially resist change at the onset but eventually accept the changes accompanying menopause and aging. Incorporating qualitative methodologies elucidates the range of experiences during menopause, individually expressed and simultaneously reflective of larger social influences.

Gaps in the Literature

The above studies of how women's experience of distress varies during midlife and the menopausal transition represent a fraction of existing literature. Studies chosen for this review illustrate researchers' various approaches in the pursuit of understanding menopause for women. For example, investigators have concluded that depression is not directly associated with menopause status because rates of depression decreased as women passed through menopause (Avis & McKinlay, 1995; Bromberger & Matthews,

1996; Busch et al., 1994; Kuh et al., 2002). Joffe and colleagues (2002) also found a higher level of depression in women during perimenopause. They attributed higher depression levels, however, to a possible sensitivity to fluctuating hormones which is also supported by other scientists (Pearlstein, 1995). Indirect causes of depression related to symptoms have also been identified. Avis et al., (2001a) proposed the "domino" effect as sleep disturbances occurring as a result of frequent night sweats may cause subsequent depression.

Fluidity versus stagnation of attitudes and symptoms surface in the physiologically and psychosocially focused studies. Whether this fluidity is due to a fluctuation of hormones or a transformative process related to aging is difficult to ascertain. Busch and colleagues (2003) demonstrated that as women transitioned through menopause, those who were previously pessimistic reevaluated it optimistically at postmenopause. The authors concluded that for many women, menopause is a developmental stage. Ogle and Damhorst's (2005) findings of women's reflection of their changing bodies support a transformative reassessment of internalized social values related to body image.

Studies support the influence of life trajectories and previous history of depression on distress, depression, or mood changes in midlife women (Kuh et al., 2002; Schmidt et al., 2004). In a rigorous ethnographic account, Bannister (1999) described the social construct and influence of aging upon midlife women in her sample. Walters and Denton (1994) demonstrated the social influences of work, and found women were most concerned about stress and fatigue. George (2001) found most women in her sample transitioned relatively smoothly, but had issues related to family, caring for aging parents,

and career conflicts. Women scoring high on neuroticism and trait anxiety scales have also been found to be at increased risk for depression and distress during the menopause years (Bromberger & Matthews, 1996; Kuh et al., 2002). However, using these instruments may allude to blame or innate personality traits as causative factors and negates neuroendocrine or social influences.

The fluctuating discourse related to HT may add to the distress women experience during this time. Women question HT use to relieve distressful symptoms, especially after the WHI results demonstrated an increased risk of breast cancer and stroke for some women who used HT. The study, however, is criticized for addressing an older population using HT for preventive rather than curative reasons. Thus, skepticism and reluctance exists among women considering HT use.

The distress midlife women experience specifically related to the endocrinological changes of menopause is inconclusive. The decreased quality of life women may experience during this time can be a result of anxieties toward aging, a life-time of stressful challenges, ineffective coping skills, and sensitivity to normal endocrinological changes. Researchers have debated conflicts over the cause of mood alterations in midlife women (Bloch, 2003; Desoto, 2003). Desoto (2003) criticized Bloch (2003) for drawing conclusions about the association between women's attitudes and their experiences and alluding to attitudes as being a "cause" and not just an association. Desoto reminded Bloch of the physiological effects of hormone changes on women. In her defense, Bloch's rebuttal supported the possible power of psychological factors influencing a woman's experience of menopause (Bloch, 2003).

With the above conflicting evidence, endocrinological or neurological influences are yet to be fully explored and discovered. The staging of menopause status may also have had a strong influence on conflicting results, especially if women had been erroneously placed in stages that would affect statistical analyses. Mostly this relates to women who may have already been in transition but were considered premenopausal. They may have begun cycle changes but were still having regular menses. According to recent staging criteria, they would have been in early transition (Soules, et al., 2001).

These directions for further study are worthy and most likely add to the body of knowledge of distress during the menopause transition. However, direct understanding about the heterogeneous experiences of distress during the menopause transition is lacking in the literature. Qualitative studies have been conducted, but they cover a broad experience of menopause and leave the potential to miss experiences of distress. A qualitative study that focuses on the experience of distress best addresses the study problem and facilitates an in-depth understanding of the physiological, psychological, social and cultural influences of their experiences. As Martin (1992) stated, "Hot flashes and women's and society's responses to them are layered with levels upon levels of intentionality and interpretation" (p. 169). Women's stories of distress provide insight into their experiences so clinicians, researchers, and policy makers can facilitate interventions geared to safely and effectively alleviating discomforts.

Conceptual Framework: Postmodern Feminism

The preceding literature review demonstrates the complex issue of studying distress during menopause. As revealed above, examining distress during menopause via the use of instruments that measure neuroticism may limit the understanding of midlife

women. A perspective that affords the saliency of heterogenic manifestations of distress must encompass a holistic and compassionate philosophy of women. The following section elaborates on a framework that achieves a comprehensive exploration of the physiological, sociocultural, historical, and psychological experiences of distress during menopause.

Some of the studies above claimed that there is no endocrinological explanation for women's psychological complaints. For example, Busch et al. (1994), concluded "…Psychological distress of middle-aged women is unlikely to be related to menopause" (p. 209). Consequently, those who are challenged by the menopause transition may not be taken seriously and potentially adds to their distress. To gain a better understanding of how women define distress and to explore how they navigate the many discourses influencing their experiences, examining their individual experiences of distress during menopause is imperative.

A postmodern feminist framework backed by phenomenological philosophy is an ideal lens to gain an understanding of distress during the menopause transition. In order to establish a rationale for this framework, this theoretical discussion will be presented in three parts: 1) a philosophical review of self, 2) an examination of women and aging, and 3) a review of postmodern feminism. The discussion will conclude with an argument for a postmodern feminist framework for studying distress attributed to menopause.

Philosophical Views of Self

How the self is viewed and understood guides the theoretical angle taken to study distress during menopause. The mechanistic model of a person is based on Rene Descarte's (1596-1650) concept of the mind/body split (Smith, 2005). The mind is

viewed as a passive receptacle for external stimuli and the subject interacts with the environment as the object. This self is idiosyncratic, autonomous and asserts radical free choice. The self is viewed as possessing a body, and along with that possesses personality traits and attributes, such as self esteem or anxiety (Leonard, 1994). Much of modern medicine including psychology is based on this model of the person (Smith, 2005). This idiosyncratic self of Cartesian thought precludes the ability to derive meaning from a shared culture (Leonard, 1994).

Postmodern theorists, including some feminists, view the self as developed from the world of language and culture (Baxter, 2003; Bloom, 1998, Weedon, 1997). In lieu of *radically free* choice of the individual, choices are *situated* and are determined by the social and cultural world in which she lives (Benner & Wrubel, 1989). Postmodern feminist researchers support the notion of non-unitary subjectivity (Baxter, 2003; Bloom, 1998; Mahoney & Yngvesson, 1992). A non-unitary subjectivity contradicts and refutes the rational, humanist assumption that humans have "an essence at the heart of the individual which is unique, fixed and coherent and which makes her what she *is*" (Weedon, 1987, p. 32).

This view of personhood reflects phenomenological concepts of self that posits the individual is embodied and situated within a socially and culturally shared world (Benner & Wrubel, 1989). Sociocultural attitudes toward aging may impact a woman's experience of menopause. Consequently, aging in Western society must be examined. The following is a discussion of the sociocultural perspectives on women and aging in Western society.

Sociocultural Perspectives on Women and Aging

Menopause can also be symbolic of aging (Ballard et al., 2005). The cultural focus on youthfulness common in current Western societies and the stigma associated with aging may contribute to women's distress during the menopause transition (Bannister, 1999). In this section of the paper, the concepts of aging and ageism, and their potential influences on women during the transitional period of menopause, will be examined. Basic assumptions of aging, societal discourses related to aging, and women's responses to their changing identities within the process of aging will be presented.

Assumptions of Aging

Aging is fluid, has on-going changes, and is a process beginning at birth, but individuals frequently interpret aging in conflicting ways (Ballard, Elston, & Gabe, 2005; Dillaway, 2005). Socioeconomic and marital statuses, employment, race, and access to healthcare are among the many factors that can affect the experience of aging (Dillaway, 2005). Additionally, since aging is different across cultures and within cultures, how a society views aging persons may have an effect on the response to aging. Researchers have suggested a life course perspective to more fully understand the heterogeneity of the process (Bernard, Chambers, & Granville, 2000; Browne, 1999). Wood (2005) suggests the examination of basic underlying assumptions regarding aging.

> 1) Aging can be understood in dynamic terms. The aging process cannot be separated from the social, cultural and historical changes that surround it… 2) Aging can be understood only from the perspective of its socio-culturally patterned variability, both within a single society and across societies. 3) Aging can be understood only within the framework of the total life course…4) Individual aging, wherever and whenever it occurs, consists of a complex interplay among biological aging, psychological aging, and interactions with the changing social cultural environment

In addressing the first assumption, the cohort a person is born into and the societal events that occur during their lifetime influence a person's experience of aging (Gilleard, Higgs, Hyde, Wiggins, & Blane, 2005; Wood, 2005). For example, babyboomers, born between 1946 and 1964 have lived through many societal changes, including the push for individual autonomy and freedom, which was popular in the 1960s. A focus on body image and behavioral control of health was customary during the modern era, and may carry into the aging process (Bannister, 1999; Bernard & Davies, 2000; de Madeiros, 2005). The preservation of a youthful body, a focus on consumerism, and the technological advances of the era have contributed to the rise in cosmetic procedures and restorative surgeries such as joint replacements (Gilleard et al., 2005).

The second assumption speaks to the importance of carefully examining the effects of diversity within each society. People from various social backgrounds such as, religion, immigration status, class, race, gender, or sexual orientation may experience aging differently (Johnson, 1995). Contemporary societies are embedded with many subcultures that can affect its members' standards and norms. Lifestyle, health practices, and attitudes toward youth, aging, authority, and industry are among the many factors and discourses that play a role in the experience and expectations of aging (Palmore & Cherry, 2004). In societies where youth and vitality are favored and revered, aging persons may appear deviant and subject to stigmatization (Phillips & Bernard, 2000).

The third assumption enforces the need to take a lifecourse perspective when examining experiences of aging, which researchers and theorists, and clinicians in the field support (Barrett, 2005; Browne, 1998; Kuh et al., 2002; Rossi, 1980). Birth, childhood, relationships, divorce, career paths, parenting, social support, and prior health

conditions are experiences that may accumulate over a lifetime and affect a person's present state.

The fourth assumption addresses the heterogeneity of aging. Aging is an individual process occurring at different times for different people and genetic, physiological, social, and environmental factors must be taken into consideration. Though aging is an inevitable aspect of living, the range and rate varies tremendously. Physical signs and outward appearances of aging are concrete examples of individual variation. The onset of grey hair and wrinkles can appear at differing rates over decades, and the responses elicited by them can differ equally (Ballard et al., 2005; Bannister, 1999; Dillaway, 2005; Schope, 2005). In stressing the diverse experience of aging, Johnson (1995) concluded her study on aging well in contemporary society with this statement:

> The major conclusion we must draw from our aging well is that there is no single image of this process and outcome. We age differently. We exist in differing human and physical environments…Heterogeneity is the hallmark of aging (p. 127).

The above four assumptions on aging reveal the complexity in understanding the multiple factors that contribute to the process of aging. The socio-cultural locations and historical events, the varying cultural and societal influences within and across societies, the lifecourses that reflect the temporality of persons, and the interdependence of others, past, present, and future, and finally, the acknowledgment of the individual, biological and environmental factors that explain the heterogeneity of experiences, may affect the attitude toward and the experience of aging. In a society where youthfulness is honored, the aged may experience discrimination or ageism. As a societal response to aging,

ageism may influence the experience of women transitioning through menopause. A discussion on the concept of ageism is addressed in the following section.

Ageism

Negativity associated with aging can lead to discrimination as in situations of class, ethnicity, gender, and sexual orientation (Palmore & Cherry, 2004). Rather than being seen as individuals, aging persons frequently are viewed as belonging to a societal category (Bernard & Davies, 2000; Palmore & Cherry, 2004). Older people have been depicted as an economic burden, since they no longer contribute to the workforce and begin to use national resources such as Social Security (Johnson, 1995; Skucha & Bernard, 2000). This status change can create feelings of dependency for the aging person (Bernard & Davies, 2000). The power relations emerge and can create a variety of aging experiences for people belonging to different societal structures.

Issues in aging, such as dependency, may affect people of the working class, minorities, women, and homosexuals greater due to previous employment, accumulated assets, and entitlements. Minorities may have periods of unemployment. Women may have worked at home a greater proportion of their lives. Gay men and lesbians may not have access to a partner's retirement pensions. Those who have had economic challenges during their younger years may not have had the opportunity to personally save for retirement. Women may find themselves divorced with minimal Social Security funds, lose access to their previous spouse's assets, and be less employable as they enter the outside workforce. These factors may result in undue stress and stigma associated with dependency (Skucha & Bernard, 2000).

Ageism in a society has the ability to affect the experience of aging. When a society is driven by ageism, a normal process such as aging can become a stigmatized event and can cause emotional duress. Palmore and Cherry (2004) are designing a tracking system to create an "'epidemiology of ageism' as a step toward its reduction if not its eradication" (p. 2). The following is an exploration of various aspects of aging for women that may affect the experience of menopause.

Women and Aging

The experience of aging may differ for men and women, and can also be affected by class, race, ethnicity, and sexual orientation (Barrett, 2005; Granville, 2000). The variation of experiences of aging among individuals and subcultures within a society are likely to contribute to contradictory feelings about aging for each individual (Ballard et al., 2005; Bannister, 1999; Ogle & Damhorst, 2005). Women have struggled with juggling roles of caregiver, mother, partner, and employee, which may affect the experience of aging (Norton et al., 2005; Phillips, 2000). The sexual objectification of women and the pressure to be physically attractive to men in a heterosexual paradigm can also lead to distress for women in midlife as physical changes begin to be more prominent (Bannister, 1999; Tiggerman & Lynch, 2001; Walker, 1985). In the later years, women live longer and generally have lower income than men (Barrett, 2005; Older Women's League (OWL) Reports, 2006).

Women have reported mixed feelings about aging (Ballard et al., 2005; Bannister, 1999; Ogle & Damhorst, 2005). Ogle and Damhorst (2005) found that women honored being older, yet were aware of the cultural pressures to maintain youthful appearances. Many of the women refuted the cultural ageist discourse and learned to accept their

bodies' changes. This duality theme also emerged in a study by Ballard and colleagues (2005) and was portrayed as "public and private" aging (p. 175). Private aging was related to the physiological body changes of the participants, such as memory loss, aches, and decreased libido whereas public aging reflected the external changes such as wrinkles and graying hair. Private aging continued under the "mask," such as hair dyes, face creams, and cosmetic procedures to hide public aging (Ballard, et al. (2005).

The multiple roles women have throughout life and especially during the midlife can affect the aging experience for women (Phillips, 2000). Women as "carers" working domestically for either their growing families or aging parents do not have retirement pensions to be used later in life (OWL, 2006; Phillips, 2000). Other women can be especially vulnerable if they have never worked outside the house and have no social security, a benefit that is based solely on "outside" work (Phillips, 2000; Quadagna, 1988). Divorce may especially affect a woman in later years if she does not gain a share of her husband's pension (Quadagna, 1988). Similar situations can occur in lesbian couples where partners do not have entitlement to each other's pensions.

Among many other factors, the social location of a woman, her life course, her partner and work status, and her social support contribute to the experience of aging. The discourses about aging in Western society may conflict with a woman's own personal experience of the aging process. A woman may fluctuate between acceptance of her aging body and frustration as she experiences ageist social attitudes. Feminists such as Gullette (2006) and Friedan (1993) push for women to embrace aging and refuse to accept the cultural definitions. Gullette (2006) suggests that women should "…decline to see midlife as a period of decline" (p.1).

Aging and Distress during Menopause

The process of aging for women may contribute to distress during the menopausal transition (Ballard et al., 2005; Bannister, 1999; Granville, 2000). Women may view menopause as a symbol of aging. In an ageist society, this may cause distress in women who may fear discrimination. Symptoms of aging may be interpreted as symptoms of menopause. This may cause women to erroneously seek treatment for menopause and subsequently be frustrated if treatment fails. A false attribution can also lead to a more negative attitude toward menopause. Physical changes of aging, either those of an internal nature such as chronic illness, or of an external nature such as wrinkles, graying hair, and weight gain, may cause stress in women's lives. In addition to a woman's personal concerns during this time of aging, other stressors such as caring for adolescents and aging parents, employment and retirement worries, or marital problems may carry extra burden. Changes that occur during menopause may be an additional stressor that may not be tolerated and subsequently causes distress.

Women's health clinicians and researchers must examine the role aging plays in the experience of distress during menopause. One way to ensure the inclusion of aging's effects on the menopause experience in a study is to incorporate a feminist framework. Moreover, in order for women to be viewed holistically and heterogeneously during this transition in their lives, a postmodern, feminist perspective should be used. A feminist perspective allows for the fluidity of an individual woman's experiences as she strives to understand her life amidst the pressures of contemporary, Western society. The following will review concepts of a postmodern feminist perspective. This will precede

the concluding argument for a postmodern feminist framework in the study of distress during the menopause transition.

Feminisms

The Oxford English Dictionary defines feminism as 1) The qualities of females and 2) advocacy of the rights of women (based on the theory of equality of the sexes). Feminism also may be viewed as "a politics" since it is meant to create a change in existing power structures between men, women, and society (Weedon, 1997, p. 4). These power relations permeate all levels of society: home, work, education, culture, and leisure. Most likely, the imbalance of power cannot be argued among the different feminist theorists. What is contested, however, is the root cause of this imbalance. Feminism also reflects the prevailing historical moments. First, in order to understand the current wave, a brief history of modern feminism will be presented.

Modern Feminism

Since the Women's Liberation Movement of the late 1960s in the United States, various feminist viewpoints have been expressed. Feminist viewpoints have reflected two main schools of thought: biological differences exist between men and women, and men and women are essentially the same (Nicholson, 1997). The first viewpoint became known as gynocentric. The gynocentric perspective includes radical and socialist feminists who believe true liberation can only be accomplished through a social structural change and women who fight to be equal to men "lacked ambition" (Nicholson, 1997, p. 3). Liberal feminists support the second viewpoint, and they believe fighting within the system through the courts is the best method. The postmodern era, however, has brought a paradigmatic change, and feminists have been driven to examine previous theories of

gender relations. Women of color and third world women represent a multicultural feminism and have criticized many facets of feminist thought, which are believed to be based on white, middle class women's struggles.

Postmodernism and Postmodern Feminism

Postmodernist themes have been generated from 20th century philosophers and theorists such as Foucault, Lacan, Derrida, Lyotard, and Irigaray (Anderson, 2004). Skeptics' criticisms of modern ideas such as universality, essentialism, rationality, objectivity, and "ultimate Truth and Reality" form the foundation of postmodern thought (Anderson, 2005). Instead, situatedness, uncertainty, instability, and ambiguity are stressed (Anderson, 2005; Baxter, 2003). Language representing reality is believed to be discursively constructed. Postmodernists refute the 'grand narratives' of the modern era that attempted to universalize Truth (Lather, 1991). Postmodern theorists including feminists have challenged the autonomous individual, the rational agent of the Enlightenment constituted by a set of characteristics (Bloom, 1998; Lather, 1991).

Since the 1980s, postmodern feminism has been proposed as a response that can "transcend the limitations of other feminisms" (Enns, 2004, p. 275). Postmodern feminism is based on an epistemological revolution about the acquisition of knowledge. Postmodern feminists resist the urge to group women's experiences into one homogenous truth (Nicholson, 1990). They have challenged the beliefs ascribed to previous feminists, and have offered a framework for critiquing the dichotomous concepts of masculine and feminine, black and white, objective and subjective, and rational and emotional. They believe these binary viewpoints distort and oversimplify (Nicholson, 1990).

The belief that gender is socially or discursively constructed stemmed from postmodern ideology. Women of color and lesbian women have contested the essential or biological "woman" in previous critiques (Combahee, 1979). This critique was a response to white, academic, heterosexual women who universalized the struggle of all women. Furthermore, the diversity of women's voices and experiences, and the questioning of all feminists' paradigms of subordination have been attributed to postmodern feminism. Fraser and Nicholson (1990) declared "…postmodern-feminist theory would be nonuniversalist [and]…would replace unitary notions of woman and feminine gender identity with plural and complexly constructed conceptions of social identity, treating gender as one relevant strand among others, attending to class, race, ethnicity, age, and sexual orientation" (p. 34-35).

Postmodern feminist thought has been mostly utilized in research and knowledge inquiry (Maynard, 1994). An epistemology characterized by a fluid plurality of perspectives is a hallmark of postmodern feminism (Baxter, 2003; Bloom, 1998). Relativism and objectivity are both rejected (Anderson, 2004). In lieu of predicting, postmodern inquiry seeks to either understand as in interpretive or phenomenological methods, or emancipate as in critical, feminist, or action research (Lather, 1991).

Postmodern feminists examine the various social and cultural discourses that influence women's positions. In the Foucauldian sense of discourse, the concept of power plays an intricate role in the formation and adoption of prevailing and competing societal discourses (Kendall & Wickham, 2000). Baxter (2003) defines discourses as "forms of knowledge or powerful sets of assumptions, expectations, and explanations, governing mainstream social and cultural practices" (p. 7). A woman positions herself

and *takes up* a particular discourse she perceives as beneficial. However, limits to discourses one can invest in depends upon various social positions such as gender, race, class, religion, sexual orientation, age, and able-bodiedness (Mahoney & Yngvesson, 1992). Competing discourses attempt to "fix the meanings of the material world" thus shaping understanding of social truths (Baxter, 2003; p. 9). Depending on context, women negotiate discourses intermittently or even simultaneously to generate varying levels of power for themselves (Baxter, 2003).

Bloom (1998) articulates a "fragmentation" of women's subjectivity, which arises creating a plurality of "subjectivit*ies*" versus one unified subjectivity (p. 5). This fragmentation is not meant to be viewed as reflecting a person who is "mentally unstable or weak, [or] lacking an enviable, unified (masculine) self" rather a means of "a more positive acceptance of the complexities of human identity, especially female identity" (Bloom, 1998, p. 6). A fragmented, non-unitary subjectivity allows a woman to be fluid and dynamic within competing discourses and work as an agent "to adapt to, negotiate or resist dominant subject positions, or alternatively, take up subject positions within a resistant discourse" (Baxter, 2003, p. 31). The following presents how a postmodern, feminist perspective will aid in the study of distress during the menopause transition.

A Postmodern Feminist Framework for the Study of Distress During the Menopause Transition

A postmodern feminist approach to study midlife women incorporates a critical examination of social and cultural discourses, as well as other factors contributing to their diverse experiences. Rather than *deny* the biological effects of women's hormones or focus *exclusively* on a woman's attitude toward aging, or examine coping from a

lifecourse of stress and hardship, acknowledging *all* possible contributing factors is most efficacious. A postmodern feminist perspective considers the complexities of menopausal women and the social and cultural discourses on sex, race, age, ethnicity, and sexual orientation.

Some feminists believe menopause has been too medicalized (Friedan, 1993), and others believe women's biological make-up has not been taken seriously enough (Sichel & Driscoll, 1999; Vliet, 2001). A postmodern feminist perspective will illuminate how women negotiate these and other competing discourses. By investing in a biomedical discourse that menopause is a disease, a woman may experience powerlessness as she approaches menopause. However, taking up this same discourse may enhance a sense of power by opening up the possibility for treatment for severe symptoms. Another woman who adopts a 'rite of passage' discourse on menopause may feel a sense of power as she transitions through, especially if she experiences manageable symptoms. A woman who does not invest in either one of these discourses, and who may be experiencing bothersome symptoms, may feel a sense of powerlessness and subsequent distress. She may withdraw, and become a silent actor between clashing discourses (Clark, 2005). A postmodern feminist lens may elucidate the multiple influences on women's experiences.

A non unitary view of subjectivity versus the mechanistic model encompasses a more holistic vision of women during the menopause transition and supports a postmodern feminist perspective. Viewing a woman as an embodied being in a social and cultural location with a life course and concerns of the future, provides a more complete picture of her menopause experience. A Cartesian model supports viewing a woman as an idiosyncratic self who possesses certain traits. Focusing on the society and

culture women are a part of would best be accomplished through more of a phenomenological examination of her experience.

A postmodern feminist lens will best inform a study on the menopause transition by examining how women act as agents and move fluidly between discourses in order to regain a sense of power over their situations (Baxter, 2003). A fluidity of movement is needed to navigate the discourses on menopause and aging. The examination of how women take up certain social and cultural discourses will illuminate experiences of distress as well as those of coping. Baxter (2003) explains how a woman acts as an agent within competing discourses. "…The social and historical constitution of the subject is not a limit on women's agency but a precondition for understanding the possibilities for action and change" (p. 31). A postmodern feminist framework avoids viewing women as 'victims' of their world, but instead as agents who choose which discourses to take up and how to position themselves in that discourse (Bloom, 1998). Since menopause and aging are laden with social and cultural discourses, this lens will best facilitate how women negotiate their various subject positions.

Postmodern feminism does not have a universal definition of the essential "woman." Thus, this perspective will allow for the range of experiences of the women studied. This best suits the study of distress because of its difficulty in defining. The socio-cultural background of each woman constitutes her experiences. Examining her everyday events with a postmodern lens will shed light on each woman's contextual experience of distress. Menopause is a time of transition and change, and women are actively trying to make sense of their experiences and their changing identities. Viewing a woman as having a non-unitary subjectivity will aid in the understanding of how she

moves between discourses during the menopause transition. Bloom (1998) emphasized the importance of focusing on women's subjectivity which is pertinent for this study.

> One of the purposes of examining subjectivity in women's personal narratives is to redefine what it means for women to write, tell, discuss, and analyze their life experiences against the backdrop of the prevailing discourses that seek to silence them. To change the master script is to change reality; to change reality is to participate in making a history different from the one the status quo would produce (p. 100).

The complexity of women's experiences during the menopause transition will be better understood with the incorporation of a postmodern feminist framework.

Assumptions

As a postmodern feminist, having an awareness of assumptions and a recognition of their influences on research is imperative. The following assumptions have informed this study, the questions asked, the method used, and the analysis conducted.

- Women assign meaning to their experiences and these meanings are influenced socially and culturally.
- Women's beliefs, in general and in regards to menopause, are influenced by various social and cultural discourses.
- Social location may affect a woman's experience of menopause.
- Since menopause is an alteration in reproductive status, women may experience a level of change even if it is exclusively the cessation of menses.
- Women differ in their experiences of menopause.
- Scientists have not discovered all components and effects of reproductive hormones in relation to the process of menopause.
- An association between menopause and aging exists.
- Western societies place high value on youth.

- Women have different experiences of aging than men and women have different experiences of aging.

Research Questions

Based on the problem, the gaps in the literature, and the chosen framework, the following three research questions were asked: From the perspective of the woman during the menopause transition (menopausal years), what is the essential *experience* of distress? What is the *meaning* of distress experienced by the woman during the menopause transition? How do women *describe* the relationship between aging and menopause?

Definitions of Concepts

Concepts explored in the phenomenon—symptom, distress, and the menopause transition—are defined below to facilitate a preliminary understanding of the issues. However, clearer and more direct meanings of these concepts will be revealed in the data, and reported in the results chapters.

Symptom

The Oxford English Dictionary (1989) defines symptoms as "a (bodily or mental) phenomenon, circumstance, or change of condition arising from and accompanying a disease or affection, and constituting an indication of evidence of it...a subjective indication, perceptible to the patient, as opposed to an objective one or sign." In their Symptom Management Model, Dodd and colleagues (2001) define a symptom as "…a subjective experience reflecting changes in the biopsychosocial functioning, sensation, or cognition of an individual" (p. 669). The symptom experience is further explored as "…an individual's perception of a symptom, evaluation of the meaning of a symptom and

response to a symptom" (p. 671). Perception of symptoms relates to an individual noticing change in the way she normally feels or behaves. People then make an evaluation of a symptom regarding the meaning, severity, cause and treatability, and how it affecting their lives. Responses to symptoms can be physiological, psychological, sociocultural, behavioral, or a combination of the various components (Dodd, et al., 2001).

Also, the difference between modern *disease* and postmodern *illness* should be distinguished. Traditionally, disease constituted an objective assessment whereas illness was a subjective condition. Unfortunately, this distinction's negative effect is the tendency to view the objective account as superior. However, Morris (1998) states, "the term postmodern illness implies a shift, incomplete and ongoing, in which the patient, no longer merely a bundle of symptoms reported by an unreliable, subjective ego, emerges at moments as a valued participant in the medical process…" (p. 39). Illness viewed from a postmodern lens takes into consideration the link between biology and culture, as it is "fundamentally biocultural" (Morris, 1998, p. 71). Therefore, symptom in postmodern terms encompasses the account of the subject in the context of social and cultural influences.

The word, symptom, may best describe a range of physical and psychological changes women may perceive and attribute to menopause. For this study, the use of symptom reflects the Symptom Management dimension of 'symptom experience'. A woman transitioning through menopause may perceive psychological or physical changes that she will need to evaluate and manage. Since this model recognizes the social and cultural influences of symptom experience, it adheres to a postmodern philosophy of

illness. When viewed phenomenologically, ‘symptom’ can also represent a woman’s recognition of a ‘breakdown’ in the everyday experience of health. Furthermore, adherence to the use of ‘symptom’ serves to maintain consistency because it is commonly used in menopause literature and by the women experiencing distressful changes.

Distress

In an attempt to develop an instrument to measure psychological distress, Massé (2000) performed in-depth interviews of 179 French Canadian adults and identified 2,200 manifestations of psychological distress. These manifestations were reduced to seven idioms of expressions: demoralization and pessimism toward the future, anguish and stress, self-depreciation, social withdrawal and social isolation, somatization, and withdrawal into oneself. The challenges of creating measurements of distress led Massé (2000) to conclude that an “incommensurability” existed between qualitative and quantitative methods and its meaning was lost in the quantification.

Due to the heterogeneity of distress and of women’s experiences of distress, a definition will not be given at this time. Moreover, the aim of this study is to examine how women experience distress during their menopausal years. Therefore, the meaning of distress will be revealed as a result of this dissertation.

Menopause Transition

The lay term for this time period is perimenopause, meaning *around the menopause*. This period generally includes a period of time before the final menstrual period (FMP) and a few years after menopause occurs. The Stages of Reproductive Aging Workshop’s (STRAW) definition of menopause transition includes Stage - 2 (early menopausal transition), when a woman’s cycle remains regular but the length of

cycle may differ by 7 days or more; and Stage - 1 (late menopausal transition) when one or two skipped menstrual cycles occur. Stage +1 is considered the period after menopause until 4 years postmenopause (Soules et al., 2001).

For this study, a broad criterion of menopause transition will be used and will be self-identified by participants. This includes an arbitrary time before the FMP, when the women self identifies as being 'in' menopause, through the following years when women continue to report symptoms of menopause.

CHAPTER THREE: NARRATIVE ANALYSIS AS A METHOD FOR THE STUDY OF DISTRESS DURING THE MENOPAUSE TRANSITION

This study used narrative analysis methodology to conduct research for the advocacy of women. The methodology was based on an interpretive phenomenological and postmodern feminist view of self. Narrative analysis supports feminist research ethics and has been used in numerous feminist studies (Bloom, 1998; Personal Narratives Group, 1989; hooks, 2000; Riessman, 1990a). Narrative analysis also brings forth the heterogeneous experiences of distress during midlife women's lives and adheres to the belief of co-creation of data between researcher and interviewee (Messias & DeJoseph, 2004; Riessman, 1993). Detailed description of the methodology is given in this chapter and includes the following sections: 1) an in-depth discussion of the research design beginning with a self-reflexive account to examine the researcher's positionality, 2) a description of the sample including adherence to human subject requirements, 3) data collection methods including technique and criteria for study rigor, 4) the detailed procedures, and 5) the process of data analysis.

Research Design: Narrative Analysis

Self Reflexive Account

As a postmodern feminist researcher investigating distress during the menopause transition, the author of this dissertation cannot claim to be an 'uninvolved observer.' Situating herself in the research study is imperative (Mauthner & Doucet, 2003). The following self reflexive narrative exhibits the factors that shape the author's understanding, create her horizon, and constitute her assumptions.

> During my pursuit of a midwifery degree, I switched my focus from birth to the end of reproduction. Peers' experiences of midlife changes and

> uncertainty about the future began to replace the focus on childbirth and raising babies.
>
> What is most relevant to my research and what contributed mostly to my feminist stance, is my empathy for women. From an early age, I began to experience and witness sexist practices in my family, relationships, and society. My mother was the oldest of seven. During the Depression, she was unable to continue her schooling beyond middle school. As the youngest of seven, I observed my older three sisters marry abusive husbands, begin childrearing very young, and upon divorcing later in life, confront the challenges of being inexperienced and unskilled in the workforce. I witnessed on a daily basis the discrimination against my disabled sister. The major turning points in my life were through my identities as a woman giving birth, terminating a pregnancy, growing up with and caring for a severely disabled sister, and learning to protect and nurture an innocent girl child.

Feminist postmodern researchers believe in a co-creation of data between researcher and study participant and an objective lens is impossible to achieve (Messias & DeJoseph, 2004; Riessman, 1993). Next is a description of narrative analysis as a method. Techniques used by the narrativists, Catherine Riessman (1993), William Labov (1997), James Paul Gee (1985, 1986), and Arthur Frank (1997), and phenomenologist Max van Manen, (1990) will be presented.

What is a Narrative?

Narratives are stories people share with others about events in their lives. The elements of language—how words are put together, the words chosen, the tone of voice, utterances, fluctuations in volume, and verb tense—constitute these stories. Embedded in this language is a discovery of what matters to the narrator, the listener, and the society and culture at large. Narratives "circulate culturally" and provide "…a means of making sense" of the social world itself (Lawler, 2002, p. 242).

Riessman (1993) describes a personal narrative as “talk organized around consequential events” (p. 3). Additionally, “respondents narrativize particular experiences in their lives, often where there has been a breach between ideal and real, self and society” (p. 3). The way a narrator tells the story, where the events are placed in a story, and what is untold becomes part of the narrative itself. Individuals’ stories may also reveal the societal discourse that penetrates their worlds and shapes meaning. The researcher attempts to capture the *lifeworld,* which will contribute to the understanding of the concept or phenomenon under investigation (van Manen, 1990).

As there is no single method that distinguishes narrative analysis, what clearly separates this method from other qualitative methods is the “interpretative thrust” that drives the researcher to interpret the protagonist’s interpretations (Riessman, 1993, p.5). The method involves a deep engagement with the text not with the intention to make causal relations but to gain access to the views and experiences of the narrator. This allows for a deeper understanding of the use of language in articulating the cultural and social lives of individuals (Labov, 1997).

In the study of phenomena, narratives play an important role in providing examples. The stories carry the meaning of daily experiences (van Manen, 1990). As a way to counter more abstract ideas, narratives create a concrete manner to uncover the deeper meanings in everyday life experiences. Narratives explore the understanding of human existence in relation to an individual’s interaction with the world. van Manen (1990) believes that narratives “can be understood as a methodolgocial device in human science to make comprehensible some notion that easily eludes us” (p. 116). Narrative

analysis as a methodology supports the examination of women's experiences from a feminist and a phenomenological perspective.

Reissman on Representation

Reissman (1993) addresses the representational decisions during the research process, and supports the need to acknowledge an involved interpretation versus an objective representation of the data. She describes the journey of representation from the beginning of the experienced phenomenon to the end when the written interpretation is read. Riessman (1993) discusses the existence of the world "before reflection begins" and how the protagonist "actively construct[s] reality" by making certain choices of what to attend to during an experience (p.9). Riessman then describes how storytelling becomes a personal narrative, how details of the experience are described, and how the choices during the storytelling reflect the cultural context. The protagonist's choices also reveal what is deemed important and what is, important to the listener of the story.

Riessman addresses the "gap" between what was experienced and what gets communicated. She enforces, that "without words…experience[s] cease to exist" (p.11). She also reiterates to whom the story is being told affects what is told, and the teller is "creating a self—how [she] wants to be known" to the listener (p.11). Riessman (1993) describes the next step of the process— transcription of the recorded conversation. Attention should focus on manners of speech such as pauses, changes in tone and volume, false starts, and unfinished sentences, to reveal hidden meaning. The manner in which text is transcribed and re-transcribed will inevitably impact the analysis and interpretation.

Analyzing experience is the fourth level of representation. Generally examined with other transcripts, decisions continue to be made while sense is created from what gets included and excluded. A new "hybrid story" is told. A fifth level of representation enters as the reader scrutinizes the written document. Members of the research team may have also contributed their input, and participants may agree on the final analyses. Then the readers ascribe final and multiple meanings. The reader and the historical context will influence understanding of the text. The multiple "authors" of a text confirm "any finding—a depiction of a culture, psychological process, or social structure—exists in historical time, between subjects in relations of power" (p. 15). Riessman (1993) concludes with the limitations of representation and "meaning is fluid and contextual, not fixed and universal" and that truly we are left with "talk and texts that represent reality partially, selectively, and imperfectly" (p. 15).

Riessman identifies the transcription and re-transcription process as essential to and inseparable from the analysis. Riessman proposes to identify narratives by incorporating Labov's (1997) method to distinguish a narrative's components. When narratives do not follow the rules of a classic story, she follows methods of poetic or prosaic rules of linguistics to restructure the text (Gee, 1985, 1986). The following section is a brief discussion of Labov's elements of a narrative followed by Gee's theories of poetic structuring.

Labov's Elements of a Narrative

Labov (1997) believed "narratives are privileged forms of discourse which play a central role in almost every conversation" (p. 1). He described a narrative as the "only example of a well formed speech event with a beginning, a middle, and an end" (p. 1). He also described a format to support his beliefs that narratives communicate experience. The following is a summary of his definitions.

Narratives of personal experience are reports of sequences of events that have entered into the biography of the speaker. These events are emotionally and socially evaluated by the narrator. Narratives have a temporal organization of at least two clauses with one temporal juncture. Structural types of narrative clauses include: 1) an *abstract*—the initial clause in a narrative that reports the entire sequence of events, 2) an *orientation*—gives information on time and place of event, and characters involved, 3) *complicating action*—reports the next event in response to the question "and what happened then?", 3) *evaluation*—tells the consequences of the event for the human needs and desires, 4) *resolution*—follows the most reportable event, and 5) the *coda*—returns the narrative to the time of speaking, precluding, *and what happened then?* Occasionally, the resolution is not satisfactory to the listener, which causes an impression of an incomplete narrative (Labov, 1997). Labov believes a narrative is a technique of reporting past events through temporal juncture. The most reportable event is the pivot where the narrative is organized. By reporting events as they first become known, the narrator attempts to transfer the experience onto the audience.

Gee's Poetic Structures

Gee (1985, 1986) clearly distinguishes oral traditions of communication from literal traditions. He has greatly elaborated on defining styles used by different oral traditions. He claims cultures and classes use different styles of oral communication, which warrant a close scrutiny of the narratives (Gee, 1985). Thus, the narratives aid in the understanding of how different groups of people make sense of experience. Gee (1985) strongly believes "...no human under normal conditions, fails to make sense when narrativizing his or her experience" (p. 11).

As a psycholinguist, Gee (1985, 1986) examined speech structures, discursively important linguistic units, and "discourse-level structures." In oral language, the length of pauses can denote discourse located at the end of clauses or "clause-like units" of speech (Gee, 1986). Longer pauses mark discourse-level breaks in the text. When exploring the meaning of text, being aware of its structure allows insight into the possible meanings and methods. The following discussion highlights the findings of his investigation of oral reporting of narratives.

He first identifies an "idea unit" or single clause representing a new piece of information. For instance, the subject of the clause or an adverb element is an idea unit. False starts and hesitations can be dropped to obtain an "ideal realization of the text," and may indicate "major boundaries in the narrative" (Gee, 1986, p. 395). The idea units in the ideal text are then referred to as "lines" as in poetry. Depending on the speaker, these lines will be relatively short or long. Gee (1986) describes lines

> 1) are relatively short, 2) start with "and" (or some other conjunction or a verb of saying), 3) have one pitch glide that terminates the line, 4) often terminate with some sort of junctural phenomena—hesitation, syllable final lengthening, a short pause, and so forth, 5) tend to be simple clauses,

> 6) display a good deal of syntactic and semantic parallelism with the lines adjacent or near to them (p. 396).

The lines may have a parallelism with a pattern noted in four lines, which Gee calls ‘stanzas.’ A single line can be a stanza, and stanzas can also be more or less than four lines. Some stanzas are patterned and transparent while others are obscure and difficult to identify. Stanzas tend to organize the lines of the texts and comprise the internal structure of sections of text. Two stanzas may form a unit itself, which Gee (1986) labels as ‘strophes.’ Strophes may demonstrate repetition or redundancy, which slows the narrative’s pace and are used in many cultures. Maintaining a consistent structure keeps the narrative moving forward and the content consistent (Gee, 1986).

A major transition in a narrative classifies a larger structural unit called a “section.” The following definition of a section is given by Gee (1986):

> 1) they tend to be large topic units, definable by one topic or theme, 2) they involve no internal changes of place, time, or major characters, 3) within sections, stanzas tend to fall into particular structures or patterns definable on the basis of parallelism, 4) they tend to end on a line with a falling-pitch glide, 5) at their opening, there tends to be a good number of hesitations, false starts, and idea units shorter than a clause (p. 399).

Sections can begin on a temporal adverb, such as “today” or “last night.” Hesitations and false starts can denote movement from one section to another.

Gee (1986) also addresses non-narrative portions of texts. They are designated by general statements, or stative verbs, that join discrete events together. Non-narrative segments may depart from the storyline. They come close to the end of narratives and are compared to what Labov (1997) calls evaluations. They can also serve as a transition between the beginning of the story and the end.

Pauses in poetic compositions are also imperative to meaning and structure. They may be more important as the length of the pause may determine the boundaries of the text more than syntax. Idea units may not be clausal; instead, short pauses may denote idea units. Medium pauses separate lines, and longer pauses come after a stanza. Each stanza is more or less organized around a) a time, b) a place, and c) a topic or theme. As the stanzas move along, the elements of time, place and topic may become increasingly specific with a summary in the last stanza.

Similarities can be noted in Gee's (1985) semantic and thematic analyses to Labov's elements of a story. Gee compared non-narrative sections of text to Labov's element of *evaluation.* He believes a temporal marker denotes the beginning and end of a narrative, which is similar to Labov's *abstract* and *coda.* The introduction of the narrative determines the setting, which introduces the time, place, and persons involved. This can be compared to Labov's *orientation*. Contrasts are frequently used to give cohesion and meaning to the story. A problem or crisis generally occurs, which can be compared to Labov's *complicating action*. The crisis and resolution can be viewed on many levels from the concrete interpretation of the actual words and images used and on a deeper representational level. Inferences can be drawn from the text. Gee uses the term *resolution* as does Labov.

The use of poetic structuring of narratives gives the researcher options to analyze data and increases the opportunity to understand how the narrator makes sense of her world. The examination of the problems she identifies as important to her, the characters and influences involved, and ways she attempts to resolve crises, is possible through poetic restructuring.

Narrative Genres

Gee (1985, 1986) recommends the examination of verb tenses for content. Habitual tense (e.g. would) denotes somewhat of a norm as in action occurring over a period of time. The use of an iterative aspect (happening over and over again) denotes repetition and possible frustration and can also denote a delay in the resolution. Riessman (1990) also focuses on the narrative's genre. A past tense denotes an event in a one time point (similar to a classic story as suggested by Labov). Episodic stories are joined together thematically rather than temporally and lend themselves well to poetic restructuring. Hypothetical stories describe how things may have been or could be (Riessman, 1990).

Frank (1995), a sociologist and cancer survivor, has written stories of the body and illness. He believes the act of storytelling restores what may have been lost for those who have experienced a breakdown of body or health. Furthermore, he states, "as wounded, people may be cared for, but as storytellers, they care for others" (p. xii). He too emphasizes the examination of genre and suggests three distinct narrative genres people use to narrativize their illness experiences— chaos, restitution, and quest. He believes not all stories exclusively conform to the three genres he suggests; however, chaos, restitution, and quest stories encompass many stories of health and illness.

In a chaos narrative, one has a sense of an "incessant present with no memorable past and no future worth anticipating" (Frank, 1996, p. 99). If restitution suggests an end, chaos stories seem to continue. Chaos and control are at opposite ends of the continuum. Generally, the chaos narrative is told retrospectively. When an individual is in the experience of chaos, the chaos precludes the ability to tell the story.

Restitution denotes an end, a solution or resolution to the problem with the hope and promise of the body returning back to its normal state. The story of modern medicine finds healing is achieved through treatment outside the body such as surgery or medication. The individual experiencing a restitution narrative ascribes to, "[y]esterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank, 1995, p. 77).

A quest narrative is the testimony of illness. The protagonist shares the lessons learned or the deeper meaning represented in the experience. "The quest narrative tells self-consciously of being transformed; undergoing transformation is a significant dimension of the storyteller's responsibility" (Frank, 1995, p. 118). Frank suggests that these three types can be part of any one illness story. When viewing illness narratives holistically, chaos stories may represent the complicating action, restitution stories as the resolution, and quest stories may represent the person's evaluation of their experiences.

Thematic Analysis

The aim of narrative inquiry is to grasp a fuller understanding of the phenomenon under investigation. The identification of themes helps the researcher grapple with the structural meaning of the text. "Theme gives control and order" to the analytical process and writing (van Manen, 1990, p. 79). Van Manen (1990) recommends three ways to identify themes: 1) the holistic or sententious approach—attending to the text as a whole and asking "what sententious phrase may capture the fundamental meaning or main significance of the text as a whole?" 2) the selective or highlighting approach—listening to or reading a text several times and asking, "what statement (s) or phrase (s) seem particularly essential or revealing about the phenomenon or experience being described?" 3) and the detailed or line-by-line approach—assessing each sentence or sentences cluster

and asking, “what does this sentence or sentence cluster reveal about the phenomenon or experience being described?” (p. 92-93).

While reviewing the descriptions of experiences, commonalities are noted. After themes are recognized, finding appropriate phrases representing a commonly shared theme is the next undertaking. Van Manen (1990) describes a theme as “…the experience of focus, of meaning, of point,” as well as, “the form of capturing the phenomenon one tries to understand” (p. 87). Themes can be words or phrases used directly by the narrators, or terms that clearly represent the meaning. Most likely, themes incorporate a combination. The researchers assert their judgments. The task is then to present themes narratively with supporting data from the transcribed texts. Van Manen (1990) elucidates the difference between a literary critique and one that incorporates phenomenology.

> [L]iterature or poetry (although based on life) leaves the themes implicit, and focuses on plot or particular incident, whereas phenomenology attempts to systematically develop a certain narrative that explicates themes while remaining true to the quality or essence of a certain type of experience (p. 97).

Summary

The details of narrative methods reveal how people understand their world in the stories they share. Riessman (1993) emphasizes the importance of representation and the actors that contribute to the choices made during the experiencing, telling, recording, analyzing, writing, and reading of people’s stories of their lives. Both Labov (1997) and Gee (1985, 1986) have similar and contrasting elements to describe methods of structural and thematic analysis of narratives. Both linguists address temporal designations or turns in a text that denote the beginning of a narrative, a problem or action taking place, a switch from the narrative tone as an evaluation, a resolution to the problem, and a

temporal change to symbolize the end. Unlike Labov who adheres to a specific story structure, Gee (1985, 1986) suggests structuring the narrative based on lines and stanzas similar to poetic or prosaic features of language. Labov and Gee suggest the examination of *how* a story is told and the content, since the narrative genre has meaning. Frank (1995) described three narrative types or genres individuals use to tell their stories to understand the process of breakdown in health.

The researcher using narrative analysis methods should closely scrutinize the structural components of a story to reveal an insider's view into the meaning of a narrator's experiences. The language used, the intonations, pauses, hesitations, and repetitions contribute to the examination of meaning of the phenomenon in question. van Manen's (1990) steps to identify themes describe options to engage with the text on a deeper level and to reveal the essence of the experienced phenomenon.

When examining narratives, Riessman (1993) suggests the incorporation of elements from both Gee (1985, 1986) and Labov (1997). Riessman (1993, 2006) proposes narratives present themselves differently. When they do not follow a more traditional format of a story as proposed by Labov, restructuring a narrative in stanzas may be more effective. The situations presented in people's lives and stories may not have a clear resolution, which signifies the narrator's world. Riessman (2006) explained her rationale for different approaches to a narrative:

> Many simple stories take the narrative form that Labov theorized more than 30 years ago. Others don't, and that's when I turn to Gee's method of listening and transcription. Either the text lacks a clear resolution, doesn't move sequentially through time, or it is about emotional "events" rather than "action" as Labov means it (C. Riessman, personal communication, October 29, 2006).

The presented options to analyze narratives and identify themes capture the women's complex experiences. The following section demonstrates how narrative analysis facilitates a thorough examination of the study questions.

Narrative Analysis as a Method to Study Distress during the Menopause Transition

Narrative analysis methodology is an effective and thorough method for researching distress during menopause. Furthermore, narrative analysis supports a postmodern feminist methodology because women, who may be generally silenced, can have the opportunity to tell their stories. Women's negotiation of influential, social and cultural discourses embedded in the narratives can be examined. If postmodern feminist methodology is concerned about heterogenic experiences of women, then narrative analysis is an effective tool to grant the expression of many voices.

With the incorporation of the techniques suggested by Labov, Gee, Riessman, van Manen, and Frank, a larger proportion of the text is available to interpret. Adhering to one method exclusively may miss a group of women's experiences. Paying attention to both structure and content of text re-transcribed into classical elements of a story, poetic structures, or non narrative segments allows for inclusiveness of data. From a postmodern feminist perspective, one essential experience of distress for a woman during the menopause transition does not exist as there is no "generic midlife woman" (Lee & Taylor, 1996, p. 154). The various ways women share information lends their narratives to various methods of re-transcription. Furthermore, the multiple examples of distress demonstrate the range of possibilities for other women's experiences. A narrative not only represents and assigns meaning to an individual's experience but also reflects the available social and cultural narratives social actors draw upon in telling of their stories

(Lawler, 2002). Using this method allows for a closer understanding of women's experiences of distress and the larger societal discourses affecting their experiences.

Sample

Human Subject Assurance

Informed Consent Process

The study received ethical approval by the University of California San Francisco's (UCSF) Committee on Human Research. Only participants that contacted the principal investigator (PI) were recruited to the study. The participants were given options regarding potential locations and meeting times. The PI also informed them of the purpose of the study and the data requested. After information was given and all questions answered, participants were given a sufficient amount of time to decide whether or not to participate.

After reading the consent (Appendix B), all participants were provided time to assimilate information. Then participants were asked if they fully understood the purpose of the study and their expectations or role. The PI was available to answer any questions participants may have had regarding the study and their role. Confidentiality and the right of refusal at any time were also stressed.

Ethical Considerations

Potential participants who declined to enroll in the study would have no further contact with the PI. Further consideration was given whether participants would be recruited from a medical clinic, and their status would not have been affected if they declined to participate. None of the aforementioned occurred in this study. After the participants were informed of the study, only those who had contacted the PI and gave

informed consent were interviewed. Efforts were made to minimize the inconvenience of extra time spent for the interview and caution was taken if discomfort was noted during the interviews. Participants were able to refuse participation at any time during the study.

Confidentiality

Only the PI, dissertation committee members, and the transcriber had access to the digitally recorded interviews. No personal identifying information was on the audiotapes or transcripts. No identifying information was retained after the digital voice files of the interviews had been transcribed. The voice files were erased at the end of the study. The PI and dissertation committee were the only persons who reviewed any descriptive data. All data were retained in a locked cabinet and password protected computers.

Nature and Size of Sample

Fifteen women (N = 15) who were either currently experiencing or had previously experienced distress during the menopause transition were interviewed. Women who self identified were initially screened by phone or email for eligibility.

Criteria for Sample Selection

Inclusion Criteria

Women, between the ages of 40 to 60, who were currently experiencing or had experienced distress attributed to menopause, were English speaking, and willing to participate were considered eligible participants. Allowing potential participants to self identify if they had experienced distress that they themselves attributed to menopause was important in order to allow for the variety of experiences. Efforts were made to include women of diverse ethnic, racial, and cultural backgrounds in order to gain a broad

representation of experiences. However, a requirement for English language use was needed because it is the language of the researchers, and no interpreters were employed.

Only women who had experienced symptoms as a result of natural menopause were considered to examine the transition without medical initiation from such interventions as an oopherectomy. Women who had hysterectomies where only the uterus was removed were eligible since endocrinological function remained. However, women who had experienced distress attributed to menopause before an oopherectomy were eligible to participate, but only experiences prior to the oopherecomy were discussed in the interviews. Women who had or were currently using any therapies were eligible. These strategies provided information on avenues they may have used to manage their distress and perceived symptoms during the menopause transition.

Exclusion Criteria

Although important information regarding women's experiences during the menopause transition could be ascertained from families and friends, all men and children were excluded in this study. The aim of this study was to directly interview women regarding their personal experiences. Since women younger than 40 would have been more likely to have experienced symptoms unrelated to menopause, they were excluded. Furthermore, since the average age of menopause is 51.3 years, women greater than 60 may have had faded memories of their transition experiences, therefore they were also excluded. Additionally, women who were between 40 and 60, but had either no menopausal symptoms or who had experienced symptoms related to menopause but had not perceived them to be distressful were also excluded. Women who had experienced symptoms after a surgical menopause, where ovaries were removed, were not eligible to

participate. Women may have encountered many of the symptoms discussed, but their experience could differ from women who gradually underwent the transition.

Recruitment

Recruitment flyers (Appendix C.a) were posted at various locations, including women's health care clinics in two west coast cities. These clinics included OB/GYN physicians, midwives, women's health nurse practitioners, and physician assistants who were asked if recruitment flyers could be placed in their facilities. Healthcare providers were given a "Dear Colleague" letter (Appendix D) to inform them of the study and were asked to identify potential participants by either 1) obtaining contact information (phone numbers or email addresses) from those women who expressed interest, or 2) giving flyers to those who may have been interested but required more time to consider participating. Women who received flyers were then instructed to contact the PI directly to participate. The investigators gave practitioners a separate flyer (Appendix C.b) with consent and included obtaining a phone number or email address from interested women.

Recruitment flyers were posted on bulletin boards outside grocery stores, in public buildings, such as libraries, colleges, and universities, in church bulletin areas, and various bulletin boards on a university campus, including the student health center. Advertisements for the study were also posted under the community volunteer section of an on-line bulletin board targeting two West Coast locations. Snowball sampling was also used. This was specifically related to a woman who had participated and who may have known others who were experiencing distress during the menopause transition. She then referred these women to the researchers. Participants were paid $20.00 for each interview.

Data Collection Methods

Techniques

Participants were interviewed using an open-ended interview guide (Appendix E). Interviews were digitally audio-recorded or audio taped, and transcribed. The data were cleaned by listening to the tape and assessing accuracy of the transcription. Each woman was interviewed for 45 minutes to 2 hours. Fifteen women were interviewed. Recruitment and interviews stopped when redundancy or saturation was noted. Participants were also asked to answer a short questionnaire (Appendix F) to assess demographics such as age, marital status, number of children, education level, and income. Since a number of women were interviewed after they had experienced their distress, they were also asked to report the demographic information reflecting the time of their distress episode(s).

Study Rigor

Qualitative research differs from quantitative investigations in assessing the 'validity' and/or 'reliability' of methods and analyses. The rigor of the study determines the quality of the research. The following section describes measures throughout the study to assure and adhere to elements of methodological rigor (Riessman, 1993).

Validation

Validation differs greatly between qualitative and quantitative methodologies. Disagreements prevail even among qualitative researchers themselves (Riessman, 1993; Sparkes, 2001). Riessman (1993) addressed validation and noted the participant and the researcher's interpretations are laden with social and cultural discourses. Stories are representations of experiences based on what the teller finds meaningful. Variation is

expected when discussing complex and troubling events. Therefore, trustworthiness is emphasized over truth. Riessman (1993) suggested four criteria to measure trustworthiness: persuasiveness, correspondence, coherence, and pragmatic use.

Persuasiveness relates to plausibility. "Is the interpretation reasonable and convincing?" (Riessman, 1993, p.65). Theoretical claims were supported with direct accounts from informants. Direct quotes from participants' interviews were included. Taking back data, analytic categories, interpretations, and conclusions to participants achieved member checking. The consents also included a clause that participants could have been asked to review their transcripts for accuracy.

Coherence can be evaluated across three categories: global, local, and themal (Riessman, 1993). Coherence addresses the need for "thick" interpretation in order to prevent an "ad hoc" analysis. The global aspects relate to the overall goals a narrator is trying to accomplish with the story. Local coherence draws attention to linguistics to relate events in the narrative. Themal coherence stresses the content—the identification of how themes present themselves within and across narratives. The final criterion, pragmatic use, is the relevance and basis from which the study becomes a foundation for another researcher to begin their work. Pragmatic use is future oriented and based on the scientific community's nature of seeking solutions to social problems. Adequate time with the data was spent to accomplish thick interpretation.

The overall trustworthiness of qualitative inquiry frequently depends on the research problem. However, Riessman (1993) reinforced that a researcher can argue for a narrative analysis's validity by providing information to confirm trustworthiness of the findings. This can occur by "a) describing how the interpretations were produced, b)

making visible what was done, c) specifying how transformations were accomplished successive transformations…and d) making data available to other researchers (Riessman, 1993). Therefore, an audit trail was incorporated and the process was demonstrated throughout the study recruitment, data collection, and analyses. Since this study focused specifically on the distress women experienced during the menopause transition, the investigators concentrated on the ways social discourse were revealed in the women's stories.

Additionally, a research team was used to compare analyses of data and assure accuracy of transcriptions. This team was composed of faculty members and peers of the PI who were conducting qualitative research and had participated in advanced qualitative methods classes attended by the PI. The computer software, Atlas.ti was used to organize the data after it was transcribed and extracted of certain themes and text as needed. This also aided in the co-analysis between the research team as information was shared and commented in the Atlas format.

Procedure and Data Analysis

Elements from Reissman's (1993), Labov's (1997), Gee's (1985, 1986), van Manen's (1990), and Frank's (1997) narrative methodologies were used for data analysis. Digitally audio recorded interviews were transcribed verbatim by a professional transcriber. The interviews included interviewer's questions and participants' utterances, hesitations, false starts, and phrases to denote expressions such as laughter and intonation changes such as a whisper or loudness of voice. Fieldnotes were made as soon as possible after each interview to capture the interviewer's observations and reflective

responses to the interview. The following describes the process used for data analysis (Table 3.1).

Table 3.1 Organization of Data Analysis

1. Interviews were digitally audio-recorded and transcribed verbatim.
   - Transcripts were cleaned by listening to audio-recordings and correcting errors, allowing for pauses, vocal changes, and emotions such as laughter and sighs.
   - Transcribed interviews were organized in the computer software, Atlas.ti.

2. Field notes were made as soon as possible after each interview.

3. Transcripts of interviews were read several times to absorb them holistically for content, emphasize each woman, and give attention to emerging narratives and themes.
   - Narratives were identified and organized according to Labov (1997) and Gee (1985, 1986).

4. Selected portions were re-transcribed into a true narrative (Labov, 1997), poetic structure (Gee, 1985), or non-narrative segment.
   - Various types or genres of narratives were identified by paying attention to verb tense, temporality, sequencing, discourse markers, and iterations.
   - For true narratives, elements of Labov's narrative were identified: (A) Abstract, (O) Orientation, (CA) Complicating Action, (E) Evaluation, (R) Resolution, (C) Coda.
   - For Gee's poetic structures: a) frame that oriented listener was identified, b) idea units were identified and line breaks made, b) stanzas were created that reflected certain topics, 3) sections were denoted that reflected larger themes as needed.
   - Narrative types such as chaos, restitution, or quest, were identified as suggested by Frank (1997).

5. All narratives were examined individually and collectively to identify common elements and themes using Atlas.ti to assist in the analysis.
   - van Manen's (1990) recommendation for theme identification was used.
   - Excerpts in the form of true narratives, poetic structures, or non-narrative segments were used to support themes.

6. Content and meaning of the narratives were interpreted. Attention was paid to:
   - Function of language and performance of identities as suggested by Riessman (1993, 2002).
   - Social and cultural embedded discourse ascribed to and resisted by the women as driven by postmodern feminist theory.

7. The data were coded on several levels:
   - Identification of narratives and structural elements
   - Symptom and distress experiences

- Thematic Analysis

8. Memos were kept at each level of analysis
   - Final memos examined the findings and reflected the research questions and previously cited literature.

After organizing transcribed interviews in the Atlas.ti computer program, the interviews were read several times with attention paid to emerging narratives and themes and then coded. Narratives were then organized into either true narratives (Labov, 1997) or poetic structures (Gee, 1985, 1986). Selected portions were then re-transcribed for detailed analysis. Whenever possible, narratives were left whole to maintain participants' voices. Interviewer's utterances and speaker's false starts were excluded. When able to reduce to a core narrative, Labov's (1997) elements of a story were identified, such as clauses that functioned to: provide an abstract for what followed (A), orient the listener (O), carry the complicating action (CA), evaluate its meaning (E), resolve the action (R) and return to the present—coda (C). Analysis of poetic structures was used for story pieces that did not contain all aspects of a narrative but 'felt' like a narrative (Riessman, 1993). At times, line breaks were made while listening for speaker's changes in pitch. This was also achieved by noted pauses or change in tone by the transcriber. The narrative was divided into stanzas and theme sections identified through content or pauses in speech. Various types or *genres* of narratives were identified by verb tense, temporality, sequencing, discourse markers, and iterations. Genres such as habitual, episodic, hypothetical, or a one time event were identified. Frank's (1997) genres of illness stories—chaos, restitution, and quest—were also identified and analyzed accordingly. These genres "illuminate in different ways how individuals construe their experience" (Riessman, 1990b, p. 1199).

Emerging themes were noted and thematic analysis was performed and substantiated with excerpts from the text either in narrative form, poetic structure, or non-narrative segments. Van Manen's (1997) selective or highlighting approach was mainly used for theme identification. Phrases that were thematic of the experience of distress represented some of the themes. Most (but not all) of the experiences of distress were a result of experiencing one or more symptoms attributed to menopause. Therefore, symptoms were frequently used as a thematic umbrella to examine experiences of distress. Attention was also given to the research questions when themes were identified.

Context and meaning of the narratives were identified through the distinct but interdependent functions of language. Reissman (1993) suggested three functions essential for interpretation of meaning: 1) ideational function expresses referential meaning of what is said: content in terms of the speaker's experience; 2) interpersonal function concerns the role relationship between speakers, and allows for the expression of social and personal relations through talk, and 3) textual function refers to structure, how parts of a text are connected syntactically and semantically (p. 21). Following a postmodern feminist approach, the diversity of participants was noted including age, economic status, sexual orientation, reproductive status, social position, race, ethnicity, political, and religious positions was taken into consideration during analysis (Group, 1989). These data were either assessed in the demographic questionnaire or surfaced during the interviews.

People's identities can also be examined when a narrative is analyzed as a performance. Through the telling of stories, identities are performed (Riessman, 2002). These identities are fluid and narratives can locate the narrator's social positioning and

other characters in the story. These positions can shift throughout the narrative. Attention to verbs that either framed actions as voluntary or compulsory, or other grammatical resources illuminating identity were essential to the analysis.

Attention was paid to discourse emerging from the data from a postmodern feminist perspective. Baxter (2003) differentiates the linguistic sense of discourse—the structure, and the social or ideological sense of the meaning. She defines discourse as "…systematic ways of making sense of the world by inscribing and shaping power relations within all texts, including spoken interactions" (p.7). Furthermore, Baxter (2003) explicates the importance of the "…simultaneous way in which individuals can *position themselves* and *be positioned* by power relations…" in the creation of identities (p.27, added emphasis). Attention was given to how women found ways to position themselves as powerful agents and how others may have been silenced by prevailing discourses.

Codes were created within the documents using Atlas.ti software and denoted aspects of the phenomenon conceptually, theoretically, philosophically, or thematically. This aided a deeper engagement with the text and further development of themes. Additionally, memos were kept at each level of analysis to reflect on the data. Final memos examined the findings reflecting on the research questions and previously cited literature. Data were collected and analyzed simultaneously and new themes were explored in subsequent interviews with other participants. This allowed for an open and dynamic hermeneutic inquiry.

Summary

Understanding how each woman defines distress and how this definition reflects the shared meanings embedded in the societal discourses is critical. The incorporation of narrative analysis methodology was an effective strategy to gain a deeper understanding of distress in midlife women's lives. This chapter elucidated the rationale for using this method by describing the various ways to analyze narratives proposed by Riessman (1990, 1993), Labov (1997), Gee (1985, 1986), Frank (1997), and van Manen (1990). These expert researchers support the value of using narrative analysis in understanding phenomenon in person's lives.

Harding (1991), a feminist philosopher, illuminates a compassionate method for viewing women that supports the use of narrative analysis to study distress during menopause.

> We frame the accounts of our cultural origins and our most cherished beliefs in story form, and it is not just the "content" of these stories that grip us, but their narrative artifice. Our immediate experience, what happened yesterday or the day before, is framed in the same storied way. Even more striking, we represent our lives (to ourselves as well as to others) in the form of narrative. It is not surprising that psychoanalysts now recognize that personhood implicates narrative, "neurosis" being a reflection of either an insufficient, incomplete, or inappropriate story about oneself (p. 131).

The next chapter is the first part of the results. Sample characteristics will be presented as well as an analysis of one woman's narratives. Following Frank's (1997) three genres of illness stories—chaos, restitution, and quest, three narratives will be discussed in detail. This will demonstrate how one woman's experiences embodied the elements of these three genres.

CHAPTER FOUR: SAMPLE CHARACTERISTICS AND NARRATIVES

The findings from this study of women's experience are complex and multifaceted. They will be presented in two chapters with a final chapter to discuss the implications and future research directions. This chapter describes the sample characteristics followed by three narratives of one woman whose menopause story represents exemplars of three specific narrative genres, as suggested by Frank (1995). Chapter five presents a thematic analysis of the women's narratives. Chapter six includes an in-depth discussion of the findings integrated with results from previous studies and synthesized in light of theoretical and philosophical discourse. The goal is to present narratives as a whole in order to include as much of the women's stories as possible. In order to maintain confidentiality, pseudonyms chosen by the women themselves are used in lieu of authentic names.

Sample

Recruitment and Data Collection

Most study participants responded to advertisements on community volunteer sections of the Internet bulletin board, or to flyers at grocery stores. The rest of the women were recruited through word of mouth or through snowballing techniques. One woman responded to a flyer placed at a menopause focus group in which she participated for another research study conducted by a clinical psychology doctoral student. Interviews were conducted at sites chosen by the women. Each woman was first asked to share her experiences of menopause and to add any specific stories that would elucidate the distress of her experiences. Some women spoke spontaneously of aging; others needed prompting. The interviews were conducted openly to allow for the issues of

importance to surface. This also follows ethics of postmodern feminist research (Bloom, 1998). Pauses and silences were welcomed in order to have a minimal level of interruption. This was explained to the participants ahead of time to reduce any potential discomfort that could have risen during the moments of silence. Field notes and e-mail correspondence were also included as data. Basic demographic data were collected on each woman (Appendix F). Some of the demographic data are missing from one woman who participated in the pilot study before the questionnaire was created. Marital and employment status, education, age, number of children, and treatment modalities were able to be ascertained from the interview. Income and number of visits to healthcare provided are missing.

Sample Characteristics

Fifteen (N = 15) women between the ages of 40 to 59 were interviewed for up to two hours each. The youngest participant stated she began experiencing symptoms of menopause at age thirty-one. Close to half of the women were still in menopause transition, and the rest were post menopause. One woman had a bilateral oophorectomy, and she addressed the symptoms she experienced prior to surgery. Ethnic/racial background included Latina, Caucasian, and African American. All of the women described themselves as heterosexual. Some of the demographic questions were asked twice to gain information about their current status and their status during the distress experiences. Table 4.1 provides the sample characteristics.

The women's employment included a range of occupations including teacher, secretarial, compensatory support, temporary work, "odd jobs," consultant/writer, artist, body worker, nurse, insurance and bank agents, and project manager. They were also

asked to list treatments tried for their symptoms. They had used hormone therapy as well as alternatives such as acupuncture, herbs, soy products, massage, exercise, vitamins, antidepressants, anxiolytics, and colonics. The women were well educated and evenly distributed across income levels.

Reports of Menopause Symptoms

Table 4.2 provides a brief description of each woman who participated in the study. The women reported a range of distressing symptoms. Common menopause symptoms such as hot flashes, night sweats, vaginal dryness, decreased libido, mood changes, menstrual changes, and sleep disruption were reported. Secondary effects such as sleep deprivation, social isolation or withdrawal, and a loss of physicality occurred as a consequence of symptoms. Some women listed other physical changes that they attributed to menopause including weight gain, hair and skin changes, increased urinary tract infections, changes in physical ability and decreased alcohol tolerance, among others.

Reported distressful symptoms were severe, frequent, unpredictable, or persistent. Some of the women found ways to remedy their symptoms. These remedies included the use of hormone therapy or other pharmaceuticals, as well as natural or alternative modalities, and surgery. Many women also strived to make sense of their experiences, either directly related to the distress, or to menopause and aging in general. Most reassessed the values in their lives, and began to incorporate these newfound values into their everyday living.

Table 4.1 Sample Characteristics

	Current	During Distress
Age		
Mean	50	
Range	40-59	31-57
Ethnicity/Race		
Caucasian	11	
African American	2	
Latin	2	
Marital Status		
Single	6	6
Married	3	3
Divorced	3	3
Living w/partner	3	3
Children		
Yes	7	
No	8	
Age during distress	13-24	13-24
Education		
Some college	5	5
College degree	5	6
Graduate degree	5	4
Employed		
Yes	14	14
No	1	1
Income		
$10,000 – 19,000	2	3
$20,000 – 39,000	3	3
$40,000 – 59,000	3	4
$60,000 – 75,000	2	0
> $75,000	4	4

Table 4.2 Visits to Healthcare Provider and Treatments Used

Visits to Health Care Provider	
0	1
< 5	5
5 –10	5
10 –15	3
Provider Helpful—Yes	7
No	2
Somewhat or sometimes	5
Treatment Helpful—Yes	8
No	5
Hormone Therapy	8
Alternative Treatments	8

Table 4.3 General Description of Participants (N = 15)

Susan Jane, 53 at time of interview, living with a partner, no children. Months of night sweats and hot flashes with subsequent sleep deprivation and a complete loss of "physicality." Symptoms occurred at age 50.
BJ, 53 at time of interview, single, no children. Distress related to aging, stigma, hot flashes, and noted other changes in hair, skin, alcohol tolerance, libido, and memory. Currently experiencing symptoms.
AJ, 54 at time of interview, married with two teens during distress episode. Depression and insomnia.* Symptoms occurred in 40s.
Kira, 54 at time of interview, single parent with one teen during distress episode. Cyclical mood changes and sleep disruption. Symptoms occurred in 40s.
Martha, 57 at time of interview, married, with two grown children. Intense emotional duress. Current decreased libido. Symptoms occurred at age 55.
Anna, 59 the time of interview, single, no children. Menstrual irregularities, sleep disruption, and decreased libido. Symptoms occurred in early 50s.
Nancy, 59 the time of interview, single, single parent of a teen during time of distress. Severe hot flashes that resulted in social withdrawal and isolation. Symptoms occurred in late 40s and early 50s.
Elizabeth, 56 at the time of her interview, married, no children. Persistent insomnia,* and decreased libido. Currently experiencing symptoms.
Candy, 48 at time of the interview, married, mother of two teens. Hot flashes and mood changes. Currently experiencing symptoms.
Leslie, 48 at time of interview, divorced, single parent of two sons during distress episodes. Cyclical mood changes. Currently experiencing symptoms but less now.
Tree, 55 at the time of the interview, divorced, had one grown child. Hot flashes, and insomnia.* Currently experiencing symptoms.
Fay, 55 at the time of the interview, living with a partner, no children. Vaginal dryness, insomnia,* and unpredictable menses, and many more. Currently experiencing symptoms except menses.
China, 40 at time of interview, single, no children. Unpredictable and painful menses resulting in social withdrawal. Symptoms began in 30s. Currently experiencing symptoms.
Daisy, *53* at time of interview, divorced, living with partner, 2 grown sons. Day sweats, irregular menses, decreased libido Currently experiencing symptoms
Jo, 59 at time of interview, single, no children. Major knee problem and subsequent loss of physicality. Symptoms occurred in early 50s

* Insomnia and sleep deprivation used when women used this word to describe their symptoms; otherwise, sleep disruption was used.

The menopause experience of one of the women, Susan Jane, profoundly illuminated the three genres of narratives, chaos, restitution, and quest (Frank, 1995). Her experiences are presented as an exemplar of the distress collectively described by many of the women. The stories of the other women presented in chapter five also have elements of chaos, restitution, and quest, and will be identified in the thematic analysis in chapter five.

Susan Jane: A Story of Chaos, Restitution, and Quest

Susan Jane was the first woman interviewed and her story erupted from her like a volcano, as if she had been waiting for the day to be able to tell her experience to someone who was sincerely interested. She spoke uninterrupted for nearly 45 minutes straight. Except for my intermittent nods, sighs and utterances of acknowledgement, I was silent. She shared her experience of intense, consistent, and repetitive night sweats for a period of nine months that resulted in severe sleep deprivation and a drastic "loss of physicality." This *chaotic* episode finally met *restitution* by the "surrender" (her term) to the use of hormone therapy. The nine months of hormone therapy gave her respite—the prerequisite for deep reflection. She then began her *quest* for understanding her experience of distress during menopause, past events in her life, and the implication for her future.

Chaos

Susan Jane's menopause experience was one of "death and rebirth." These themes penetrated her narratives throughout the interview. Once an extremely physically active woman, the months of lost sleep created the "death" of her identity as an accomplished woman "in the physical, mental, and sexual prime of [her] 40s."

The first is an exemplar of a chaos narrative. It represents Susan Jane's sense of loss of control and the frantic, unsuccessful attempt to regain it. This story demonstrates the habitual chaos in her life at that time. She covered many themes, thus her story was well suited to be re-transcribed into poetic structures. It is an exemplar of a chaos narrative, and can easily be restructured into stanzas and sections that represent meaningful themes in her life. The titles of the sections and stanzas are based on the interpretation of the narrative. Susan Jane was asked if she could describe one particular night and this was her response:

Setting

Oh yea,…it's like you go to bed,
get to bed around 11:00

Affect and Conflict

Stanza 1 (sleep disruption)

12:30 you wake up,
your body is totally drenched in sweat,
you're kind of trembling,
you kind of wake up
you're hot, you're flashing,
you're uncomfortable
you don't know what's going on
so you get up and you calm yourself down

Stanza 2 (losing control)

there's a sense of panic about it
losing control over your body,
and then you get up and many times
I couldn't go back to sleep
for another half hour
then you go back to sleep after you try hard
and you're uncomfortable,
and you wake up again at 3

Stanza 3 (going into disease)

and go through the same cycle of
discomfort, panic, lying awake
wondering what the fuck is going to
happen to you
how long this is going to go on
you start going into disease

Enduring Role Strains

I. Money/Work

Stanza 4 (bag lady)

like about, if I don't get enough sleep now
I won't be able to work in the morning
if I don't, how many days
is this going to go through
where I can't go to work at all
and I'm going to become a bag lady
where I'll lose everything

Stanza 5 (spiral)
I mean just the spiral,
it's dark, you're exhausted,
and you're emotional
and you can't think clearly
and then maybe you go back to sleep again
and it happens again at 5
so you have three bouts in a row
and you went to bed at 11
and maybe you wake up at 7:30
after you've gone back at 6

Stanza 6 (exhausted)
and you're absolutely exhausted
Not only are you exhausted physically,
emotionally, you're a wreck
and you're completely freaked out,
your hormones are crazy

Stanza 7 (function)
and then you're supposed to get up
and act like,
it's a nice day and you know
and you just want to stay in bed all day
and you're thinking
if I go through this again,
if I keep going through this,
I'm just not going to be able to function.

II. Self Help/ Self Image
Stanza 8 (remedies)
And that's what happens, you know,
and then you spend some time in your day,
what time you can
running around the health food stores
trying to find remedies
or reading things, or trying to get information, you know
and you're doing it, you're doing your thing

Stanza 9 (all jingled)
and you're alone
and you're, you look like shit.
You look like shit because you didn't get any sleep
and your emotional self is all jingled
and then you look at yourself
and then you feel bad,
your self esteem goes down.

III. Woman/Femininity
Stanza 10 (estrogen)
You don't want to put any,
you're not interested in dressing or grooming
because when the estrogen starts going down
as Dr Reeves says,
all the feminine inclinations
goes out the window

Stanza 11 (depressed)
you don't want to do any self care.
So that when the self care
starts going down the tubes,
then you look even worse.
Like when, one is clinically depressed,
it's just a downward spiral,
it just keeps going down.

Stanza 12 (no energy)
And like I really want to say
I need to get up,
I need to fix my hair,
I need to put on some make up,
I need to clean the house,
you have no energy so there you are,
you're back in that, it's, it's pretty insidious.
And you know you're not attractive,

IV. Sexual Being

Stanza 13 (partner)
you have a mate,
and you think you're
going to lose your partner.

Stanza 14 (sex)
You can't have sex
because when the man
gets on top of you,
that the heat, the hot flash, it makes it,
like if you have a hot flash
and you feel like you're 100 degrees,
if he gets on top of you,
you feel like you're 200 degrees,

Stanza 15 (symptoms)
so sex becomes very difficult
and also if you're not having a hot flash
and you want to have sex,
if he wants to have sex,
it could bring on a whole bunch of
symptoms.
So it's like…
Hot flashes and sweating

Stanza 16 (pay the price)
so you may want to have sex with him
to express affection
but if you have sex
you're going to pay the price physically.
So it's like
you're dammed if you do,
and you're dammed if you don't.
It's like every way you're fucked. [laugh]
It's like wooooaa, too much.
You get the picture?

In a chaos narrative there is a sense of an "incessant present with no memorable past and no future worth anticipating" (Frank, 1996, p. 99). This story of repetitive nights and days in Susan Jane's life portrays this incessant present. She was unable to speak of a particular night since there were so many of them. Riessman (1990) refers to this genre of narrative as habitual. The conditional past tense is used—this *would* happen, to reveal the recurring events. Riessman (1990) believed however, that a habitual narrative cannot draw the reader in, as can a one-point-in-time story, and thus it feels more distant and less emotionally affecting. This 'habitual' narrative of Susan Jane's rents that argument, for she has vividly drawn the reader into the emotional field of her life, even more so since it is repeated over and over again.

The chaos in this narrative is portrayed by the constant use of *and then, and then;* "the words peck away at the reader just as [Susan Jane's] life pecks away at her" (Frank, 1995, p. 99). If chaos exists on the opposite end of the continuum as control, Susan Jane demonstrates this phenomenon clearly in the first stanza, "there's a sense of panic about it, losing control over your body." Frank (1995) suggests that "emotional battering is fundamental to chaos." This battering imbues Susan Jane's narrative and is even directly addressed, "I mean just the spiral, it's dark, you're exhausted, and you're emotional and you can't think clearly." In a restitution story of a person with symptoms, a remedy is achieved. By contrast, in a chaos story, the inability to accomplish this task adds to the loss of control.

This chaos narrative demonstrates how the hot flashes and night sweats in Susan Jane's life affect her being in four distinct ways: 1) work; 2) self image/self help; 3) femininity; 4) and sexual being. How Susan Jane delivers this narrative demonstrates that these aspects are important to her, affecting not only her present symptoms, but raising concerns for the future. The use of poetic structures fits this narrative well. Though there is a beginning and an end to the narrative, there is no resolution in the narrative presented thus far. Riessman (1993) defended her use of poetic structures for narratives that are not quite narratives. They do not include a plot, have few narrative clauses and include verbs in the present tense rather than the simple past. She further explained that stanzas are: "…the building blocks of the narrative, groups of lines said together about a single topic, a vignette, in the form of a stanza" (p.51). Gee (1991) stated that each stanza represents an image, similar to a camera focused on a scene.

The stanzas used above in Susan Jane's story of a particular night, fall naturally into showing the different elements in her life that are being affected. She sets the stage by orienting to place (bed) and time (11:00 pm). In addition, this piece reveals how Susan Jane's life fell into chaos for the nine months of her distress before she finally found restitution. Stanzas 1 to 3 introduce the problem, a detailed description of what it is like to wake up one and half hours after going to bed—"your body is totally drenched in sweat, you're kind of trembling…." Susan Jane uses the second person to represent a universal person, as if this happens to "one" who has this symptom. This has the effect of making it real, creating the possibility that this could happen to the reader. It may also be a way of distancing herself from the memory of the experience. Frank (1995) believes that chaos stories can only be told as a reflection.

In stanza 4, she switches to "I" when it is a time that is very personal to her. "If I don't get enough sleep now, I won't be able to work in the morning," reflecting the thoughts and concerns running through her head in the "dark" of the sleepless night. This stanza also introduces the role strains—the aspects of her life that are being affected by her experience. This assessment of the event is similar to Labov's evaluative clauses. Riessman (1990) considered evaluative clauses to be the "soul" of the narrative, conveying both "quality of mind and the attitude of the narrator." Both money and work were identified as concerns —"I'm going to become a bag lady." In stanza 5, Susan Jane's use of the word, "spiral" illuminates the incessant quality of her fears. In addition, the repetitive use of the word "*and"* demonstrates her frustration and repetitive spiral of sleeping and waking "three bouts in a row."

Susan Jane nearly acted out her story. Her intonations, lack of pauses and certain emphases on words facilitated an understanding of the magnitude of her experiences. In stanza 6, when she described the effect of the repetitive awakenings, she dragged out the words, "a-b-s-o-l-u-t-e-l-y e-x-h-a-u-s-t-e-d" as if living the spent feeling. She said in that same stanza, "you're completely freaked out [and] your hormones are crazy." It is unclear whether she was alluding to the 'crazy hormones' as the *cause* or the *effect* of her state of being. In the next stanza, she recounted the contradicting role she must play when daytime arrives, "then you're supposed to get up and act like it's a nice day" when she would really rather stay in bed all day. The need to endure in order to maintain daily demands was apparent. The fear of not being able to function, clearly expresses the fear of future repercussions related to work, finances, and supporting herself.

Stanza 8 introduces the next section, Self Help/Self Image. She describes daytime as spent "doing your thing." In her case, it is spent searching for remedies to find an end to her suffering. Susan Jane tells of the isolation that comes with personal turmoil and a decreasing self image. "You're alone, and...you look like shit." She ends that stanza declaring her "self esteem [is going] down" which segues into the next section, Woman/Femininity. She attributed the decline of "all the feminine inclinations" to "when the estrogen starts going down." This ascription however, was influenced by written discourse, a book authored by "Dr. Reeves."

Susan Jane tried to maintain some sense of dignity. She told herself "I need to fix my hair, I need to put on some make up…" and surrenders to the lack of "energy." She admitted to the "insidious[ness]" of her situation then moved to the next compromised identity—that of a sexual being (Stanza 12) which introduces the next section. The

potential consequences of her declining self image surfaced in her fear of "[losing her] partner." The obtrusive physical effects of engaging in sexual activity when prone to hot flashes came to life. "If you have a hot flash and you feel like you're 100 degrees, if he gets on top of you, you feel like you're 200 degrees." Compounding the difficulty, Susan Jane related a twist of this painted picture—wanting to engage sexually with her partner when she was not in a state of flush. However, the dreaded fear of bringing on a hot flush precluded her from fulfilling her and his desires. "You want to have sex if he wants to have sex, it could bring on a whole bunch of symptoms." The trap of this chaos, with no hope of escape, climaxed as Susan Jane's frustration with her sexuality found her "dammed if you do, and…dammed if you don't." The narrative ends here as her voice rose to nearly a shout, "every way you're fucked. It's like wooooaaa, too much." It is impossible to disagree with that statement after her detailed description of "one particular night" during a very distressful time in her life.

Chaos stories are hard to hear; they represent that which no one wants to experience (Frank, 1995). The stories simultaneously spark both a deep fear of and a compassion for human suffering. Frank (1995) posited that the story teller tries to get the listener's recognition of her chaos. That is apparent in Susan Jane's coda, "you get the picture?" This profound question ended her interview.

This narrative was a robust exemplar of the habitual chaos narrative genre, as well as the restructuring technique of poetic structures. The syntactic structure of *and then and then*, the rapid rate and rhythm of the voice, and the swift movement from deteriorating topic to topic drove the story forward in a persistent exigency. Susan Jane's description of her "nights" demonstrated the downward spiral typical for chaos narratives

(Frank, 1995). Separate stanzas and sections organized the narrative in a natural manner. Susan Jane's vignette's affected identities adhered together in separate 'snapshots' or 'images' of the meaningful components of her life. Frank (1995) referred to the chaos narrative as the "anti-narrative," explaining that narratives imply a sequence of events connected through time. Susan Jane's narrative has elements of connection. However, they crumbled upon each other, as pieces of her life crumbled upon her—the embodiment of distress during the menopause transition.

Fortunately, restitution became part of Susan Jane's story, but only after enduring nine months of the chaos elucidated above. The following narrative is one of restitution as she tells of how she eventually found a way to move out of the chaos in her life

Restitution

Susan Jane first became aware that she was entering menopause when she was visiting her boyfriend's parents during Christmas holidays. She had a political disagreement with her boyfriend's father, which according to her was "a bombshell that disturbed the domestic equanimity." Susan Jane began having hot flashes that night. "I started waking up three or four times a night," and thought at first it was just a "stress reaction" to the fight. However, the hot flashes continued and she realized, "Oh, I guess this is it, I guess I've entered it." She lamented, "but it was taking place in a place that wasn't my home, and it was cold, and it was uncomfortable so that's how it [menopause] started."

She returned home where the hot flashes continued. The chaos narrative previously presented described her life during the nine months of severe hot flashes and night sweats. Ascribing to an alternative medicine discourse, she feverishly searched for

natural remedies, and engaged in a rigorous regimen of yoga all to no avail. She eventually surrendered to taking hormone therapy. The following narrative demonstrates her restitution. It has a beginning and an end and elements of a true narrative. It is presented in Labovian structure (Labov, 1997). The symbols placed at the end of lines reflect the following elements: (A) abstract; (O) orientation; (CA) complicating action; (R) resolution; and (C) coda. Some lines were omitted for brevity.

Abstract
So basically I gave myself 9 months to try and experiment with alternatives
and I had signed up to go to [place] in October for my birthday
and I knew I couldn't go to [place] in the condition I was in

Orientation
so in August of that summer I went to a nurse practitioner
who was affiliated with a very classical gyneco… female gynecologist in [place]

Complicating Action
and I just walked in and I said, um, I said,
"whatever you have to do just give it to me."
And she said, "what'ya want? [Laugh], and I said "what'ya got?"
And she said, "well if you go on estrogen…
it'll be great! So, what'ya want?
I'm going to give you this prescription and you're going to go over to Costco
and I guarantee you're going to feel better tonight if you take it right now,"
and sure enough I went over to Costco and I got a prescription for uh, uh,

Resolution
…I took the estrogen that night and the next morning I took the progesterone
and it was like, it was almost like nothing had ever happened.
So that was really, really wonderful **(E)**
in that there was like 90% of my symptoms went away immediately **(R)**

Evaluation
but there was also this sense of grief **(E)**
in that I realized that those nine months that I had suffered
because of my mental attachment
to the idea that somehow being drug free or out of the classical medical model to
[not take] estrogen had basically been for naught.
And that was really hard to swallow, I mean that was really tough. **(E)**

…so I went on the estrogen and progesterone
from September 04 until um about July of this year. **(O)**
I started to feel that… I could feel in my body
although the drugs were controlling symptoms
I felt that they were masking the symptoms **(E)**
and I went off in July and I've been drug free, let's see, August, September, October,
three months, and I really feel compared to where I was in December of 2003
although I'm not completely symptom free in that I still have minor hot flashes…

Coda
So in my mind and in terms of how I am based on when I started
I feel like not only am I turning the corner,
but I feel that I'm pretty much in the finishing line of like,
the dramatic story of, you know,
like before I went on the HRT there was this one morning
and I looked at [boyfriend] and I said, "they shoot horses don't they?"
and I just looked at him and I said,
"if this is what it's like to live as a, quote, menopausal woman,
I cannot do this, I cannot take this."

Frank (1995) proposed that restitution "is a stage in the embodiment process of illness that every body passes through" (p.84). However, he also declared that "…some bodies show a greater affinity for restitution narratives than others" (p. 84). If this was the entirety of Susan Jane's story, then her menopause experience would embody the restitution narrative. There were stories from other women in the study who sought to find remedies for their symptoms of menopause. Some women's stories were very similar to Susan Jane's and others embodied more of a chaos story where restitution seemed impossible. Other women surrendered to the hope that their suffering would pass eventually with minimal intervention. All of the women in the study tried some method to achieve restitution, but none reflected the intensity of Susan Jane's efforts to restore her body to normal.

Frank (1995) also believed that the restitution narrative is based on the body as a machine, something to be fixed when "it" breaks down, reflecting a more mechanistic model of personhood. Susan Jane's narrative certainly demonstrated the desire to be fixed. The restitution body seeks an outside agency for reparations (Frank, 1997). The natural remedies or herbs sought by Susan Jane could be viewed as this agency. An intense exercise regimen such as the one she incorporated to heal herself is not an "agency outside the body." However, it reflects the search for a changed body, the search for restitution. The restitution story requires adherence, thus demanding "a disciplined body" (Frank, 1995, p. 87). Susan Jane's life prior to entering menopause established the background to her efforts to heal herself after menopause. "I had been healthy and very successful at being healthy my whole life using alternative modalities." It would seem natural for her to attempt to "fix" her symptoms from menopause using alternative therapies based on her description of herself. Susan Jane's past success at healing herself established the logical response to the hot flashes and night sweats she was having with menopause. Frank (1995) called this the "logic of restitution—future sickness already will have been cured" (p. 90).

Susan Jane ascribed to the alternative healing discourse to the extent of complete "mental and physical breakdown." She was accustomed to successfully restoring her body with natural therapies and took personal responsibility for her body's failure this time. "I have to work harder, I have to work-out harder, I have to push myself harder to find something to deal with the remedy." Medical treatment was out of the question for her, as she did not believe in it. "Well I have to do everything I have to do that I can find out about that didn't have anything to do with the medical profession or drugs because

that has always been my approach in the past…" Susan Jane allowed herself nine months of "experimentation" searching for an alternative cure, as she, "…a person who was robust, vital completely into [her] body… was becoming like a handicapped person."

The chaos of her life ended when she sought traditional medical care. A restorative visit at a health spa was the impetus because she "knew she could not go in the condition [she] was in." At the end of her story, she received a prescription for estrogen and the assurance that she would feel better. Her chaos ended almost over night, yet she grieved alongside the victory. She struggled with the realization that she had suffered because of her rigid attachment to a natural healing discourse. The pain in thinking she was responsible for her suffering was reflected in the evaluative comment, "And that was really hard to swallow, I mean that was really tough."

The basic storyline of the restitution narrative is, "Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank, 1995, p. 77). The belief in a healthy tomorrow or a restoration to what was before drives the protagonist forward. Susan Jane believed in a healthy tomorrow, but did not expect it to take so long. The distance between the past and future influences the breakdown narrative as does the intensity of the on-going present. Not only did a breakdown in her body occur, a breakdown in what she believed in also greatly impacted her. What she valued—the *desire* to have an optimum physicality, and the *way* she knew to get there—intense self disciplined regimens, are both lost. This story could end there—a woman experiences intense hot flashes, night sweats, and sleep deprivation constituting nine months of utter chaos, finally finds a solution—the end. However, Susan Jane's story does not stop here, as will be elucidated in the following quest narrative.

Quest

Frank (1995) wrote: "Restitution stories attempt to outdistance mortality by rendering illness transitory. Chaos stories are sucked in to the undertow of illness and the disasters that attend it. Quest stories meet suffering head on: they accept illness and seek to use it" (p. 115). Generally, a quest story represents an acceptance of change, and an attempt to find meaning in it. It is a journey of understanding, demanding reflexive exploration that results in transformation on some other level. Something is to be gained from suffering that only can be achieved by hitting the depths, and rising anew. Susan Jane told of her quest to find the meaning behind her distressing menopause experience. Since a quest story is mainly evaluative (does not have a plot or multiple themes), it will be presented in non-narrative segments.

> Reconnecting to the perennial philosophies was the only way I had a framework and a scheme for sorting, of seeing what I was going through was an initiatory process here, and it was like a death-rebirth process and then I was going to have to understand it in that context even though the people around me were in denial about it or didn't want to understand about it in those terms that if I wanted to survive it and thrive it and become this sort of reborn person as it were in this next phase of life and become an early crone that I needed to get with the program in my own psychology on a very deep spiritual level.

The "people around" Susan Jane to whom she refers are midlife women in an art group she attended who were exploring transitions through art. She had an experience with the leader of the group who did not understand Susan Jane's "death/rebirth process." The woman asked Susan Jane if she was contemplating suicide. It seemed to Susan Jane that the woman did not understand her deeper process. "To me she was tremendously ah, ah, terribly, spiritually, ah and intellectually deficient and unaware and unsophisticated

about the deeper levels of this process of menopause." Susan Jane was asked when in her menopause experience did she begin the spiritual journey. She responded,

> Probably I think I started doing it really soon after I realized this woman who had this advanced, she had like this doctorate in um you know women's studies and you know dealing with like women's midlife crises and I heard this woman totally not get me and I said, "Oh shit, I'm not going to get any help out there. There is no help out there…"

Upon further inquiry, Susan Jane said that she could only start the journey of trying to make sense of what had happened after her suffering had ceased. "When I went on the HRT and didn't have to deal with suffering, you know, really deep physical suffering it was just unrelenting. I think that's when I withdrew because I have the physical strength and stamina to kind of function more normally…" Part of this need to reexamine her life and values also stemmed from having her symptoms alleviated by hormone therapy. She follows the last statement with:

> I mean cuz it was a real, it was a real blow to me as a person to think I had suffered because I didn't want to take these drugs you know cuz like, you know, you think, I think I'm doing the right thing, yet, in a way taking the drugs was a defeat for me yet it wasn't a defeat because it worked. And so I have this schizophrenic reaction so I had to kind of like draw down and really evaluate, like wow, you know who do I believe, you know, you know, it was kinda like serious issues of self trust. You know, here I was trusting my ideas of not doing the medical/not doing drugs was right and it turned out to be wrong.

This breakdown in discursive belief became a battle between trusting herself and trusting the medical model. She equated the alternative mode of healing with self healing and anything related to conventional medicine as something outside herself. It is easy to see then why she took it so personally. The fact that she needed to "surrender" to HRT is

seen as a complete letdown of self. Ultimately, her menopause experience initiated the quest to "soul search."

> So, there was, you know, I had to do some like soul searching and I do think that, I do think that kind of the stripping away of your attachment to your physicality and your well being and this was I was trying to express to the woman at the Y. I believe now, it's like a preparation for the ultimate confrontation with mortality which is your death. This menopause is saying, "you know, you are not going to be all that you were in your 20s and 30s and 40s and 50s and you've got to psychologically get ready for the fact that you are going to die," and that's not a bad thing.

She embodied the quest narrative with the journey to re-evaluate her prior attachments. Her values before her menopause experience (attachment to her physicality) moved through a "confrontation with mortality" and were replaced by a pursuit to psychologically prepare for death. She found a way to turn all of this into something positive—"that's not a bad thing." The following summarizes her quest story.

> And it can be depressing - it's like your soul through the vehicle of your body is preparing you if you take the opportunity to start disidentifying, like Joseph Campbell says, you know there's a light bulb and you're the light. Are you going to identify with the light bulb or are you going to identify with the light? He says, like aging is you have to stop identifying with the light bulb and identify with the light and he said if you have a car and notice the pieces start falling off that's what it's like when you're aging and in menopause, your pieces are starting to fall off; your hair isn't as beautiful, your skin isn't as lustrous, you try to lose weight which was, you know a painless thing before menopause you try to lose weight, and so on a deeper level I think it really is your wake up call to get ready to die but also along with that is and all the books on menopause say this, it's also your last opportunity to be really authentic and honest with yourself and say, you know, between now and the time I do die, what's really meaningful to me and what do I really want to do and how do I want to spend the time that I have left in the most productive and personally meaningful way to me?

Susan Jane is a woman who was accustomed to reflection. She stated later in the interview: "I've had a uniquely deep, psychologically take to life." It makes sense that

she would examine her experience of menopause on another level. She was greatly influenced by the Jungian psychologist Joseph Campbell. Frank (1995) also referred to Campbell in his chapter on the quest narrative. He spoke of Campbell's "schematic of departure, initiation, and return" (p. 119). Susan Jane addressed the concept of initiation in the excerpt above. The "hero" is the protagonist in Campbell's moral philosophy story of the myths. The departure begins with a "call" that Frank suggests is the "symptom" in illness stories—"a sign that the body is not as it should be" (p. 117). Frank believed that initiation in illness stories are the physical, emotional, and social sufferings that the person endures; and the return can be viewed as the phoenix rising from the ashes. In recovery from illness, the person no longer suffers, but has been transformed.

Frank (1995) cited Campbell while discussing the quest narrative of illness stories because of his important influence on people interested in self-help and self-reflection. Susan Jane's quest story embodied the three elements of Campbell's journey. She even referred to the initiation—"what I was going through was an initiatory process here." She acknowledged that although she had to re-evaluate her beliefs in self or natural healing, if she had gone on hormone therapy earlier, she would not have had the profound transformation that she had.

> And although I'm grateful for HRT for getting me out of the hell of physical suffering, you have to be careful because part of that descent is part of that initiation so it's like you have to strike that balance between going down to Hades and the ascent up to learn what it is to learn what it is that you can only learn by having made that descent and ascent, you know what I'm saying?

Frank (1995) believed that the quest narrative most distinctly reveals the voice of the ill, and thus is most often published. Susan Jane wanted to tell her story. During her quest story, she stated:

> How was I going to transfer the energy that I have not so bodily based into a more spiritual and psychological and intellectually based way in giving back to the community? And this interview is a perfect example of that. You know, I cannot necessarily give as much physically as I was giving, but I have wisdom and the experience of my experience and that is what I have to learn to give back now.

A person who experiences deep suffering and has looked for and found the deeper meaning of it, emerges with a need to help others. She becomes "the compassionate being who vows to return to earth to share her enlightenment with others" (Frank, 1997, p. 119). Susan Jane's process embodied this desire as she declared her need to "give back to the community." She stated this need also as a result of being in the women's group and not receiving the help she needed, especially from the group facilitator. Not only did Susan Jane want to tell her story just to tell it, she wanted to help others who may have had similar distress going through menopause. "And that's part of my impetus and motivation to respond to the ad, that I do think that there will become more help out there."

Summary

The purpose of this chapter was to demonstrate how one woman's narrative of distress during the menopause transition could be examined using Frank's (1995) three types of illness narratives—chaos, restitution, and quest. These three narratives together constitute Susan Jane's complete menopause story. If her menopause experience was examined as an episode in her life, the three narratives together reflect the structural elements of a story as proposed by Labov (1997). The complicating action climbs and climbs and may seem unceasing as in a chaos narrative. The protagonist achieves

resolution—the restitution narrative. Finally, the protagonist evaluates the meaning of the experience—the quest.

Through Susan Jane's narratives, many discourses present in today's Western society were illuminated. The medical model of healing through pharmaceuticals and the self healing model are two very strong opposing discourses. Many women invest in a non conventional healing discourse as Susan Jane did. Discourse on aging, sexuality, femininity, homelessness, and spirituality surfaced in all three narratives. Susan Jane moved between discourses as she strived to cope, restore, and make sense of a complete breakdown in embodied health.

Susan Jane's narratives of restitution, chaos and quest may not be reflective of every woman's distress during menopause. However, some aspects of all of these narratives constitute parts of the other women's stories included in this study. Some women may have achieved restitution sooner; some never experienced the level of chaos; but all sought after the meaning of their disruption. The many stories of the other women will be presented in the following chapter. Thematic similarities will be reflected in the narratives of distress, while simultaneously representing the heterogenic contextual worlds of each woman.

CHAPTER FIVE: THEMATIC REPRESENTATION OF FINDINGS

The purpose of this study was to explore the experience of distress during the menopause transition. Specifically, the research questions were: (1) From the perspective of the woman during the menopause transition, what is the essential experience of distress? (2) What is the meaning of distress experienced by the woman during the menopause transition? (3) How do women describe the relationship between aging and menopause? This chapter will report findings in relation to the research questions. Women's experiences of distress surfaced in myriad of ways. The richness of their stories reflected the complexities of their lives. This thematic analysis represents the manifold and heterogenic experiences of distress experienced by the women during the menopause transition. Commonly shared themes were identified in the narratives and will be presented in this chapter.

Most of the women relayed symptoms as an intricate component of the menopause transition, and these contributed to their experience of distress. The first section of this chapter, *The Experience of Distress in Menopause* includes exemplars specifically related to manifestations of distressful symptoms. The second section, *The Meaning of Distress* presents narratives that described how women's symptom experiences impacted their lives, and how women made sense of their experiences of distress. Even though *Meaning of Distress during Menopause* includes narratives related to aging, the third section of this chapter, *The Relationship of Menopause to Aging*, focuses specifically on experiences of aging, including both the bitter and the sweet.

The Experience of Distress in Menopause

This section of the chapter is divided into two parts: 1) Physical aspects, or "physicality" of symptom experience and 2) the relationship of context to distress— the "contextuality" of symptom experience. Women described symptoms using metaphors and images in an attempt to relay the intricate and intense experiences. These stories will be presented under the "*Physicality" of Symptom Experience.* Women often reported similar symptoms; however, the manner in which they played out in their lives varied tremendously and reflected a diverse contextual dimension. These stories will be presented in the *"Contextuality" of Symptom Experience.* Social and cultural discourses about the body, healing, aging, sexuality, and spirituality will be addressed throughout.

"Physicality" of Symptom Experience

Symptoms such as hot flashes, night sweats, vaginal dryness, decreased libido, menstrual irregularities, and insomnia were reported by women in this study. Women also spoke of mood changes, joint and muscle aches, weight gain, breast tenderness, headaches, sugar and alcohol intolerance, hair and skin changes, and loss of courage, among other noted changes attributed to menopause. For many of the women, the extreme and intense symptoms experienced resulted in feelings of a loss of control and narratives related to this experience will be presented here.

The physical or embodied experience of a symptom was distressful in and of itself for many of the participants. The following stories portray some ways that women experienced distressful symptoms related to menopause.

"On Fire"—Hot flashes or Night Sweats

BJ described a particular experience of a night sweat. It is re-transcribed into a poetic structure to highlight the iterative quality of the experience.

Stanza 1 (bed)
Literally, I would go to bed
and the bed would just heat up
and I mean, would be like it was on fire,
and I'd be soaking wet
and I'd get up out of bed

Stanza 2 (sofa)
and I'd go to the sofa,
and the sofa would be freezing…
The sofa was freezing,
and I'd fall asleep
and I'd wake up on fire

BJ continued to tell about moving back and forth from the bed to the sofa all night long searching for relief from her overheated body. Though she attempted a resolution by moving to a cooler spot, this only temporarily resolved the problem of being "on fire." The seemingly unceasing event has elements of a chaos story as did her repetitive use of the word, *and* throughout the narrative.

Anna spoke of needing to shed layers of clothing while having a hot flash. "I was in school, and I would just be uh suddenly, you know, I had to layer. Suddenly! And you have to take your . . . your jacket off. Then open your blouse and, you know, fan yourself off, drink a little water…" While sharing her experience, there was a panic tone in her voice as she recalled the urgency to remedy the situation. Anna revealed the unpleasant discomfort of the heated body of a hot flash.

"Electric Head"—Sleep Disruption

Kira spoke of the qualitative nature of her sleeplessness. Waking suddenly in the middle of the night was one of her distressful menopause experiences.

> I've had this symptom where I wake up at 4 to 5 in the morning just feeling, like, my head is electric. And I wouldn't really call it a hot flash as I've seen described in the literature where you sweat and you think the temperature of

> the room is hot but it's almost feels like I have electricity pulsating through my head…I just feel like it disturbs my sleep and I get tireder and tireder…

Kira made it a point to distinguish what she experienced at night as something different from a hot flash. The use of the word, "electric" may denote heat, but in her case, it was used to describe the suddenness of her being awakened. "Electricity pulsating" through her head elicited a very disturbing sensation that appeared to be a common experience for her. She later spoke of how estrogen "ameliorated" this symptom, thus she concluded that it was of hormonal nature.

AJ's experience with menopause was related to depression and insomnia. She reiterated her feelings of exhaustion related to her insomnia and addressed weight gain that she experienced during that time. "Yea, those behaviors like being out of control with eating were just sort of again tied to depression and insomnia being out of control." This sense of lack of control infers the helplessness that she too felt during this time of her life. The inability to mandate sleep when so desperately in need was completely beyond her control as was the reaction to the depression and out of control eating.

"Gushing Blood Like a Fountain"—Menstrual Changes

Some women experienced unexpected menstrual flows. Fay opened her interview with an experience she had while out shopping with her boyfriend. She shared,

> And I felt like I had to go to the bathroom. So I walked up this big flight of metal steps to get to the bathroom and I discovered that I was gushing blood like a fountain, and my pants were bright red with blood, and I got really embarrassed and I stuck a big wad of toilet paper in my pants.

Fay's shopping excursion with her boyfriend was juxtaposed against the sudden "gushing blood" staining her pants. She continued the story saying she ran downstairs,

told her boyfriend what happened and took a bus home. This story depicts a vivid example of the distress that can be experienced with menstrual changes.

"Loss of Control"

Susan Jane shared the extreme breakdown of her physical abilities as a result of nights and nights of interrupted sleep from night sweats. When she was asked what she found the most distressful, control was also raised as an issue of concern as expressed in this poetic structure.

> Well, without a doubt, the absolute feeling of loss of control over my physicality as if I were dying… it's the synergy between the loss of your physical control and the loss of your mental control because you are so sleep deprived…

This narrative reflects Susan Jane's overall menopause experience as it encapsulates the chaos that was present in her life at that time. She did not hesitate to say that it was truly the complete loss of her control over her physicality that she found most distressful.

When Kira was asked to describe her feelings about menopause, part of her answer was, "Well, it made me feel out of control like I couldn't be the way I wanted to be…I felt just really kinda helpless." Her answer implied a change from how she normally felt in life. It described a story of difference and distress. She wanted to "be the balanced person" she used to be, in control of herself and her life. This infers that at one point in her life she felt empowered—the antithesis of helpless.

Nancy also spoke of "being out of control." She initially stated, "There's a feeling . . . there's a feeling of being out of control. Totally." She distinguished physical aspects—"you don't have control of physically how you're feeling," from the emotional

aspects—"there is a little control over mentally how you're feeling;" and then combined the two—"or emotionally how you're feeling about your physical." Nancy reiterated why the sensation of a lack of control would be bothersome for her since, she was "always trying to be in control." However, knowing this about herself caused her to be assertive about gaining control over the things she could still control. She accomplished this by being less spontaneous or making certain she would retire a certain time at night to at least have "quiet time" even if she couldn't sleep. She stated, "The only times I think that I felt out of . . . really out of control were when I had a really bad hot flash and I was in a hot setting in my car or in a climate that was real hot."

Loss of control was reported as the most distressful by women in this study as reflected in the stories above. First, this signified that these women were accustomed to a certain level of control over their lives. This may be a conscious sense of power or control or it may be more subtle as a taken for granted understanding of health. Good health may provide a sense of control, yet may not be reflected consciously until it is lost. The loss of control the women spoke about addressed the physical symptoms they were having as well as their emotional responses to them. Women who experience symptoms they do not understand or cannot find an effective way of treating, may experience a feeling of loss of control. Experiences of loss of control in this study manifest from a familiar sense of control in the past and the unknown trajectory for the future. Loss of control seemed to reside in the present moment of ceaseless turmoil.

The above exemplars of the "physicality" of symptoms portrayed the embodied experience of common menopause symptoms. Some women used metaphors to describe the intensity of their experiences. The manner in which they spoke of these experiences,

such as increasing the tone of voice or rate of speech supplemented the words chosen and emphasized the intensity of their experiences. The narrators attempted to elicit images in order to create an understanding of their embodied symptom experiences. Many women described feelings of "loss of control" as most distressful. Their experiences exist within the context of their lives that are situated within the larger social, historical, and cultural influences. The following narratives portray the situated context of the women's experiences of distress.

"Contextuality" of Symptom Experiences

"The Whole Package"—Work

China's main concern related to menopause was the change noted in her menstrual patterns. She was forty at the time of the interview, and reported her symptoms began when she was in her 30s. She listed other symptoms such as urinary tract infections and sleep disruption, and then illustrated how she came to think of her symptoms as menopause. "'You're a classic case,' I've heard it over and over, you know, 'for menopause.'"

The following narrative is about working at a football game as a concession worker, and having the unexpected happen. It is re-transcribed into a true narrative per Labov (1997). (A = abstract; CA = complication action; E = evaluation; R = resolution; C = coda.)

Abstract
I'm getting to the end of it [period] now.
Orientation
I got my period a week and a half ago
and I had to go to a football game
Complicating Action
and I was crying, and I thought I had to go pee and I didn't.
And I . . . finally I didn't get a break. I had to beg for one.

I thought I had to and it turns out it's my period…
It started out as a good day. By the end of it was bad. (E)
It was a disaster… (E)
It was horrible. Horrible.
Had I totally expected it and then,
it would have been better, (CA)
Coda
I just felt horrible. I felt crampy. I felt both. (E)
I'm dealing with football fans and it's terrible
So it was like the whole package.
I had to beg for a break because I didn't know what was going on.
I'm talking about like seven hours later. (CA)
And they didn't give me my ten minute break
Oh I'm debating whether I want to go back and it's not laziness.
Well don't you think they'll think I'm lazy? (E) (C)

Not only did China have to deal with the physical symptoms of bleeding and cramping, the demands of the work environment greatly impacted the situation causing her more distress. China brought to attention the distress related to the unexpected nature of the experience as she stated had she known, "it would have been better." Amidst her discomfort, she was unable to even take a 10 minute break. She worried that if she did not return, they would think she was lazy. China clearly painted a picture of a woman anything but lazy, but the unfortunate reality of others' inability to ever know what she experienced lingered in the aftermath of her story.

"I'm a Totally Different Person"—Temporality

Martha's main distressful episode was experienced in the context of a relatively stable work and personal life. Her relationship, a long-term union of 25 years was generally a source of support for her. Her sons were grown and living outside the home. The following narrative about her primary experience of distress was shared at the very beginning of the interview. Her main experience of distress was an emotional episode that lasted only a day or two, but frightened her enough to seek immediate treatment.

Abstract
Um, but the thing that . . . that . . . that . . .
that was really bad
Orientation
was I just suddenly started feeling
so mentally out of it . . . just crazy. (CA)
Like just very suddenly I felt, um, (pause) anxious.
Uh, I felt anxious. I felt paranoid. (CA)
I felt just really, really crazy.
And it was like so out of context with my life, but I . . . I (E)
just really felt like it had . . . it must be hormonal… (E)
It just . . . it was just so off the scale for me. (E)
I just went running to the doctor to get hormones, (R)
I knew I was either going to lose my relationship,
or I (raising volume) was going to lose my job.
Or I was just going to lose my mind
It's just like that bad. (E)
..I cannot possibly function in my life with this. (E)
So, it's . . . it's hard to explain, you know.
Sudden mental illness. (laughter release)
But I just felt so crazy and awful and, you know, just anxious. (CA)
And just like I wanted to jump out of my skin. (C)

Martha emphasized the unexpectedness of her experience by using the word sudden twice in the first couple of lines and juxtaposed it with the contrast of her normal state of being. She stressed that she did not recall ever having any incidence like this in the past. She judged the emotional intensity, sudden onset, and not fitting in with anything else going on in her life as "hormonal" that sent her "running to the doctor for hormones," the only way she could think of to resolve this distress.

Past and future merge in the present moment of her episode. Loss was the main fear for the future, and she expressed this concern emphatically that she would either "lose her husband…lose her job…or lose her mind." Her voice rose during this part of the story accompanied by a serious toned laughter as if the incredulousness of the situation was bordering on comical. She elaborated on the difficulty in portraying her state and described a feeling of wanting to "jump out of her skin."

Martha resolved the experience by seeking hormone therapy. She justified this action with fears of loss and inability to function, and clearly defined the event as being "totally out of context with [her] life." This showed that she was searching for meaning for this sudden change in mental state.

Candy shared concerns about mood changes. She relayed a story that included her mother, her grandmother, her daughter, her coworkers, her husband, and her cat. Her mother brought to her attention that her "whole attitude has changed." Her daughter reprimanded her for "snapping" at her grandmother. She was "edgy" at work because of "the changes." Her husband just "backs off and he leaves [her] alone." When asked what she found the most distressful about this, she concluded with, "My attitude, like I said it scares, it scares me. It really does because it's like I'm a different, totally different person." Candy expressed fear about not recognizing the person she had become. She came to this realization in relation to the past. She relayed what was important to her—familiarity of self, and her relationships at home and at work.

"A Painful Reminder"—Sexuality

Fay lived with her boyfriend who was 12 years younger than she. This age dynamic became salient at other points during her interview. She relayed that a great source of her distress stemmed from vaginal dryness during intercourse. The following is a narrative shared by Fay about one particular night of lovemaking with her boyfriend.

Abstract
Well I can give you a specific day. Um (pause). . .
Orientation
I was going through having sex with my boyfriend
and I was really enjoying it,
Complicating Action
and all of a sudden I got really, really dry.
And he's taking an anti-depressant-it took him longer.

And it began to really be painful.
And he didn't want to stop because it meant that he'd have
to build up impetus again, (E)
and I had to forcibly ask him to stop and use a lubricant, (R)
because it was getting painful (E)
and I didn't want to tell him it was getting painful (CA)
because he was . . . I knew if he was hurting me he would stop. (E)
He wouldn't want to go on.
And um, I just couldn't get through to him (CA)
because he couldn't tell that I needed lubrication
and it was just a painful reminder that I'm getting old.(E)
Resolution and Coda
So now we keep a ton of lubricant by the bed.

Fay introduced the story by telling us that not only was she having sex with her boyfriend, but she was "really enjoying it." This point contrasted what was to follow—the sudden onset of feeling dry. Moreover, her boyfriend's personal circumstance with depression and subsequent use of antidepressants affected his ability to reach orgasm, and amassed the distress related to Fay's vaginal dryness. The fact that she "didn't want to tell him" when it began hurting reflected her strong need to care for him and his sexual needs. It appeared that who she was really 'forcing' was herself in order to finally assert her needs, even though they conflicted with his at that moment. The twelve year age difference between Fay and her boyfriend shaped her experience of this symptom. The sad realization in her final evaluation that the whole episode was "just a painful reminder that [she was] getting old," profoundly portrayed the intensity of the meaning of the experience for her. She chose to discount his contribution to the problem and placed the onus on herself.

Martha told of her decreased sexual drive that she attributed to a decrease in reproductive sex hormones. Treatment with oral and topical testosterone was not very successful. She shared her concerns. "The other thing that uh, that was distressing to me

um, was that my libido was really low…It's just gotten worse and worse. I don't like it at all." She elaborated about why this was distressful to her. "That's distressing because I think oh, you know, is this guy going to stay with me if I don't want to have sex, you know?" The gravity of her concern was apparent, as she emphasized that "it's really not a good thing." The decrease in libido highlighted the context of her concern as she worried about the affect it might have on her relationship.

A decrease in libido among married women was not always presented as distressful, such as described by Elizabeth. She lamented that her previous focus on sex prevented her from doing things such as "…research this historical period, or go make a quilt or go dancing." However, she revealed the key to her success as a married woman with decreased interest in sex was that her husband had decreased interest also. "And it works in my relationship with my husband and that's what . . . that's all that matters. And . . . That's . . . that's . . . that's what matters." Her relationship was not threatened by her lack of libido, in contrast with Martha's experience.

The contextual backgrounds of the women's lives were demonstrated to affect symptom experiences. Work environments, relationships, concerns for the future, and comparisons with the past impacted and were part of the women's experiences of distress. The narratives shared by the women illuminated their particular situations. The context of their lives contributed to, or more accurately, constituted the distress experienced by the women. The consequences of the effects[?] of the distress on their lives are presented in the following section.

Summary of the Experience of Distress during Menopause

The narratives and excerpts above demonstrate how symptoms of menopause elicited distress for the women in this study. Many variables in the women's lives contributed to this distress making it nearly impossible to measure quantitatively. Women spoke of the embodied experience of symptoms. At times, all consuming physical sensations appeared to absorb and disrupt the women in their everyday living. The intricate interactions with personal relationships, co-workers, children, other women, and mothers impacted the women's experiences with far reaching consequences. Home environments, work situations, past experiences, and future dreams created the backdrop upon which the women's symptoms unfolded.

Symptoms beckoned to the women that change was happening to their bodies. For women who did not know what was causing the changes, uncertainty confounded the experience and created a sense of deviation from their usual way of being. This uncertainty itself may have contributed to some women's distress. However, when these changes were attributed to menopause, the women could attempt to regain a feeling of normalcy based on a new identity as a menopausal woman. For many of the women, the inability to obtain control over their symptoms cascaded into toppling sensations of discomfort, pain, suffering, and compromised health similarly experienced in persons with debilitating illness.

Experiences of distress during the menopause transition expressed layers of complexity. Conflicting discourses surrounding menopause and treatment modalities contributed to an inability to move fluidly to regain positions of power. For example, the strict investment in a natural healing discourse delayed effective treatment for Susan

Jane's persistent night sweats. Women felt feelings of helplessness as they struggled to make sense of, and find resolutions for their symptoms. Symptoms jeopardized the quality of life for some women as social withdrawal was the only way they could regain a sense of control over their situation. The inability for others to understand the extent of women's symptoms was also shown to cause distress. Lack of empathy and jokes of menopause created a sense of invalidation for some women.

The women's narratives regarding the physicality, context, and consequences of symptom experiences helped to gain an understanding of the heterogenic meaning of distress during the menopause transition. The relationship between menopause and aging may also have an impact on menopause experiences. Stigma and shame associated with aging or sexuality in a Western society may silence women who are transitioning through menopause. The next section elaborates on this theme.

The Meaning of Distress during Menopause

The symptoms experienced by the women resulted in subsequent distress that impacted their lives in various ways. The consequences or repercussions of these symptoms will be presented in this section under *Consequences of Symptom Experience*. Some women were unable to find others to discuss menopause with and attempted to make sense of this silencing. Others experienced shame of embarrassment related to outward expression of symptoms. These narratives will be presented here under the theme, *Silence, Stigma, and Shame.*

Consequences of Symptom Experience

Various consequences occurred as a result of the women's menopausal experiences. Disruptive symptoms caused some to withdraw socially. Many felt that

they could not find anyone who could understand the extent of their experiences. Some were concerned that their symptoms would occur in the middle of a social situation and that they would be unable to handle the consequences. For some, this withdrawal resulted in social isolation that drastically caused a decrease in quality of life. Some women reflected on the losses that accompanied menopause, such as an end of fertility. The following stories depict the consequences of some women's experiences that contributed to their distress.

"Death within a Death"—Social Withdrawal/Quality of Life

What was most significant for China was the development of menopausal symptoms early in life. She addressed how menopause began taking a "toll" on her life quality. The sudden onset of symptoms precluded her from engaging socially for she felt her reaction to them would affect her ability to behave in an acceptable manner. China expressed the distress of this as she stated, "I didn't have anybody who understood much, or could talk." She explained that she withdrew because she did not "want to lash out at people and be in pain and hunched over." The sad reality of this withdrawal became clear when she declared, "I feel robbed of my youth a bit." She elaborated further.

> I didn't want to meet anybody. I didn't . . . you know, I didn't get married, I didn't . . . you know, I haven't dated in (pause) two years or had a boyfriend in six. And it just didn't feel good.

This theme was apparent throughout China's interview. Her social life was extremely affected by her symptom experience which ultimately constituted the gravity of her distress.

The following narrative by China in answer to what she found most distressful demonstrated how severely China's social life had been altered by her symptoms.

Abstract
You're going to laugh at this one.
This isn't even a physical thing.
This was a day I was actually feeling good.
I'll tell what was the most distressing one.
Orientation
I was going through my temp series; I had ended a job.
And I'm going down, I'm in the elevator…
Complicating Action
and I don't know if they were lawyers or accountants…
get on board. Just asked me if um,
I wanted to join them. I mean as a friend…(CA)
I was like I was feeling better but I was like,
what if I see them again?
What if I come here again? What if I don't feel good? (CA)
What if something . . . what if? You know. (sad voice)
I was worried. . . (E)
and I was actually feeling one of my better days.
It was distressing... (E)
It's like what if I wasn't feeling good and they're wondering (CA)
what's wrong with me and . . .They'd be wondering
why is she so unfriendly? (CA)
I didn't want to come off as being unfriendly.
And he was . . . they were disappointed. (E)
Coda
That's how the whole thing came up.

This narrative, an answer to what was the most distressful for her is a true narrative (per Labov); she told of a one point in time to describe how her life was being affected. China hesitated to join the party out of fear of what might happen in the future. She worried about the future as she feared seeing the men at a later time when she was having symptoms. She did not want to be perceived as "unfriendly." It was a fear of what might happen, not only in the immediate future, but anytime later, that stopped her from participating in a simple social event. This clearly demonstrated the social impact of her symptoms on her life and the subsequent distress.

Nancy's main distress with menopause was due to her hot flashes. She experienced frequent hot flashes as she told, "as soon as one would go away within the next half hour, one would come back." The frequency and duration of both the hot flash itself and its "gradual" dissipation created an almost continuous sensation. They affected every part of her life. She quit her gym membership since working out caused an increase in hot flashes. Even reading a newspaper became difficult, "if I was reading something and . . . and I had a hot flash, I'd probably quit . . . it would be distractive. I would lose the point of the article…"

Nancy figured out ways of coping but eventually socially withdrew. She explained that it was "because of the lack of understanding with people, and sort of making fun of it all." Nancy dealt with her discomfort with people by staying "away from them." She declared, "for the most part, I'm more isolated than anything." Nancy concluded that "…it's the severity of all that they didn't . . . wouldn't have understood, which I didn't really get into." She told a story regarding a gift she was given during her distressful episode of menopause demonstrating this lack of understanding.

Abstract
And then oh, people would make fun of it right?
The menopause . . .
Orientation
I even had a girlfriend . . .
it was at Christmas time,
Complicating Action
and she gave me a pendant . . .
Something about menopause.
Like being proud to have menopause.
I threw it away. (R)
It was not funny. (E)
…Somebody's going to appreciate this, but it's not going to be me.
Coda
Okay? Even now I would not appreciate that pin. (E)
So that must have meant that she didn't have it so bad (E)

or she wouldn't be giving out pins on that.

Nancy framed this story by telling that people "make fun of [menopause]." There was an angry tone throughout this story. She was not proud of a condition that had been causing her distress. Her evaluation of her friend's experience with menopause may be accurate—that she had a milder time or that she may have been past it. Jokes about women and menopause may be an attempt at softening the experience of symptoms of menopause. However, Nancy did not find humor in such trivialization of her hardship.

Much of Susan Jane's menopause narrative was discussed in chapter four. However, she specifically addressed a decrease in quality of life as a result of her nine months of night sweats. She elaborated, "Cuz for me it was such a decline in the quality of my life and in the quality of my physicality and the enjoyment of my sexuality that it wasn't worth it." She spoke of "riding a wave of ecstasy" until her menopause hit and declared, "that's all over with, like all this work you've done, you're back to square one." Her recap of this loss was "a death beyond a death within a death." Juxtaposing who she was before menopause with who she became post menopause, clearly portrayed the drastic changes that had occurred for Susan Jane, as well as the subsequent distress. Tree described the lack of support from others about her insomnia as the most distressing.

> …And then at night like I wouldn't necessarily be hot flashing but I just wouldn't sleep. And that was really frustrating on all kinds of levels. First of all, just insomnia itself, but also because people don't believe you. They're like, "it's impossible, you actually are sleeping and you think you're not.

Tree found others' discounting of her experience to be stressful, as she mostly sought expressions of sympathy. "I couldn't even get people to just say oh, you poor thing you're not sleeping." Later she demonstrated how finding just one person who shared similar experiences helped alleviate much of her distress. "But just having that one

person validate . . . like yeah this is real really made a tremendous difference for me. And, it also caused me to increase talking about it." This positive outcome from sharing with another woman strengthened her plight to share her experiences with others because, as she said so eloquently, "I need to get support when I go through things in life."

"No Longer a Choice"—Fertility

Menopause brings an end to fertility. This consequence can cause some women to reflect on this loss. Jo raised the issue of not having children and illuminated the struggle of a single woman wanting a child but not if it meant being a single parent.

> And I think um . . . though I'm not sure, I think also menopause brought the realization that no, I am not going to have children. I think that um, I knew I didn't want to have children by myself.

Jo spoke of a woman who became pregnant at 48 and had twins raising the hope for her at one point in time. However after going through menopause, she felt,

> it's no longer a choice. And I think that sense of um (pause) . . . sadness about not having children . . .Is part of my . . . I'm . . . I'm not sure that I . . . that distress is the right word but it's a sadness. (said in a strong, calm voice).

Jo spoke softly and slowly with many pauses when she talked about not having had children. It was apparent that this had been difficult for her. She distinguished this feeling of sadness from actual distress, but the grief was salient in this excerpt.

Even for women who had not planned to have children, reaching the end of their fertility may cause distress. BJ told of her experiences.

> So, um, [pause] Not having kids, um, that's an issue for me. I mean it's not a huge issue but it's probably one of the things that you think if you had anything to do over, you know, I would have had…I didn't want kids when I was young enough, and then I had to have a hysterectomy.

BJ spoke quietly and paused frequently while speaking of not having children, indicating the depth of her emotion. Though she first confronted this loss after her hysterectomy, the feelings resurfaced during menopause.

> When you look at your life and you look at again where you're at, some of life's lessons you've learned and it just seems like some of those lessons that other people get, you will never get, because I think you get them through your children and you will never get them. I'm certainly not.

BJ may be struggling with a discourse that supports the value of having children. Conflict was present though she did not linger long with the sentiment. She reassured the listener that not having children was not "terrible." However, she concluded with the statement, that "it's just something she may have done differently."

The above stories are exemplars of distress caused by the consequences of symptom experiences. Some grieved the loss of fertility that accompanies menopause. Many women withdrew socially. Though the reasons for withdrawing differed, the end result remained the same—isolation. For some, this withdrawal was a way to cope and/or make sense of their situations. Many of the women spoke of their lives being affected socially, professionally, and personally as they learned to live with situations that compromised their quality of life. The women's experiences shared through narratives and excerpts provide a fuller understanding of distress related to symptoms during the menopause transition.

Silence, Stigma, and Shame: "This Taboo Subject"

Silence about menopause was reported by some of the women. Some felt they had no one to talk to about it, or that when they did attempt to ask other women about their experiences, they were generally met with resistance. The association between

menopause and aging influenced the feelings of shame for some; for a woman to mention their passing through menopause, would be to admit they have "joined" the aged.

Outward expression of symptoms caused shame and embarrassment for some women reflecting deviation from a social norm. Various experiences of silence, stigma, and shame surfaced in some narratives. The following stories portrayed the subsequent distress associated with this theme.

BJ, who responded to participate via email, stated in her letter, "I'd love to talk about this taboo subject." When she arrived for the interview, she raised the topic even before the interview began. Once the audio-recorder was on, she was asked to repeat what she said. *Before I ask you the first question, I'd like you to address what we were just talking about.* "You mean about being silent about it, like the shame?" She elaborated further.

> I talk to other women about it, (I tend to have younger friends) and they don't even want to talk about it, you know? They'd say, "well, yea, it was hard for me or…Yeah, and they don't talk about it. It's like, "I'm over it." …It seems that women, and I can relate to this as well. It's seems that women instead of embracing it as a passing or as a rite that you go through, see it as doom, it's like the aging process, the fear that you are over the top, and so and don't want to talk about it. And I have a hard time getting information.

The fact that BJ mentioned taboo in her email and began her interview with the same topic shows the significance of her concern. BJ interpreted a lack of acknowledgment from others as women's feelings of doom that they were "over the top." She implied that women, including herself, did not want to talk about menopause because to talk about menopause meant that you admitted you were getting old. Menopause and getting old were regarded as the doom in a society that did not value aging persons. The unfortunate outcome of this "taboo" was unveiled as BJ could not seem to access

information. It was the need for, and lack of information that contributed to her distress. The following stories revealed similar concerns.

Tree had much to say about the silence of menopause and spoke about why women did not want to discuss it. "Why . . . why . . . why can't women talk about this major, profoundly important transition in their lives?" As Tree tried to make sense of the silence, she came up with her own answer reflected in this next excerpt.

> And I think part of the reason why it's so secretive . . . there's . . . it's a very complex…situation. But I think a lot of it has to do with um, women seeing themselves as feminine and no longer . . . when they're no longer fertile . . . and women have had a long history in this culture of hiding their age. And if you're in menopause, you know, you're not a kid. And, you know like, and also some people associate it with the cessation of their feminine . . . feminine attractiveness.

Tree believed she had figured it out. Women identify with being feminine. Femininity is reflected in the ability to be fertile. Menopause is the end of fertility, thus some people might associate menopause with the "cessation of their feminine attractiveness."

The silence regarding menopause was a theme throughout Tree's interview. She shared that she was a stoic woman when it came to "physical symptoms," but she found it distressing "the way people don't talk about it." Tree also told of her mother's reaction to the topic.

> And also I'm curious like, my mother won't tell me about . . . about menopause. And so it's like we've had fights about it. It'd be like I want to know, Mom. I want to know what happens. She won't talk about it. *What does she say?* She just . . . just, you know, ignores me. She won't talk about it.

The frustration is apparent. Tree was asked why she thought her mother did not want to talk about menopause, and she answered, "Oh I believe my mother is . . . is . . thinks that

sexuality is something secretive and shameful." Tree's narratives depicted two separate reasons why women might not talk about menopause experiences. One was in relation to aging and associated loss of femininity. The second one, reflected in her mother's case was due to the shame of sexuality. Both of these might indicate social and cultural reasons for the silence of menopause.

When Kira was thanked for participating in the study, she stated, "Well at least someone is interested in me and my menopause." Menopause may have been something that consumed her consciousness; however she felt like she had to keep it to herself. Similar to BJ and Tree, Kira's interpretation of this silence was in relation to aging. Later in the interview she discussed the topic again.

> I didn't want to have menopause in a way because it would make, mean that I wasn't young… Cuz like I don't want to be old and I think of it like if you're, like if you haven't had menopause yet then you're like younger than someone who has had menopause already… so there's that whole, you know, symbolic, psychological thing of getting older and wanting to still be feminine and attractive and still having that young woman power…

Kira thought that for a woman to acknowledge she was in menopause would be to admit she was of a certain age. Kira continued this narrative by saying she was getting "used to it," but reiterated that her friends still did not talk about it much. She believed that "…people are kind of suffering privately."

Susan Jane was frustrated with lack of answers to the questions she asked older women regarding treatment for her vasomotor symptoms. She talked about asking older women in the aisles of stores or at work about what they did for symptoms of menopause.

> I'd try to strike up conversation, you know, women don't want to talk about this. It either didn't happen to them and it doesn't exist or um oh well, "take Premarin." I had a good friend, a massage client and I told her about my problem, she said, "well I've been taking Premarin for 15 years. What's your problem?" So, you know, it was like that response, so um.

The response that Susan Jane got when asking older women also revealed conflicts around the decision to use hormone therapy. At one point, Susan Jane struggled to find ways to treat her hot flashes and night sweats without using hormone therapy. Dismissive answers to her questions increased her helplessness and difficulty with decision making about alternatives.

Silence, stigma, and shame were closely intertwined. In a society where aging may not be honored, especially for women who were accustomed to "young woman power," signs of aging may be undesirable. Since menopause and aging are also closely intertwined, signs and symptoms of menopause may be stigmatized. The following stories demonstrate the shame and embarrassment that women experienced or feared experiencing in the future, as a result of outward exposed symptoms.

Below is Nancy's story of a tropical vacation. After this trip she discontinued trips to warm destinations. The narrative is presented in Labovian format.

…A couple of years ago I traveled to an area . . . (A)
like it was more like tropical hot area.
And I was outside where . . . I love tropics. (O)
I love the heat and the warmth, right?
And I remember walking down the street,
and here comes the boys, "Hi Nancy."(CA)
And I was . . . my face was like all red and dripping. (CA)
…And he said, "Are you okay?" And I said, "Yeah I'm okay." (R)
So it was showing. It was definitely showing… (CA)

Nancy's experience in the tropics was not what she expected; sarcastically noting that she loved the warmth and heat, but "not this trip." She then told of running into the boys while she was having a hot flash. She spoke not *just* of being "all red and dripping" but of feeling exposed, "it was showing, it was definitely showing." Nancy inferred

embarrassment with this repeated phrase. She emphasized this outward exposed experience over the hot flash itself.

The fear of being publicly exposed while having a hot flash surfaced with other women as well. BJ shared what concerned her.

> And, you're just sitting in a room and suddenly you're just soaking wet and that is just, that is horrid. That to me is just absolutely, that is probably one of the worst things because there's nothing that you can tell people, uh, that this is normal? It, that to me is just the biggest fear I have is being somewhere, a place where I have to explain what is happening to me.

To BJ, experiencing a sudden episode of hot flash in a public setting was anything but normal. This fear implies BJ's internalization of a particular social norm that differed from a midlife woman having a hot flash. If a hot flash was a socially accepted occurrence, then BJ would have nothing to explain or fear.

Tree found a way to resist the embarrassment associated with hot flashes. She told of two separate dating situations and how she handled her flash experiences.

> …I was having hot flashes and every time I had one, I leaned over to him and I said, "I'm having another hot flash." And I could see that it makes him uncomfortable. But I thought, this is who I am, you know? And if you're interested in me, then you're interested in knowing that I'm dealing with this…

The last part of the statement was spoken very emphatically and animated, as she told of taking up a discourse that demands acceptance of her, including her hot flashes. This also implies that she personally acknowledged the embodied experience of a hot flash and resisted the popularly accepted discourse that may disempower women.

"But You Know it's Not"—Caught Between Discourses

Competing discourses on menopause may cause some women to become silent actors caught in between (Clarke, 2005). Medical models of menopause suggest that

menopause is a deficiency disease; some feminist models claim it is a natural occurring life passage. Meanwhile, *all* women do not fall into any *one* of those categories causing them to struggle with these competing discourses in order to make sense of their own experiences. This can also cause some to withdraw, or silence their concerns. BJ contrasted her difficulty in gaining information about menopause with others' ease by which they can encounter help with "cancer or a common cold." Susan Jane expressed, "menopause is like a disease, but you know it's not" yet for her it was "as devastating as any other illness out there." BJ and Susan Jane are experiencing something other than the embodied health they are accustomed to, and they also know it is not due to a disease. There are categories for those who are diseased (e.g. cancer or cold), but not for those who are experiencing symptoms from a natural physiologic life transition. The distress expressed by these two women demonstrates the limbo state of this undefined condition. They are caught between prevailing discourses.

The silence, stigma, and shame associated with menopause contributed to women's distress. When they looked to others, frequently older women, they were met with resistance which caused some to feel alienated. Some believed the association between menopause and sexuality caused shame when the topic was raised. Other's attempt to make sense of this silence led them to believe that the aging associated with menopause may contribute to this commonly experienced theme. A publicly exposed symptom was experienced as an outward expression of this aging process and also contributed to women's experience of shame and consequent distress. The discussion on aging to follow will further illuminate the women's thoughts and struggles with the aging process.

The Relationship of Menopause to Aging

Aging: "The Bittersweet"

It is nearly impossible to study menopause without examining aging. The intertwining of menopause with aging makes it difficult to determine if women are responding to menopause itself or the aging process. Moreover, menopause *is* a physiological process of aging; the senescence of ovum induces menopause. Menopause occurs at the same time other signs of aging are presenting, thus when women experience signs of aging they might understand them to be menopause. Some of the women in this study believed that a decrease in estrogen speeds up manifestations of aging such as drying and thinning skin, hair loss, decreased libido, decreased metabolism resulting in increased weight gain, among other things. Jo clearly stated this belief; "…so I think the physical changes with aging and menopause—I don't know how I would separate them out. I'm a woman. I have menopause. It comes with aging."

Most of the women shared "bittersweet" feelings toward aging; some sweet and some bitter. For others, the two were so intertwined it was difficult to discern the prevailing sentiment. Modern Western discourses related to women and aging surfaced throughout the women's narratives. The following section is an analysis of women and aging, bringing to light the bitter fears, the losses, and glimpses of their concern, and how they strived to make sense of and live with the accompanying changes. Narratives that depict the bitter make the link salient between distress and menopause, as the fears of aging take precedence. The sweet aspects of aging will be presented in the subsequent section.

Aging: The Bitter

Connections between aging and menopause were raised when women spoke of stigma and shame. Some believed that the reason why women did not want to talk about menopause was because it meant they admitted to aging, as noted in some of the women's stories above. Physical changes in appearance and physical ability were often addressed. Many women also raised concerns about declining mental acuity.

When asked about aging, several women began their discourse with reflections of their mothers' experiences. A couple of women gave examples of their father, one of which was in relation to the positive aspect of aging. Occasionally, women lamented the absence of mothers who had died early in their lives as they were not able to observe and consult their mothers about aging or menopause. Some used their mothers' physical or mental decline as benchmarks when they thought of aging. Perspectives and concerns toward loss and death became apparent. For some, these issues were raised in relation to their parents' decline or death; for others, it was the death of close friends, or their own loss or decline of physical ability. The following are the women's narratives about the "bitter" experiences of aging,

When Martha was asked about appearances and aging, she began her answer reflecting on her parent's death. She told that her parents both died at the age of sixty-one "not too far down the road" from Martha's age of fifty-seven. She believed that their early death from cancer and heart disease made her "more tuned into the health part" of aging. She shared some concerns about changes in her appearance. She spoke of getting a glimpse of her legs while in an "upside down" pose during a yoga class. She lamented, "What happened to my beautiful legs?... I'm never wearing shorts again." Martha

generally focused on the health aspect of aging, but was not exempt from experiencing some distress related to the outward physical changes of aging.

Daisy overall had a neutral attitude toward aging. She spoke of how she appreciated older people and how she found them beautiful. She specifically made a comment on how men were attractive when they were older and women lose their attractiveness. Below she spoke of others' reaction to her aging.

> And then there's also the how you feel invisible. You don't get looked at by guys anymore. Well still, sometimes. But you're kind of invisible.

Daisy's speaking of being invisible demonstrated feelings of non existence. Due to aging, she believed her presence did not even get acknowledged. She addressed some of the positive aspects of this.

> But then in a way it's a freedom too because you're not being harassed by guys or looked at as a sex object, but then because our . . . our culture values that, there is . . . there is . . . it's kind of a dichotomy. And sometimes it's more freeing and other times it's not. And I used to be where I used to like to be noticed…

Daisy moved fluidly between enjoying her new "freedom" from the male gaze; yet she grieved it at the same time. This narrative placed after the invisible one, demonstrated that even though she might not have appreciated being looked at as a "sex object" at least she was looked at. The choices seem clear—sex object or invisible.

Jo spoke of her recent interaction with "a group of women…mostly contemporary, some of years younger, some older." She reflected on their "vitality" and the various ways they were aging. This caused her to ponder about her own future. "I think it's not knowing what my vitality is going to be. What my . . . the years, the days, the moments, are going to be like." Jo addressed the uncertainty of aging as she

examined how others were aging around her. Vitality was important to her, and the mystery of what hers will be like is of concern.

> Um, mental capacities . . . what will mine be like? How I will um, care for myself? What kind of resources . . . I know what kind of resources I have, and what effect how's that going to work for me?"

As Jo continued her narrative, she reflected on the different ways people around her have aged. As an "aquatic therapist," she had been exposed to people as old as 100 who were vital and "still moving." She reiterated again that "we don't know how it's going to be," and "…it is a mystery that I reflect on a lot . . . a lot." Working with older people, some who are spryer than others, allows her to see the variation, possibilities, and uncertainty of aging.

Stories of death and illness surfaced as the women reflected on aging. Below are narratives of two women who shared stories of their mothers. These stories vividly demonstrated the impact their mother's experiences had had on the women when they thought of aging.

BJ's mother had early onset Alzheimer's. BJ closely witnessed the devastation this illness caused and feared the acquisition of this disease. "Ah, a fear with aging is Alzheimer's. Ah I really have a fear of Alzheimer's because my mother had it." This fear became more real as she believed she was beginning to show symptoms that her mother had. "Because I see things that mother did, that I do." The seriousness of her concerns became visible with the contemplation of suicide.

> My mother died of Alzheimer's and she had early onset Alzheimer's and I am really confused about what I want if I got the disease. Well, I mean I want to, I may want, ah, I may want to not live. It's hard to say, but…

Her experience with her mom contributed to BJ's future concerns. "…So, you know the thought of having Alzheimer's and living in that kind of hell is not appealing to me." BJ spoke about ending her own life should she find herself enduring similar circumstances as her mother. Suicide was introduced as a resolution.

Like BJ, Susan Jane responded to the question of aging by introducing her mother. She too spoke of suicide. She framed the following narrative by stating that her feelings toward aging "are very complex." She shared that her mother had committed suicide at the receipt of a terminal diagnosis, while her father was "at the golf course playing golf." She felt differently about her mother's suicide now since being a massage therapist of older persons. She believed she had "seen so much pain and suffering." These experiences contributed to her feelings regarding aging.

> And I don't feel that I need to live on this earth um in a compromised state and that's my decision. And my attitude toward aging, is um, I would be inclined to do the same thing and I, I have talked about this to [boyfriend] and he knows how I feel about it and I feel pretty strongly about it.

She introduced the idea that she would consider suicide and spoke of mercy killing, referred to as the "Kavorkian option." SJ developed an empathy that she wished to use wisely in her own life and it set the foundation for her argument that taking her life would be an act of self compassion, as the "beneficiary" of all she had come to know about death, suffering and aging.

The excerpts of women's stories demonstrated the complex nature of aging. Losses, already experienced, as well as the fear of impending loss prevailed. The physically active women became uncertain about how long they would be able to continue their pleasurable pastimes. The loss of this "physicality" called forth the development of new identities. Other themes that surfaced were concerns about loss of

dignity, becoming disabled mentally or physically, and being dependent. Changes in outward appearances further impacted the women's concerns. Martha lamented about her once "beautiful legs." Kira feared her loss of women power and inability to find a mate. If women invest in the discourses that only youthful women have beauty, this can become distressful to the women as they age unless they learn or find ways to resist this particular discourse and embrace another. Experiences of being invisible were shared and reflections on death, including suicide surfaced at various times in the women's narratives. Nevertheless, for most of the women, there were also stories describing the *sweet* aspects of aging. These stories will be shared in the following section.

Aging: The Sweet

Most women in this study shared experiences about the bitter aspects of aging. However, without any prompting, all of the women relayed some positive aspect of the changes that accompany aging. Women spoke of newfound beauty, freedom, or wisdom that they were not aware of during their younger years and these stories are shared below. Moreover, both the bitter and the sweet were mixed, as women fluidly moved from the positive to the negative sentiments. The following narratives demonstrated further the complexity of the aging process in Western society.

When asked how she felt about aging in general, Leslie spoke articulately and affirmatively about the positive changes noted in her life.

> . . . you know what's interesting. I feel more comfortable with myself. I don't care. I . . . I don't care as much anymore what people think. (laughs) So . . . and it's kind of freeing in a way.

She reflected upon the sweetness that might come with aging and speculated that she might have felt less sure of herself when she was younger. She continued to address her

renewed comfort, not only in relation to others in general as she was “beyond” needing to “look perfect” but in relation to men in her life. Being single and without interest in dating was not seen in a negative light—rather as something liberating. She continued along these lines.

> I’m Hispanic and so you grow up very co-dependent, very nurturing towards men. Their needs come first. That’s over with. It’s kind of nice.

She took up the discourse of the powerful aging woman who finally puts her needs first. At the same time, she resisted her cultural, “Hispanic” discourse that would place her in a lesser power position in relation to men.

AJ’s response to the aging question included a reference to her mom who died in her forties. This experience impacted AJ’s perspective of aging quite significantly. Though she got “annoyed with the fact” that she was aging, she was able to “intellectually and emotionally reframe” it.

> If you’re like my mother, you die when you are 48, you don’t have an opportunity to age, and, so I see, the absence of having that person. I see great opportunities to know my children as they become adults, to know my grandchildren as she was never able to.

The “annoyance” of dry skin, and graying hair, pales in comparison to having the opportunity to age, making those “all tolerable.” By comparing herself to others, she resisted the stereotype of the retired person who “wouldn’t know what to do” with themselves. This resistance perhaps puts her in a more powerful position as she ages. Furthermore, her mother’s premature death could be viewed as a gift to prevent AJ from lamenting over the losses associated with aging and instead, to appreciate the gains.

Jo experienced a change of awareness that she attributed to menopause and aging. This came as a result of noted physical changes.

> You know, I wouldn't be in the place I'm in without slowing down and um . . . thinking about or reflecting on what it means to be in the moment. What it means to um . . . to take a walk rather than go for a run. Um . . . and how the experience is different and right now the . . . I think the experience is richer. That you're still . . . I'm still using my body but I'm actually seeing the world differently.

She evaluated the difference as "richer" with a newness in her life reflecting robust energy. With a sigh, she shared how she was now "…being really . . . being more in (sighs) um, relationship to myself and the world in the moment rather than doing." Not only did Jo develop a *new* relationship to the world around her, but also to herself. There was a sense of depth, and an awareness of the "moment" that came from slowing down and not always "doing." The calming and softness of her voice when relaying this information reflected the reverence for this new connection. She clearly described that different things were showing up for her that had not been available to her in the past. She perfectly described this phenomenon, with her statement, "being more in relationship" with herself and the world.

Kira began her reply to the question about aging with "mixed feelings." She spoke earlier in the interview of the shame related to aging and menopause. She moved fluidly from sentiments of concern about aging to those of celebration.

FRAME
I think I have mixed feelings.
Stanza 1 (physical beauty)
I want to be attractive.
I want to attract men,
um, so there's that whole aspect
of being afraid not to be young
and being unattractive,
fear of aging in that way.

Stanza 2 (mature and wise)
In another way,
I think of aging
as a real positive thing,
like I'm mature, and wise,
I have confidence, I know what I think

Kira expressed the fear of aging as a single woman and her ability to "attract men." Her deep concerns reflected what Kira valued—sexual attractiveness, physical strength and mental acuity. Aging threatened her sense of personhood, what made her as a woman attractive, physical and mentally capable. She moved fluidly to take up an alternate discourse of the "mature and wise" aging woman.

The women in this study were self-identified as experiencing distress during the menopause transition. In the bitter section on aging, stories of losses and fears were dominant. In this section on the sweet aspects of aging, many of the same women shared stories of changing values, and newfound appreciations for themselves and the world in which they live. Some had referred to menopause as the pivot upon which life turns, and a "last opportunity" to take advantage of the "beauty" in life, instead of regretting the mistakes of the past. The sweetness of aging may stem from the quest of seeking meaning in change.

The women's narratives also demonstrated how discourse played an important role in women's sense of self and power during this time. If they invested in a discourse that revered youthfulness, fear, sadness, and loss was experienced. Conversely, when women entertained a discourse of aging women as having the ability to be in relationship

with the world like never before, they gained a sense of dignity and power. It was apparent from these stories that aging represented a fluid movement between discourses. This can be seen as the "shift" that can occur. However, what was clearly elucidated was how women shifted from moment to moment, as Kira showed in her *mixed feelings* poem. From one line to the next and back again, she moved fluidly between discourses. A fluid movement demonstrates that change can occur and that women may have choices in which discourses they invest in.

Summary

This chapter presented themes of distress related to the menopause transition. The complexity of distress as a concept warranted a thorough investigation of its manifestation. The women expressed this complexity through narratives of symptoms compiled with stories of societal and cultural discourses that were shown to affect the experiences of menopause and aging. Narratives of other sentiments of menopause highlighted experiences of distress both expected and unexpected. Stories related to aging reflected both the bitter and the sweet. As aging and menopause were at times tightly woven, women interchangeably attributed experiences to both. Most importantly, although themes were identified related to symptoms or other sentiments, the heterogenic experiences of distress were represented in the women's individual contextual stories.

The use of narrative methods allowed women to tell stories about what was meaningful to them. Additionally, the incorporation of different narrative methods facilitated the interpretation of the text as the various ways that women tell stories were exposed and became available for interpretation. Using a postmodern feminist lens further illuminated the ways in which women negotiated available discourses.

All the women in this study reported at least one distressful symptom that they considered menopause related, and some women reported more than one. Hot flashes, night sweats, sleep disruption, decreased libido, vaginal dryness, and mood changes surfaced most often in the narratives. The individual experiences of these symptoms varied according to the circumstances and context of the women's lives. For example, Fay's vaginal dryness was exacerbated by her boyfriend's decreased ability to reach orgasm. Elizabeth's decreased libido was tolerable because her husband shared a mutual disinterest. China's menstrual changes were exacerbated by her work environment. These myriad ways that distress manifested as a result of symptom experience supports the effectiveness of narrative analysis as a method to study the phenomenon.

The consequences of symptoms manifested in a decreased quality of life for many of the women as they attempted to live with and handle changes in their bodies. Some women withdrew socially. Sometimes the withdrawal was perceived as an act of power and was used as a time to contemplate the meaning of the experience or to re-evaluate values and priorities. However, China felt her early menopause "robbed" her of her youth. The inability to find others from whom to receive empathy or sympathy challenged many of the women. Their attempts to reach out for information from other women were met with resistance. This silence was interpreted by some as shame associated with aging and/or the female body. Symptoms of menopause became a symbol of stigmatization. A "dripping red face" became a brooch of menopause—something Nancy and others, found humbling.

The stories of aging, rich and revealing, demonstrated the fluidity of subjectivity. Kira's poetic narrative made this explicit. From line to line she switched from discourse

to discourse as she celebrated her wisdom, confidence, balance, and lots to offer with fears of losing her "young woman power" or physical and mental capacities. Women's memories of their mothers' experiences impacted their understanding of aging. Susan Jane stated how "complex" aging was for her as she relayed the changing meaning of her mother's suicide. BJ reflected on her mother's experience of Alzheimer's and how greatly it influenced her aging self both positively and negatively. Both she and Susan Jane subscribed to a "euthanasia" approach as they contemplated suicide as an empowering and self compassionate way to combat the fear of serious illness. The "beauty" of menopause and aging were both revealed as women saw their current age as the "last opportunity" to be who they wanted to be. In AJ's case, aging was seen as a gift that her mother had been robbed of. She viewed her mother's early death as a loss of an opportunity to know her adult children and grandchildren.

What surfaced in the women's experiences across themes was what they valued as important. They found ways to act as powerful agents even in the midst of enduring times. Relationships to people, both publicly and privately affected their experiences. Relationships with others were shown to carry significant importance. Fay's relationship with her boyfriend surfaced throughout her narratives. China's relationships at work were part of every story. Nancy's feeling of public humiliation was in relation to strangers, although she knew them enough to feel a sense of vulnerability during a hot flash. Martha and Elizabeth's relationships to their husbands, and Tree, BJ, and Susan Jane's relationships with their mothers are among the many revealed in the women's narratives of distress.

Women's work—the demands, concerns, and influences also seemed to impact women's experiences. China spoke of needing to "beg" for a break to tend to her hygienic needs; Jo worried about her future resources, and Susan Jane shared concerns of becoming a "bag lady." Martha feared losing her job because of her intense experience of emotional instability. Candy "snapped" at others at work, even though it was the "best job" she had ever had. Issues regarding work were prominent as they discussed the impact it had on their experiences either currently, or as the projected into the future.

Women expressed distressful feelings of loss of control during their experiences of menopause. Control was something the women were accustomed to or valued, thus a slipping away of it was experienced as distressful. The concept of control is equally as complex as distress as it is laden with historical and gender implications. In the experience of illness, Frank (1995) sees control as the opposite of chaos. Many of the women's narratives revealed elements of chaos. Susan Jane's story of "one particular night" paradigmatically expressed the incessant presence that is the hallmark of chaos, and plausibly, the antithesis of control.

The following chapter will continue a discussion of these outstanding aspects of women's lives during the menopause transition. Woven into the discussion will be how these results compare to other findings from prior research on menopause and aging. Limitations to the study will be presented as well as implications for nursing and suggestions for future research.

CHAPTER SIX: DISCUSSION AND IMPLICATIONS OF STUDY

The intent of this study was to increase understanding of the experience of distress during the menopause transition. Most studies on distress have not been able to grasp the full meaning of menopause to women as they often use proxies to measure distress which leads to a decontextualization of experiences. Furthermore, the prior use of theoretical frameworks that support innate personality traits as the cause of women's distress contributes to the negative stereotyping of women during menopause. This study examined the experience of distress, as defined by the women who took part in the interviews.

This study has presented various ways distress may manifest during the menopause transition. Data in the form of true narratives, poetic structures, and non-narrative segments illuminated the heterogenic experiences of distress. These experiences included the "physicality" or embodiment of symptoms, the context in which the symptoms were played out, and the subsequent consequences on quality of life. Distress also manifested as a result of the stigma and shame associated with aging and/or sexuality—both intricately related to menopause. A loss of control over the physical and emotional health constituted distress for some of the women. A postmodern feminist perspective facilitated the examination of how women negotiated prevailing social and cultural discourses on menopause and aging.

This study aimed to explore the questions: From the perspective of the woman during the menopause transition, what is the essential *experience* of distress? What is the *meaning* of distress experienced by the woman during the menopause transition? And, how do women *describe* the relationship between aging and menopause? This chapter

includes a discussion of the findings presented in the preceding chapters and their theoretical implications in light of the research questions. Additionally, implications for nursing and recommendations for future research will also be addressed.

Discussion

Essential Experience of Distress

The menopause transition inevitably constitutes some changes in a woman's physical and emotional being. For some women these changes may be minimal and hardly noticed; for others they can be very distressful, (Avis & McKinlay, 1995; Ogle & Damhorst, 2005; George, 2001). Symptoms such as hot flashes, night sweats, vaginal dryness, decreased libido, menstrual irregularities, and insomnia have all been associated with menopause (Avis, et al., 2001b; Guthrie, et al., 2003). Some studies have also linked menopause to mood changes, joint and muscle aches, weight gain, breast tenderness, and headaches (Dennerstein, et al., 2000; Avis, et al., 2001a). All of these symptoms were reported by the women in this study in addition to decreased alcohol tolerance, skin and hair changes, yeast infections, and urinary tract infections among others.

The narratives of the women included an in-depth contextual background of their symptom experiences. These generally included other people in their lives or certain environments such as work, home, or public places. The role that these factors played in the women's experiences were revealed as the women told of the details and circumstances surrounding their symptom experiences. These data provided insight into the phenomenon of distress during the menopause transition unlike any previous studies. Though previous attempts have been made to examine the sociocultural contributions to

midlife women's experiences, because of the use of proxies and a focus on individual personalities, valuable understanding of the phenomenon had not been gained.

Women's narratives of symptom experience not only described the intensity, severity, and frequency of symptoms, but the words and phrases offered by the women delivered clear images of the phenomenon of symptoms related to menopause. Martin (1992) spoke of the benefit of addressing the detailed experience, the "phenomenology of menstruation" (p. 106), of type, color and consistency of flow to girls as they approach menarche. The descriptions in this study painted a vivid picture of the embodied experience—the "phenomenology" of menopause symptoms.

Studies examining vasomotor symptoms found that nearly 85% of women experience some hot flashes during menopause with 15 to 20% of those being severe (Kronenburg, 1990). Previous quantitative studies have only been able to measure intensity with scales generally rated from mild to severe or disrupting normal life. Bromberger and colleagues (1999) found that 37% of women with hot flashes reported distress compared to the 18% of women without hot flashes. Although it is important to ascertain the percentage of women experiencing distress during menopause, much is lost in the quantification of symptom experience. Through the detailed descriptions used in this study, women have demonstrated *how* hot flashes, unpredictable menses, sleep disruption, and issues related to sexuality, can cause distress for a woman who is experiencing severe or persistent symptoms.

In previous studies, researchers have attempted to explain why some women experience distress more than others and have looked at personality types, attitudes, and individual coping capacities. Nedstrand, and colleagues (1998) examined stress and

coping in women with hot flashes, and found that even after hot flashes were treated, women still reported symptoms of anxiety. They concluded that some women have lower coping skills or a "neurotic" tendency. Using a postmodern feminist perspective in this study, women's experiences were not viewed as being the result of individual variations in personality. Attributing distress to personality violates core principles of postmodern feminism. It supports Cartesian philosophy and modern gynocentric feminists who suggest that an individual possesses an innate, biologic self (Benner & Wrubel, 1989; Weedon, 1997). Postmodern feminists believe that the individual is always the site of conflicting forms of subjectivity (Baxter, 2003; Bloom, 1998; Weedon, 1997). The latter stance allows for change; whereas the former "fixes" an individual and precludes the opportunity to alter circumstances.

A postmodern feminist framework also allowed for the contextual background of a woman's life to be seen as a contributing force in the experience of distress during the menopause transition. In this study, not only spatial, but temporal contexts of women's lives were shown to impact women's experiences. Martha's severe mood episode was in the context of both past and future as she compared her present state to the past and feared the future loss of job, husband, and mind. Susan Jane's distress was related to her loss of "physicality" from months of sleep deprivation and she feared becoming a "bag lady." The term, "bag lady syndrome" describes a fear specifically experienced by women that they will not have future financial security (Truett, 2004) and generally describes an aged homeless woman (Wardhaugh, 1999). The term "bag lady" is generally used jokingly and disparagingly (Wardhaugh, 1999).

In previous studies, references to past are used generally from a lifecourse perspective where women's pasts are demonstrated to affect symptom experiences (Kuh, et al., 2002; Schmidt, et al., 2004). However, they often explore life trajectories where women are shown to have disruptive life experiences that tend to impact their ability to tolerate or cope with present challenges. Future is examined in a manner such as Reynold's (2000) study on catastrosophisizing where associations between distress and "…despairing anticipations about the future" are found (p. 114). Using those frameworks, women are seen as inflating situations, or lacking ability to control reactions to current circumstances. The stories told in this study portray women as having reasonable concerns for the future situated in socially and culturally shared values and life experiences. The reader is able to understand how these concerns contribute to, or more accurately, constitute women's distress during menopause.

Studies have examined other social factors of women's distress and have found associations with social support, presence of teens in the house, marital satisfaction, and difficulties with family members (Bloch, 2001; Kuh, et al., 2002; Schmidt, Haq, & Rubinow, 2004; Walters & Denton, 1994). Avis and colleagues (2004) found that being married increased quality of life in midlife women across four ethnic groups. Many of the women's narratives in this study involved partners. Martha shared concern about losing her husband due to her emotional instability and decreased libido. Conversely, Elizabeth's decreased libido was not a problem for her because of her husband's acceptance of it, which was "all that mattered." Fay shared numerous accounts of the role her boyfriend played in her experiences. Studies have also examined the "empty nest" (grown children leaving the house) syndrome (Schmidt et al., 2004) and did not find an

association with midlife women's depression. No one in the present study expressed distress related to children moving out of the house. However some women grieved over the loss of opportunity to become mothers. Perhaps there is a "never filled nest" syndrome as BJ and Jo both expressed distress about never having children, which becomes an irretrievable fact during the menopause transition.

Relationships with work were discussed as stressors in some of the women's narratives. These included issues with co-workers, work environment, concerns regarding work in general, and concerns about future resources. China was a paradigm case to demonstrate the role work plays in experiences of distress. Being employed as a temporary worker placed her in stressful work conditions. The story of working at a football concession stand while having a painful, unexpected menses showed how much a demanding job created distress for her. Her deep concern about not "lashing out" at people caused her to withdraw from social engagements. Martin (1984) addresses the pressures of a "society where most people work at jobs that require and reward discipline of mind and body, [and where] loss of discipline would be perceived negatively" (p. 121). Walters & Denton's (1994) study of working women found that stress was associated with hours worked and having other than a white collar job. Findings in this study support the impact of work on experiences of distress for midlife women but demonstrate in more detail how this is played out.

Distressful experiences related to symptoms frequently resulted in social isolation and a decreased quality of life for some women. Avis and colleagues (2003) looked at health related quality of life and found that menopausal symptoms explained impaired social function. The social withdrawal experienced by the women in this study was

shown to create a snowball effect resulting in increased experiences of distress. This was especially apparent in Nancy's, Susan Jane's, and China's situations. Bromberger and associates (2001) found that among women who had more than five friends, only 19% reported distress versus 39% of those with no friends. A study such as Bromberger and colleague's (2001) did not reveal the bi-temporal direction of this association. The findings from the present study revealed the complexity of distress in relation to social support. Many women in this study withdrew from people partly because they did not feel they were receiving the support they needed. Perhaps it is the quality of the social circle that needs to be addressed rather than the quantity.

Distress was experienced for many as intense and persistent symptoms. Most often, experiences of distress were greatly embedded in the contextual background of the women's lives. Distress resided at the intersection of symptoms and vital constituents of women's lives, such as interpersonal relationships and work. The context of time—past and future—merged in the present, creating a canvas for distress to unfold upon. Distress also manifested as social withdrawal and a decrease in quality of life, both consequences of prior distressful experiences. Women attempted to make sense of their experiences in order to understand the changes in their lives and other's reaction to them. The meaning of distress as the women interpreted it as well as what surfaced from their narratives will be discussed in the following section.

Meaning of Distress and Relationship between Menopause and Aging

The difficulty in answering this question provided the impetus for the study itself. One of the main difficulties in defining distress is that it means different things to different people and depends highly on the specific situation. Distress was not defined at

the beginning of this study because it was the intent for the participants of the study to define it themselves. Interpretation of data was needed to discover the undertones of the experiences. However, the women sought to evaluate the events in their lives and frequently relayed to the listener their interpretations. For some women, distress was interpreted as a loss of control. Mainly (but not exclusively), meaning surfaced in the narratives that reflected the theme, *Silence, Stigma, and Shame.* The intersection between menopause and aging comprises much of this theme; therefore aspects of the third research question—"How do women *describe* the relationship between aging and menopause—will be woven into the discussion here.

Silence, Stigma, Shame

Stories of silence, stigma, and shame were shared by many. Silence was experienced when women reached out to others. This accounted for distress among the women in various ways. BJ felt she could not receive the information she needed; Susan Jane felt alienated. Experiences of silence and feelings of alienation were a major finding in a study conducted by Engebretson & Wardell (1997) on women initiating hormone therapy. The researchers identified five factors contributing to "intergenerational silence"—marginalization of women, cultural value of youth, lack of active vocabulary, social factors, lack of rituals to mark menopause, and economic issues (p. 266). Silence is not a novel concept in menopause. Books have been written about it such as, *Silent Passage* (Sheehy, 1993) and *Screaming to be Heard* (Vliet, 2001). Nearly fifteen years later the phenomenon still exists. The data in this study demonstrate that silence persists among menopausal women and triggered subsequent distress for many of the women in this study.

Stigmatization of menopause and aging was found to be the reason for the silence experienced by some of the women in this study. When women invested in discourses that supported a decrease in value of aging women, menopause was seen as something to be avoided or hidden. Either the woman admitted having these beliefs themselves as in Kira's case, or suggested that it was the reason for other's silencing, as when Tree spoke of women losing their "feminine attractiveness." Kira explained succinctly that she did not want to have menopause yet as it would mean she was not young anymore. She feared losing her "young woman power."

Shame associated with a publicly exposed symptom caused distress for some as told by Nancy in the tropics or by BJ when she hypothetically spoke of having a hot flash in public. These examples reflect the shame of experiencing the unexpected obtrusion of the feminine body, usually kept hidden from public view and perhaps deemed outside the bounds of perceived normalcy. Taylor (1985) spoke of emotions such as shame only being able to exist as a reflection of some notion of standards shared in a society. He stated, "To feel shame is to sense that I fail on some standard... (p. 111). Women's stories of embarrassment or shame while having a hot flash in a public place may demonstrate a sense of failing on some standard. This standard must be one other than that of an aging, menopausal woman. Tree learned to resist ageist discourse by talking about *it* whenever she could as she declared, "this is a part of who I am." Others decided to socially withdraw and become silent. Most of all, the women did not believe they were recognized, supported, or that they received the empathy and attention that a person experiencing distress deserved exacerbating their sense of distress.

Competing discourses regarding menopause and aging may contribute to the silencing of women as agents of their social world (Ballard, et al., 2005; Bloom, 1998; Clarke, 2005; Ogle & Damshorst, 2005) Medical discourse claims menopause is a hormone deficiency disease in need of replacement and treatment (Stolberg, 1999). As a backlash, modern feminists have reclaimed menopause as a natural reproductive passage (Friedan, 1993; Worcester, 2004). Women who are experiencing distressful symptoms may not identify with any of these discourses, thus they may not find the help they seek, or may not be taken seriously when they do. As silent actors they "…are rarely recognized by medical professionals and, even then, are usually marginalized" (Clarke, 2005, p. 122). BJ and Susan Jane addressed the frustration of not fitting into prevailing discourses when they spoke of not being taken seriously for their distressful symptoms. This also supports research by Engebretson and Wardell (1997) who identified a reason for the silence experienced in their sample was "the trivialization of experience" by others including medical experts. Women withdraw from the competing discourses and become alienated, socially isolated, and silent. Nancy felt hardship when she received the "proud to have menopause" brooch as a gift. How she made sense of her friend's insensitivity was to assume her friend had an easier time with menopause compared to her own experience.

Changes in appearance present challenges for some midlife women, especially in the context of a Western society that values youth over aging (Browne, 2003). Women in the present study reported concerns about physical appearance which confirms previous findings (Bannister, 2000). Bannister (2000) also reported that some women identified with the image of "the wiser older woman" (p. 753). Other studies have shown that as

women age, they may place less emphasis on the importance of their bodies (Tiggermann & Lynch, 2001). Even though the women in this study self identified as having experienced distress related to menopause, all but one spoke of new found and cherished values that had accompanied aging. These findings support other research (Bernard & Davies, 2000; Ogle & Damhurst, 2005). Mostly all of the women had mixed feelings about aging. Studies have illuminated the confusion among midlife women as they vacillate between welcoming their new empowered identities while at the same time grieving the losses of youth and expressing fear of future losses (Bannister, 2000). This was clearly demonstrated in Kira's poetic narrative, *Mixed Feelings*. This mixed celebration and uncertainty of aging has been reported elsewhere (Ballard, et al., 2005; Bannister, 2000; Dillaway, 2005). It also strongly supports the ability for a woman as a non-unified subject to move fluidly between discourses (Weedon, 1997). Experiences of aging in this sample demonstrated how aging is a complex process involving biological, psychological and environmental interactions (Wood, 2004-2005) and how it is deeply embedded in prevailing social and cultural discourses.

Meaning given to symptoms and experiences of menopause greatly reflects the prevailing societal discourses on aging. The findings in this study support that a contributor to distress experienced by women during the menopause transition may be the result of ageism in Western society (Gullette, 2006; Palmore & Cherry, 2004; Pohl & Boyd, 1992). The tightly woven association between menopause and aging may compound experiences of both. If a woman invests in an ageist discourse, distress may be exacerbated by the shame of menopause symptoms. The subsequent effect of silence may also cause distress as women withdraw in isolation. The results of this study address

gaps in the literature as in-depth data were gathered on pertinent experiences of distress related to stigma and shame of a common occurrence such as menopause.

Loss of Control

Studies have examined perception of control during menopause from various angles. Reynolds (2000) examined effects of "catastrophising" which is partly described as "berating the self for failing to control the current situation" (p.112). Beyene, Gillis, & Lee (2007) found that women in their forties reported feeling in control of many things in their lives, such as their health, and were not as concerned about menopause as much as aging. Many of the women in this study reported feelings of loss of control as being one of the most, if not the most distressing of their experiences. Loss of control denotes temporality as loss is generally in reference to something that was possessed previously. In this study, the feeling of being "out of control" implied that the women were accustomed to some level of control in the past. This supports findings from Baylene and associate's (2007) study. When the women spoke of control, they distinguished between physical, emotional, and "emotional over physical." It is likely that the women who reported a loss of control in this study would score high on the neurotic and catastrophizing scales (Bromberger & Matthews, 1996; Kuh, 2002; Reynolds, 2000). However, such an examination is based on a Cartesian discourse that the mind, separate from the body, has control over it (Benner, 1987; Lawler, 2002; Morris, 1998).

Wallhagen (1998) suggests viewing control "within a culturally bound, person-environment framework" (p. 135-136). Control in this study was revealed in the context of the women's experiences and would have been missed in single measures of specific attributes such as neuroticism. When examining illness stories, Frank (1995) suggested

that control resides on the opposite side of the continuum from chaos. Even when control was not raised specifically in the narrative, many women shared stories of symptom experiences that contained elements of chaos. This chaos was revealed by the iterative quality of the narratives and incessant nature of events. The breakdown of health as the women knew it, occurred. Control may have been something the women were accustomed to in the past when everyday living was taken for granted. This may have induced a false sense of control, so when a breakdown occurred, a loss of control was experienced (Morris, 1998).

Postmodern bodies are seen as inscribed by prevailing social discourses in the form of discipline in order to achieve the perfect Utopian body (Morris, 1998). Strict adherence to exercise and diet regimens is believed to be the key to achieving and maintaining a sense of health. Susan Jane was a paradigm example of this as she strived to restore her health with a rigorous regimen of exercise, yoga and herbs. The committed but unsuccessful attempt to regain lost control contributed to the distress she experienced.

The findings in this study have illuminated the role that discourses on control may play during the menopause transition. However, many questions remain unanswered about the concept of control in a midlife woman's life and how this might impact her overall health during this phase in her life. Moreover, these findings support the need to examine control from a social cultural perspective rather than from one that views sense of control as a personality attribute or learned behavior. The experience of loss of control may actually be a backlash to the prolonged inscription of postmodern ideologies that individuals need to be disciplined and "in control" (Morris, 1998).

Summary

The essential experience of distress, the meaning of distress, and the interaction between menopause and aging were investigated in this study through personal narratives. The "physicality" of intense, severe, and persistent symptoms resulted in full embodied experiences. Though many women experienced similar symptoms, the contextual background of their lives caused heterogenic expressions of distress. Past and future merged in the present and impacted experiences of distress. Interpersonal, professional, and social relationships and issues directly or indirectly related to work affected the level of distress of many women.

Results from this study demonstrate that many discourses on menopause and aging exist. The closely knit bond noted between menopause and aging compounded menopause experiences for some women. Elements of ageism surfaced primarily in the form of social discourses on aging that women used to interpret their own beliefs as well as the actions and beliefs of others. The silence and lack of people to talk to about menopause was in part attributed to the stigma of aging and was demonstrated to cause much distress for some women. Being caught between discourses was shown to cause alienation and marginalization. Many women found that a loss of control was most distressful.

Significance of the Study

The results of this study add to the body of knowledge of menopause and aging. The robust stories of midlife women's experiences have illuminated the phenomenon of distress. Previous literature on distress during menopause has attempted to *explain* and measure distress quantitatively. This study aimed to *understand* the phenomenon. The

previous qualitative studies looked at changing identities and effect of discourse on menopausal women, but none focused on the phenomenon of distress. Frank (1997) stated, "…the teller of an illness story seeks to learn the true name of the disease" (p. 3). This is significant to healthcare providers because the tendency and need to categorize, reduce, and diagnose may marginalize those who fall on the periphery. Perhaps the most significant effect of this study was for the women to have had the opportunity to tell their stories, especially when silence and alienation were an integral component of the stories they told.

Experts in the field have recommended the exploration of the sociocultural elements of menopause experiences (Utian, 2005; Woods & Mitchell, 2005). The results of this study revealed many complex social and cultural elements of symptom experience during the menopause transition. However, the framework and method used in this study created the ability to examine interactions between women's experiences and their surroundings in a more effective way than has previously been employed by other researchers. Hearing women's stories revealed much more about their sociocultural contributions to experiences of distress than previous studies have been able to capture via the use of proxies. The understanding gained from this narrative analysis of women's experiences increases the awareness of a potentially marginalized group of women. If some women may be feeling alienated, unsupported, unacknowledged, and unable to get information, then systemic changes need to be made.

Study Limitations

A narrative analysis study is an interpretation of a woman's story which is told from the woman's perspective and with her own interpretation. Through the theoretical

framework, the re-transcription, and analysis of data, the researchers create their own interpretation. Additionally, readers of the study will have their own interpretations. The interpretations of researchers will always reflect their assumptions or "gaze." To address these, measures were taken in order to accomplish trustworthiness of data and to assure study rigor. The following measures were taken to achieve this.

Four criteria were used to measure trustworthiness: persuasiveness, correspondence, coherence, and pragmatic use (Reissman, 1993). Persuasiveness was achieved by supporting theoretical interpretations with direct quotes from participants' interviews. Correspondence was accomplished with member checking and with the use of a research team to compare analyses. One woman confirmed an interpretation of her data with the following comment. "You and I are absolutely on the same page, and I have no criticism of it at all. It's brilliant!"

Coherence was evaluated across three categories: global, local, and themal (Riessman, 1993). The global aspects relate to the overall goals a narrator is trying to accomplish with the story. Local coherence draws attention to the use of linguistics to relate events in the narrative to one another. Themal coherence stresses the content. Thorough attention was paid to all three categories. The discussion, significance of study, nursing implications and future research address the pragmatic use of the study.

The intention of this study was to focus on women who had experiences of distress. Thus, only women who had self-identified as having experienced distress during the menopause transition participated in this study. This was a purposeful sample with the aim of understanding the specific phenomenon of distress. It is possible that stories from women who had an easier time with their menopause transition may have

contributed to and enhanced the understanding of menopause, but such was not the aim of this study.

The women self-reported their ethnic and racial backgrounds as Latina, African American, and Caucasian, thus the sample reflected diverse representation. However, no other ethnic or racial group was represented. Furthermore, only heterosexual and able-bodied women were interviewed. Experiences of lesbian or disabled women would have added valuable insight into the phenomenon. Only one interview was conducted per woman, thus preventing further inquiry after analysis of data began. Though the sample size was small, narrative analysis methodology is best suited for small samples as attention must be paid to the nuances of speech, individual context, and social discourses embedded in the narratives.

It is difficult to determine what portion of women in the general population is represented in this study. Population studies have demonstrated that many women transition through menopause without much hardship (Avis & McKinley, 1995). Mostly all women who responded to study ads were included in the sample and flyers were retrieved after cessation of recruitment. However, upon hearing the title of the dissertation in informal social settings, many were interested in participating. Unfortunately, due to time restrictions for the study these women were turned down. A steady trickle of women responded, but very few (n = 2) were recruited from healthcare offices. It is possible that women who were currently experiencing distress may not have been able to tell their story. When defining chaos narratives, Frank (1995) stated that most chaos stories are told retrospectively. One participant reported that she would not have been able to participate in a study during her distressful episode. If women are

silenced during these episodes, the exact proportion of women experiencing distress may not be known.

Implications for Nursing

The understanding gained from this study will broaden nurses' knowledge about the experiences of women during the menopause transition. However, nurses also need to know about the women who experience distress and may be suffering privately and in silence. Findings from this study should caution nurses about the detrimental effects of assuming women are *not* experiencing distress. Accustomed to remaining silent, women may need to be encouraged to speak about their concerns.

Additionally, when a woman presents to a clinic with complaints of menopause symptoms, the level of distress must be ascertained. As this assessment is being made, attention should be paid to the context of the woman's life. *How* are these symptoms affecting her relationships with self and the world? What meaning does she place on vaginal dryness, for example? Does she fear she may lose her partner? Is she older than her partner? What is going on with her partner? Is she able to communicate her concerns to him or her? What accommodations are made for her symptoms? There are a multitude of questions to ask that could unveil the experiences of vaginal dryness, hot flashes, decreased libido, and sleep deprivation, among the many other symptoms described in this study.

In addition, if a woman presents to a clinic highly symptomatic, especially with vasomotor symptoms that are disrupting quality of life, a detailed risk assessment needs to be conducted with the patient regarding the use of hormone therapy. Current recommendations support the use of HT for severe symptoms in low to medium risk

women for around five years (NAMS, 2007). Lifestyle changes and use of non pharmaceuticals may be explored though evidence conflicts regarding the effectiveness and safety of alternatives. Most importantly, the discourses of menopause, aging, and models of medicine and healing need to be uncovered.

As has been previously discussed, many symptoms reported by the women in this study have been found in the literature to not be directly associated with menopause (Utian, 2005). It may not be necessary for the clinician to determine the cause of the symptoms women present with in order to provide compassionate and empathetic care. The findings of this study support that illness is the "human experience of loss or dysfunction" (Benner & Wrubel, 1989, p. 8). It would be beneficial to focus on the symptom experience as "an individual's perception of a symptom, evaluation of the meaning of a symptom and response to a symptom" (Dodd, et al., 2001, p.669). Additionally, it would serve the best interest of the women, if nurses would evaluate their own assumptions and discourses about menopause and aging. The particular discourses that the nurse is invested in will affect her or his response to, and treatment of, women in menopause.

The findings on how women negotiated discourses demonstrate the need to discuss with women the prevailing societal and cultural discourses on norms regarding menopause and aging. Discussions such as these can help illuminate the choices women may or may not be aware of or have resistance to. Additionally, since women shared concerns regarding their health as they age, nurses may encourage them to create advance directives for healthcare. The data collected in this study support the need for women to be able to tell their stories and connect to women similarly situated. Clinicians could use

this information to advocate for and develop menopause groups in their areas. The North American Menopause Society (NAMS) has created a guide to provide "how to" tips for healthcare professionals for developing menopause discussion groups (Boggs, & Resenthal, 2000).

Nurses must be aware that every illness or breakdown in health has a story that includes a past and hope or concern for the future. Benner & Wrubel (1988) advise nurses to be aware of these stories for within each narrative,

> …plans are threatened or thwarted, relationships are disturbed, and symptoms become laden with meaning depending on what else is happening in the person's life. Understanding the meaning of the illness can facilitate treatment and cure. Even when no treatment is available and no cure is possible, understanding the meaning of the illness for the person and for that person's life is a form of healing, in that such understanding can overcome the sense of alienation, loss of self-understanding, and loss of social integration that accompany illness (p. 9).

Future Research

This study examined the experience of distress during the menopause transition and discovered the expressions of distress among the women studied. The stigma and shame resulting in alienation of women experiencing distress was most disturbing. Future research is needed to investigate these experiences in more depth in order to fully understand the intricacies of these phenomena. Additionally, methods to manage these experiences warrant further investigation.

More information needs to be gathered about the experience of women and aging in Western society. The discourses that aging women take up to position themselves in more powerful ways need to be revealed in order to aid women in resisting less powerful positions (Baxter, 2003; Browne, 1998). Examining narratives of aging women from a

postmodern feminist perspective will facilitate informing women of the choices they have and to advocate for more choices. As Bloom (1998) declared, "it is particularly critical to interpret women's narrative in ways that help the narrators to examine their roles, choices, and pains so that they may assume power" (p. 69). Midlife women are already feeling effects of ageism, and as revealed in this study, had constituted some of their distress.

Additionally, studies that further explore the experiences of shame among women with menopause symptoms may help answer some of the unanswered questions. An investigation of others' responses to women experiencing menopause could reveal more about the phenomenon. Interviews of partners, children, and the general public about women they have known who struggled with the menopause transition may give further insight into the stigma and shame of menopause experiences. Their stories may reveal current social and cultural discourses and attitudes toward women during the menopause transition.

Another direction for research on midlife women is to develop and promote the interaction between women as well as the interaction between women and their healthcare providers. One way to achieve this would be to investigate the effect of a different model of healthcare delivery. A model based on group pregnancy care, known as *Centering Pregnancy* could be adapted for midlife women (Rising, Kennedy & Klima, 2004). In lieu of individual provider visits, the pregnant woman receives her prenatal care in a group setting. Individual time is incorporated into the sessions and group discussions of pertinent pregnancy and birth concerns take place. This same model could be adapted to provide annual visits for midlife women. Midlife women would meet over

a period of time to discuss pertinent health issues related to aging and menopause. In addition, the routine care that is provided during their annual visit may be incorporated. This would need to be examined as a pilot study, but results from *Centering Pregnancy* care studies have demonstrated positive outcomes for the women participants (Grady & Bloom, 2004). Similar results could be achieved for midlife women in an attempt to assuage the difficulties they confront at this time. If silence and alienation were among the pertinent findings of the present study, then *Centering Midlife Women* may reduce some women's distress and prevent the experiences of "suffering privately."

The issue of control needs to be explored in more depth. The discourse of control is laden with philosophical, theoretical, and political complexities. The aspect of control needed to be investigated is not one that explores self efficacy or means of coping. It is the attachment to control itself as a postmodern condition. This may also be the core of the shame. Perhaps the societal norm is control. Research that would examine this in more depth could reveal needed understanding of how it is playing a role in women's experiences of distress.

Conclusion

With more than 20 million women of menopausal age (45-54 years) and nearly 22 million additional women entering menopause over the next 10 years, (Projections of the United States Census Bureau, 1999-) experiences of menopause have become an important concern. Researchers agree that the menopause transition may be challenging for women as fluctuating reproductive hormones may cause physical and psychological symptoms (Avis & McKinlay, 1995; Pearlstein, 1995). Some women experience varying

levels of distress during this time which is not fully understood. Therefore, the aim of this study was to examine women's experience of distress during the menopause transition.

Using a postmodern feminist perspective and narrative analysis methodology, attention was paid to the heterogenic experiences of distress revealed in midlife women's stories. Individual open-ended interviews with women who had experienced distress during menopause were conducted to hear how women described their experiences of menopause and aging. What was most important in this study was to examine how the contextual lives of individual women affected, and were affected by, their experiences of menopause and aging. The use of narrative analysis methods suggested by Labov (1997), Gee (1985, 1986), Riessman, (1993), Frank (1995) and van Manen (1990) allowed for the illumination of women's stories expressed in various structural ways. The women in this study were aware of the closely knit intersection between menopause and aging. In an attempt to make sense of their experiences they frequently interchanged the two while telling stories of distress.

One of the purposes of the framework chosen was to examine how women navigated between available discourses. Discourse in this study was defined as "forms of knowledge or powerful sets of assumptions, expectations, and explanations governing mainstream social and cultural practices (Baxter, 2002, p. 7). The understanding that women act as agents who choose positions of varying degrees of power guided some of the analyses. Attention was also paid to how women resist positions of less power. Additionally, the fluid movement between discourses was illuminated. The movement between discourses could be observed due to the understanding of a non unitary

subjectivity (Bloom, 1998). This counters the conception of self as a rational, idiosyncratic individual with fixed characteristic traits and attributes (Weedon, 1987).

For some women, feelings of loss of control were experienced as a result of severe and/or persistent symptoms. Not only did a breakdown in health occur, but also a breakdown in beliefs and values. For some, it was a trust in self that was previously believed in and lost. What mattered to the women—their health, physical and mental capacities, spouses, partners, children, mothers, work, and the public eye contributed to and constituted a portion of their distress. The sense of alienation as a consequence of being silenced was a major finding in the study. Experiences of shame and stigma related to aging and menopause penetrated many of the women's narratives. The heterogenic experiences of distress during the menopause transition unveiled in this study demonstrated the complexity of the phenomenon. The findings from this study support the need for an increased sensitivity to the needs of women who may be experiencing severe symptoms that interrupt quality of life. Weedon (1997, p. 33) stated:

> The collective discussion of personal problems and conflicts, often previously understood as the result of personal inadequacies and neuroses, leads to a recognition that when have been experienced as personal failings are socially produced conflicts and contradictions shared by many women in similar social positions.

Rather than blaming women for their inability to cope, or for having a neurotic personality, the results of this study have created an empathic understanding of the complex experiences of distress women experience during the menopause transition.

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APPENDICES

Appendix A. Grid of Literature Review

Appendix A. Summary of Critiqued Literature on Distress during the Menopause Transition by Alphabetical Order

Author & Year of Publication	Purpose	Design	Sample	Methods &/or Instruments	Results	Comments
Avis, et al. (2001a)	To assess if decreased estradiol is related to depression	Longitudinal cohort over 3 years	Subsample of population sample Women 43-53 N = 309	· CES-D · General symptom questionnaire	· CES-D not associated with menopausal status or estrogen levels. · CES-D associated with hot flashes /night sweats and trouble sleeping (p = .04). · Concluded with "domino hypothesis"	· Sufficient sample size drawn from general population and longitudinal nature of this study strengthens its validity.
Avis, et al. (2003)	To determine if early perimenopause was associated with HRQOL	Cross-sectional	Multiethnic population sample of women 42 - 52 N = 3,302	· Medical Outcomes Short-Form 36 (SF-36) · 5 Subscales to measure: 1) bodily pain 2) role limitations due to physical problems	· Women in premenopause had better HRQOL than did those who were in perimenopause. · Japanese women consistently scored higher on all subscales, whereas Hispanic women	· Large multi-ethnic population sample. · Findings suggest that symptoms among menopausal women play an important role in the health-related quality of life.

				3) role limitations due to emotional problems 4) social functioning 5) vitality	generally scored lower · Compared with Whites, Blacks were more likely to report compromised functioning on pain ($p < 0.0001$) and social functioning ($p < 0.0001$) and less likely to report impairment on vitality ($p = 0.002$) · Multivariate analyses: → education and financial strain explained the differences in role-physical, vitality, and role-emotional domains. → menopausal symptoms explained impaired functioning in the role-physical, bodily pain, vitality, and social function domains, but not in the role-emotional domain.	

Bannister (1999)	To examine perceptions of women's changing bodies within the Western cultural context	Ethnographic	Women 40-53 N = 11	Narratives were obtained and analyzed using Spradley's Developmental Research Sequence Method.	· Women's experiences laden with contradiction · Themes included: → loss → cultural influences that perpetuated ageism and sexism → lack of consistent information about menopause → redefining self → issues of self care · Most useful method for treating health complaints was dialoguing with other women	· Strengths include: → an introduction describing theoretical frameworks related to ageism and sexism → explicit explanation of the method → adherence to rigor including credibility, transferability, dependability, and confirmability. → sufficient excerpts from interviews to support various findings → member checking
Bloch (2001)	To examine the effect of body image and self esteem on menopausal symptoms and attitudes toward aging and menopause.	Cross sectional	Women aged 43-63 N = 51	· Questionnaire developed to assess attitude toward menopause and menstruation · Shortened version of Rosenberg's	· Mean age of menopause was 53.8 · 82% (n=42) of the women were already postmenopausal. · 39.3% using HRT · Of those reporting	· Author repeatedly drew cause and effect conclusions throughout the paper. · Small sample size, cross sectional design, and 82% of the women already

				self esteem scale ·Body awareness questionnaire from Straub and Richter-Appelt.	symptoms, 50.9% reported hot flashes, and 60.8% had complaints of being tired and weak. · When asked if menopause is coupled with unbearable difficulties → 13% agreed → 57% did not agree → 29% thought it was partly true. · Women who regarded menopause negatively reported more → sleeping disorders ($p < .01$) → and depression ($p < .05$) than those who regarded it positively · Those who described the losses of menopause, rather than the reliefs,	postmenopause limit the findings. · No mention of instrument · Raised awareness of vast emotions that may accompany the transition.

					reported more → sleeping disorders ($p < .01$), → nervousness ($p < .05$) → tiredness ($p < .05$) → hot flashes ($p < .05$)	
Bromberger and Matthews (1996)	· To examine effects of pessimism, trait anxiety, and life stress on depressive symptoms in middle-aged women. · To explore if stress moderated the effect of optimism on depressive symptoms.	Longitudinal cohort	Women 42-50 N = 460	· Spielberger Trait Anxiety Inventory · BDI · Modified version of the Pilkonis Life Event Schedule	· Women who were pessimistic, in the presence of on-going stressful problems, reported more depressive symptoms. · Pessimistic women who experienced a stressful life event had elevated depressive scores ($p < 0.01$). · Women who scored higher on trait anxiety had more depressive symptoms ($p < 0.001$) · No specific interactions between trait	

					anxiety and stress or menopausal status. · Researchers suggested that people with a negative affect "…do not require stressful events to make them vulnerable to depression in midlife" (p. 210).	
Busch and colleagues (2003)	To examine women's psychological development during menopause and to investigate the relationship between women's appraisal of menopause and symptom reporting.	Longitudinal population based study using Grounded Theory and quantitative statistical analysis (5 years)	Women all 48 years old N = 150	Qualitative interviews	· At baseline: → 56% had neutral expectations of menopause → 31% negative → 13% positive · At study end: → 16% neutral, → 17% negative, → 67% positive · Both pessimistic and pessimistic-positive scored higher in depression, anxiety, and interpersonal sensitivity, hostility, and	· Prolonged engagement over a 5 year period provides credibility ·Use of same interviewer maintains consistency. · 48-year-old women may already have been experiencing symptoms thus prevent a pre-assessment of their expectations of menopause. · Validation of the findings obtained as

					somatization. · At Time 1, the negative groups scored higher in negative mood, memory difficulties, and joint pain · At Time 2, the pessimistic group also scored higher in vasomotor and urogenital symptoms · At Time 3, the pessimistic group still reported higher levels of negative mood, memory difficulties, sleep related problems, and joint pain (all p<.01).	each interview was read, coded, and analyzed by two independent raters. · Creative examination of menopause as a process
Cain et al. (2003)	To investigate the sexual functioning and practices of multi-ethnic midlife women.	Multiethnic, Longitudinal	· Subsample of 3,302 women from an initial population sample of 16,065 Women 42 - 52 at BL	A self administered sexual activities questionnaire consisting of 20 items created to assess sexual activity	· 79% percent of women had engaged in heterosexual sex with a partner in the previous 6 months · 23% reported that sex was not important or not	· The finding that 77% of women in the study report sex as important to them indicates the role that sexuality plays in women's lives at this age. · Menopause status was determined by

					very important · 44% said it was moderately important · 32% reported that sex was quite or extremely important in their lives. · Menopause status was not a predictor of importance of sex or of having it in the last 6 months · 67% of those not having sex in last 6 months stated not having a partner as reason · Menopause status was not a predictor of intercourse frequency, sexual touching or oral sex · 20% reported vaginal or pelvic pain during intercourse · perimenopausal women were more likely than premenopausal	cycle regularity alone without any objective gonadal levels · Large, multiethnic population sample adds to generalizability of study

					women to report frequent pain with intercourse (AOR = 1.42, 95%CI = 1.21 – 1.67).	
Finset, et al. (2004)	To investigate the bidirectional relationship between various sex hormones and 1) prolactin, and 2) musculo-skeletal pain and 3) psychological distress during the menopause transition.	Longitudinal cohort over 5 years	Women with a mean age of 51 years at the start of the study N = 57	General Health Questionnaire	· No significant changes over the menopausal transition in distress or pain. · Distress at T1 (but not at T2 or T3) was inversely associated with DHEA-S level at T1 and T3 ($p < 0.05$ for both). · No association between the other hormones and distress. · Significant relationships were found between prolactin at T1 and T2 and distress at all three time points ($p < 0.05$ to < 0.01). · No association between prolactin at T3 and distress	· Longitudinal study, objective measures, and the testing of associations in both directions add to the strength of study. · Associations between prolactin and distress, although inconsistent, suggest possibility for other endocrinological cause of distress during the menopausal transition.

					· Multivariate analyses: → None of the hormones at T1 predicted symptoms at T2 or T3. → Prolactin dropped during the menopause transition, most significantly among those who were distressed.	
George (2001)	To examine and interpret the experience of the menopausal transition of American women.	Phenomenological	Purposive sample of women 48 to 62 N = 15	Questions asked: → "What was the experience of menopause like for you?" → "What did you anticipate the experience to be like and what actually happened?" → "What were the most significant changes that took place during this time?" (p. 79).	· Three main themes: 1) expectations and realizations, 2) sorting things out, and 3) a new life phase · Most women had positive responses to the menopausal transition and felt like it was a new beginning free of birth control and periods.	· The method is described in less to fully grasp the philosophy behind the method. · Dependability is confirmed with a reporting of an audit trail · Credibility is present member checking with participants reviewing the transcriptions and analyses. · Sufficient quotes were given to support the

						analyses. ·Sample was representative of different ethnicities and races
Haskell (2004)	To determine what proportion of women discontinued the use of HT after WHI findings and to compare the effects of discontinuing abruptly or tapering off slowly.	Cross sectional	Population sample of women, 43- 88 on HT N = 73	None mentioned	· Mean age of the women was 62 · 37/48 women (77%) had stopped the use of HT after hearing news of WHI. · Mean age of those who discontinued was 64 versus 59 for those who decided to continue. · 40% of the 20 women (n = 8) who had stopped abruptly versus 71% (n = 12) of the women who tapered off had experienced a recurrence of menopausal symptoms (p = .11).	· Small sample size may have prevented statistical significance. · No mention of study instruments or description of the methods used for discontinuation of HT use. · N no demographic data was collected which could have illuminated other potential factors that influence decision making
Joffe, et al. (2002)	To test the hypothesis that depression and	Cross sectional	Convenience sample of women	· CES-D	· Women in perimenopause with vasomotor	· Suggests that women may struggle the most

	hot flashes were both markers of a sensitivity to the effects of fluctuating estradiol levels on neurotransmitters.		attending routine care at a women's clinic. Women 40 - 60 N = 476		symptoms were 4.27 (95%CI, 1.4 – 13.8) times more likely to be depressed than those without vasomotor · No association with depression found in premenopause or postmenopause women with vasomotor symptoms.	during menopausal transition rather than post menopause · Cross sectional nature limits assessment of temporality · Only well-established tool was the CES-D · No mention of validity testing for other instruments · Menopause status was based on a one time self-reporting of cycle regularity and no objective markers used.
Kuh and colleagues (2002)	To examine lifetime risk factors for women's psychological distress in midlife.	Longitudinal birth cohort	Subsample of 1569 women, aged 47 from large national longitudinal cohort from Medical Research Council National Survey of Health and	· Maudsley Personality Inventory to test for 'neuroticism' · Present State Examination as a measure of anxiety · Other questionnaire for symptom	· Women with high levels of distress between 47 and 52 had different life trajectories than those without distress. · Women with distress were more likely → to come from divorced parents	· Intercorrelation analyses were done comparing annual scores, and were noted to be between 0.55 and 0.69. ·No mention of reliability testing (e.g. Cronbach's alpha) on instruments used. · Menopause status

			Development (MRCNSHD) (original birth cohort of 2547 women and 2815 men)	assessment	(p = .002) → to have scored higher on the neuroticism scale (p = .004) → or exhibit antisocial behaviors (p < .001) as an adolescent → to have had prior psychological (p < .001) or health problems (p = .014) as an adult; → or to have current family and work stress (p < .001). · Having teens or younger children contributed to higher symptom scores (p = .016) → as did having higher or lower than normal body weight (p = .004). · Little or no association between menopause status	was self-assessed and there was no description of how the status was determined · The use of personality instruments that measure neuroticism remains to be questioned as a valid or ethical tool to predict distress for menopausal women.

					and distress.	
Nedstrand, et al. (1999)	To assess if women with vasomotor symptoms had a lower stress-coping than those without symptoms and if stress coping would change after the reduction of vasomotor symptoms with hormone therapy.	Randomized-controlled trial	Convenience sample from gynecological clinic N = 33 · 16 symptomatic · 17 controls	· Stress Coping Inventory (SCI) · Eysenck Personality Inventory (EPI) · Kupperman index	· Women in the treatment group had significantly lower stress-coping than controls at baseline ($p = 0.02$). · Stress-coping did not change in the treatment group even after symptoms were abated, and they scored higher on the neuroticism scale than the asymptomatic controls ($p < 0.01$). · Change in symptoms noted in the treatment group by physicians and by subjective reporting of the women. · Physicians noted a larger reduction of symptoms than the women reported.	· Small sample size and lack of placebo weaken results · Use of personality trait, specifically neuroticism depicts a negative view of women who are struggling with the menopause experience.
Ogle and Damhorst	To explore how Midwestern	Grounded theory	Purposive and snowballing	Open ended interviews	· Some women distressed about	· Much theory was incorporated

(2005)	European American women transitioning into their middle years experienced and thought about their changing bodies and the various related societal discourses.		sampling Women 37 – 47 N = 20		their changing bodies but "came to terms with" the changes · Weight gain was a consistent theme · Two "ideological adjustments" were identified: 1) the shift from an emphasis upon external to internal aspects of self and 2) the questioning of dominant discourses about the female body	throughout the article establishing a sound foundation · Comparisons with previous studies substantiated findings · Many quotes and excerpts from the women's interviews. · Process of analysis described in detail aided the reader in following conclusions drawn. · Noting of frequent meetings and discussions by the research team · Independent audit process established an "interrater reliability of 98%" add to trustworthiness of data. · No assumptions or self-reflexivity of authors were given, which reflects a lack of transparency
Reynolds	To adapt a pain	Longitudinal	61 women	Catastrophic	· Catastrophic	· Study was

(2000)	questionnaire to understand individual experiences of symptoms of menopause			Thought Questionnaire	thoughts and distress related to hot flushes (NS) declined over time ($p < .05$) · Those taking HRT (n = 19) reported more distress related to symptoms than the women not on HRT (n = 42) (NS) · Catastrophic thoughts at Time 1 and Time 2 were related to increased distress at Time 1 and at 12 months. · Catastrophic thoughts were related to "weak beliefs in control over their physical or psychological effects" (p. 118). ·Positive association with frequency of flushes and catastrophic thoughts was found at Time 1 but not at 12 months.	exploratory in nature · Thorough attempt to examine the variation of distress related to hot flashes experienced by menopausal women. · Reliability of this instrument was confirmed by comparing results from different time frames as well as intercorrelation among questionnaire items using Cronbach's alpha (reported at 0.94).

Schmidt, et al. (2004)	To assess if adverse lifetime events are associated with depression in midlilfe women.	Case-control, cross sectional	Women N = 100	· CES-D Scale · Beck Depression Inventory (BDI) · Modified Life Events Section of the Psychiatric Epidemiologic Research Interview · A modified Daily Rating Form (DRF)	· Depressed women reported → lower marital satisfaction ($p < .01$) → more undesirable life events ($p = .001$) → greater life events that decreased their self esteem ($p < .001$) · Co-existence of hot flashes and depression resulted in different life event patterns · Hot flashes did not moderate the effect between life events and depression.	· The large sample size, methods to determine menopausal status, the use of well-matched controls, and the validated tools to measure depression and life events strengthen the reliability and internal validity of the findings. · Marital satisfaction as a sole measurement of social support limits findings.
Stephens, Carryer, and Budge (2004)	To explore contradictions observed in women's attitudes to HT.	Focus group discussions (7)	48 women	Social constructionist framework	· 6 interpretative repertoires identified: → 'Threatening change' constructed menopause as a time of unwarranted change	· Thorough and detailed theoretical framework in the introduction · Authors established a lucid understanding of the proposed conclusions and arguments set forth.

					→ 'Biomedical' was the classic construct of menopause as a depletion of hormones. → 'Drug' repertoire referred to an opposition to HT and compared its use to illicit drug consumption. → 'Natural' repertoire challenged the notion of menopause as a deficiency condition. → 'Marriage' repertoire was used by women who were using HT out of a responsibility to maintain their family relationships. → 'Feminist' repertoires were used by women not trusting of the biomedical world	
Walters and	To investigate if	Cross sectional	Convenience	· An unknown	· Women most	· Cross sectional

Denton (1994)	women's health concerns were mainly reproductive in nature, or were centered around their work or other aspects of their lives		sample at workplace Women ≥ 21 (N = 356) Majority being 45 to 64 years old	questionnaire with open ended questions such as: "What are the three most important health problems for you?" · Other questionnaire with a list of health and social issues	often (20%) declared stress as most bothersome. · Women most concerned about → road accidents (58%),breast cancer (53%), being overweight (47%), stress (45%), and arthritis (42%) · Health problems most frequently experienced in the previous 6 months were tiredness (68%), stress (60%), disturbed sleep (46%), being overweight (45%), and finding time for themselves (46%). ·Main predictors for stress were → hours worked, → having other than white collar job → having problems with other family	design does not allow an understanding of temporality · No discussion of instrument reliability or validity. · Thought provoking look at middle class women in an industrial town and experience of health and concerns about health. ·Researchers raised an argument for the need to further explore social construction of illness.

					members or money. · Main predictors for tiredness → working outside the home → problems with money were · Main predictor for depression → loneliness	
Woods, et al. (1997)	To compare those with PMS to those with a low-severity (LS) symptom pattern on physiologic indicators of stress such as arousal and response, stress hormone arousal, stressful life circumstances, anger, self and social control and interpersonal sensitivity.	Case-control	Women over 40 N = 21	· Menstrual Symptom Severity List (MSSL) · Life Events Survey (LES) · Spielberg Anger Expression Scale (STAXI) · SCL-90 (hostility subscale) · Personal Opinion Survey (POS) · Stroop Word Color Test ·Urinalysis of epinephrine, norepinephrine, and cortisol	· 13 had LS pattern · 10 had PMS pattern, of which only 8 had sufficient data. · No significant differences between groups or across cycle phases for epinephrine, norepinephrine, or cortisol, but there was a trend toward higher norepinephrine levels premenses in the PMS group. · Women with PMS compared to women with LS pattern: → experienced	· Strong theoretical framework was given · Instruments were tested and reported to have sufficient reliability scores. · Both objective and subjective measurements used for analyses.

				· Measurements of blood pressure, heart rate, and electromyelogram (EMG).	more negative life events in the past year (p = 0.02) → increased hostility (p = 0.01) → interpersonal sensitivity (p = 0.01) → more concerns about social control during premenses phase (p = 0.01)	

Appendix B. Consent to Participate in Study

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO (UCSF) CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Study Title: Women's Experience of Distress during the Menopausal Years

Marcianna Nicholls CNM, PhDc, MPH, (UCSF Nursing Doctoral student) and Holly Powell Kennedy CNM PhD, (Associate Professor from the UCSF Department of Family Health Care Nursing) are conducting a study to learn about the experience of distress during menopause.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

Why am I being asked to take part in this study?

You are being asked to take part in this study because you are a woman who has experienced (or is experiencing) feelings of distress that you associate with menopause.

Why is this study being done?

Some women go through menopause without the experience of symptoms or distress and some women experience much distress related to the symptoms or this time of their lives. This study is an attempt to uncover the meaning of distress during the menopause transition for those who have experienced it with the hope to assist healthcare practitioners care for women during this time in their lives.

This study is being funded by a scholarship to Ms. Nicholls.

How many people will take part in this study?

The researcher plans to interview up to 20 women. Some will be asked to be interviewed more than once.

What will happen if I take part in this research study?

If you agree to be in this study, the following will occur:

- You will be interviewed by the researcher at an agreed upon location for an agreed upon time.
  You will be asked about your experience of distress during the menopausal years.

- The researcher will make a voice or audio recording of your conversation. After the interview, someone will transcribe the information into a computer and will

remove any mention of names. The audio-recording will then be destroyed at the end of the study.

- The researcher will interview you one to three times depending on the agreement between the two of you. Each interview will take 30 minutes to 2 hours, but the total time required for all interviews will not be more than 4 hours.

- You may be asked to review the written transcript (s) or findings that have surfaced in the analyses.

How long will I be in the study?

You will be interviewed one to three times for a total time commitment of one to four hours.

Can I stop being in the study?

Yes. You can decide to stop at any time even after an interview has begun. Just tell the study researcher right away if you wish to stop being in the study.

Also, the study researcher may stop you from taking part in this study at any time if she believes it is in your best interest, or if the study is stopped.

What side effects or risks can I expect from being in the study?

- The interview may be time consuming and at times may seem boring to you, but you may stop at any time.
- Some of the questions may make you feel uncomfortable or you may not want to answer them. You may decline from answering any question or delay answering until an agreed upon time.
- For more information about risks and side effects, ask one of the researchers.

Are there benefits to taking part in the study?

There will be no direct benefits to you. However, the information provided may benefit other researchers, healthcare practitioners, or women who are trying to understand the experience of distress during the menopausal years.

What other choices do I have if I do not take part in this study?

You are free to choose to not participate in the study at any time. There will be no penalty should you choose not to participate.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information

may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used. All email correspondence will be protected by using established encrypted codes. When the findings are published if any direct quotes are made they will not be linked to your name.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include the University of California, San Francisco Committee on Human Research

What are the costs of taking part in this study?

There will be no costs to you, other than the time spent, as a result of participating in this study.

Will I be paid for taking part in this study?

You will be paid twenty dollars ($20) in cash for each interview you complete.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way.

Who can answer my questions about the study?

You can talk to the researcher(s) about any questions or concerns you have about this study. Contact the researchers, Marcianna Nicholls at 831-809-0455, Marcianna.Nicholls@ucsf.edu, or Dr. Holly Kennedy at 415-476-0335.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (above). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the **Committee on Human Research**, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at **415-476-1814**, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143.

****

CONSENT

You have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, you should sign below.

Date	Participant's Signature for Consent
Date	Person Obtaining Consent

Appendix C.a Advertisement to Participate in Study

ARE YOU A WOMAN BETWEEN 40 AND 60 AND HAVE EXPERIENCED DISTRESS THAT YOU RELATE TO MENOPAUSE?

HAVE YOU HAD SYMPTOMS THAT YOU FELT OVERWHELMED BY THAT MAY BE ASSOCIATED WITH MENOPAUSE?

Researchers at the University of California San Francisco School of Nursing invite you to participate in a study that aims to investigate the meaning of distress as it is experienced by a woman during the menopausal transition. You would be asked to tell your story in a face to face interview(s). If you are interested, please contact the researcher, Marcianna Nicholls CNM PhDc MPH at 831-809-0455 or Marcianna.Nicholls@ucsf.edu
A twenty dollar ($20) cash gift will be given for participation.

Appendix C.b Advertisement with Consent

ARE YOU A WOMAN BETWEEN 40 AND 60 AND HAVE EXPERIENCED DISTRESS THAT YOU RELATE TO MENOPAUSE?

HAVE YOU HAD SYMPTOMS THAT YOU FELT OVERWHELMED BY THAT MAY BE ASSOCIATED WITH MENOPAUSE?

Researchers at the University of California San Francisco School of Nursing invite you to participate in a study that aims to investigate the meaning of distress as it is experienced by a woman during the menopausal transition. You would be asked to tell your story in a face to face interview(s). If you are interested, please contact the researcher, Marcianna Nicholls CNM MS at 831-809-0455 or Marcianna.Nicholls@ucsf.edu
A twenty dollar ($20) cash gift will be given for participation.
I consent to be contacted by the researchers either by phone or email. _____Participant; _____Witness
Date_____ Phone #_____ Email _____

Appendix D. Dear Colleague Letter

Dear Colleague,

I am writing this letter to inform you of a study that I propose to do on midlife women. The title of the study is, "Women's Experience of Distress during the Menopausal Years." This will be a qualitative narrative analysis that aims to investigate the meaning of distress as it is experienced by a midlife woman.

Some midlife women experience symptoms during midlife that they attribute to menopause and that can cause ~~or~~ distress. This study is an attempt to uncover the meaning of distress that some women may experience during the years associated with the menopause transition with the hope to assist healthcare practitioners and women alike in understanding the phenomenon and to develop appropriate and effective interventions.

I would like to request if you would be so kind as to introduce the study to any of your patients who you may think would be interested in participating. The age of the participant must be between 40 and 60 and have either experienced distress in the past or currently experiencing distress that they attribute to menopause. The study will incorporate the use of face to face interviews for 30 minutes to 2 hours and participants may be asked to be interviewed more than once. Participants will receive $20.00 cash per interview, and there are minimal risks only. I have enclosed two flyers with information regarding the study. One includes a consent to be contacted by the researchers if the woman decides that she is interested in participating. If she is undecided, she could receive the other flyer with my contact information should she choose later to participate in the study.

This study is done as part of my dissertation as a UCSF Nursing Doctoral student under the guidance of professors who are experienced qualitative researchers at the University of California, San Francisco School of Nursing. It has also been approved by UCSF's Committee for Human Research, an internal review board that reassures the safety of all participants.

Thank you sincerely for your assistance in this much needed research.

Marcianna Nicholls CNM PhDc MPH
Nursing Doctoral Student
Department of Family Health Care Nursing

2 Koret Way, Box 0606
UCSF School of Nursing
San Francisco, CA 94143-0606
Marcianna.Nicholls@ucsf.edu
831-809-0455

Appendix E. Key Participant Interview Guide

Thank you so much for agreeing to participate in my study.

As I have previously explained on the telephone, I am interested in learning about your experience of distress during the menopause years. I'm interested in any information you deem relevant to share with me regarding this experience. Specific examples to clarify any points would be especially appreciated. Please note again that the information is confidential and if any quotes are used in a written document, the confidentiality will remain.

Tell me about your experience of menopause.

Probes:

- Tell me about what you found distressful or challenging. Please give me a specific example.
- Tell me about physical or emotional symptoms you might have experienced?
- Can you give me an example about a time when you were having symptoms that were bothersome/troublesome? What did you do/think/feel? How were they different from the times when symptoms were less troublesome? Can you tell me a story about a time when symptoms were less bothersome?
- How have these symptoms (or the distress related to them) affected your quality of life?
- What kinds of things do/did you do when you were having symptoms?
- If you sought help for the distress of menopause what happened?
- Tell me about a time when what you did helped or didn't help?
- What has worked for you? What has not worked for you?
- What support do/did you have at this time in your life? Tell me about the way this is or had been supportive for you? Could you give me an example?
- Tell me about what else was going on in your life at this time? Work? Family? Relationships?
- Tell me how you would feel about any group participation during this (that) time of your life.
- In general, how do you feel about menopause?
- Tell me about what it is like to age? Can you tell me a story about that?
- Tell me what you found the most distressful?
- Is there anything else you would like to share with me?

Appendix F. Demographic Questionnaire

Name you would like to go by for study_____

1. What is your current age? _____

   What was your age when experiencing distress during menopause? _____

2. What is your race or ethnic background?

   □ African American
   □ Caucasian
   □ Hispanic
   □ Asian
   □ Other

3. Currently, are you

   □ Married
   □ Single
   □ Living with a partner
   □ Divorced
   □ Widowed

   During the time of your distress, were you

   □ Married
   □ Single
   □ Living with a partner
   □ Divorced
   □ Widowed

4. Do you have sex with

   □ Men
   □Women
   □ Both

5. How many children do you have? _____

   If any, how old were they during your experience of distress? _____

7. How many years of school have you completed?

   □ Some high school
   □ High school degree
   □ Some college
   □ College degree
   □ Graduate degree

8. Are you currently employed?

   Where you employed during your episode of

distress?

□ Yes
□ No

□ Yes
□ No

9. What type of work do you do? What type of work were you doing when you were distressed?

_____
_____

10. What is the current annual income of your household? During the time of distress?

□ Less than $5, 000
□ $5,000 – 9,999
□ $10,000 – 19,000
□ $20,000 – 39,000
□ $40,000 – 59,000
□ $60,000 – 75, 000
□ Greater than 75,000

□ Less than $5, 000
□ $5,000 – 9,999
□ $10,000 – 19,000
□ $20,000 – 39,000
□ $40,000 – 59,000
□ $60,000 – 75, 000
□ Greater than 75,000

11. Have you ever visited a health care practitioner when experiencing distress?

□ Yes
□ No

11 a. If yes, how many times?

□ < 5
□ 5-10
□ 10-15

11 b. Did you find him or her helpful?

□Yes
□ No

12. What kinds of treatment have taken for your menopausal symptoms?

□ Traditional hormone therapy
□ Natural or bio-identical hormone therapy
□ Herbal treatment
What kind? _____

□ Acupuncture
□ Other_____
□ None

12a. Did you find the treatment helpful? (Please give details if you'd like.)

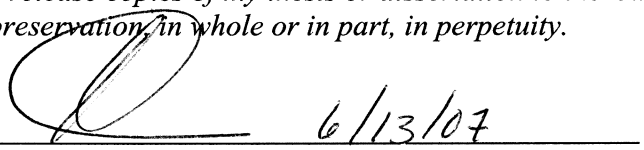
_____

Publishing Agreement

It is the policy of the University to encourage the distribution of all theses and dissertations. Copies of all UCSF theses and dissertations will be routed to the library via the Graduate Division. The library will make all theses and dissertations accessible to the public and will preserve these to the best of their abilities, in perpetuity.

Please sign the following statement:

I hereby grant permission to the Graduate Division of the University of California, San Francisco to release copies of my thesis or dissertation to the Campus Library to provide access and preservation, in whole or in part, in perpetuity.



6/13/07

Author Signature Date