

A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES
OF BLACK NURSES THROUGH THE MENOPAUSE

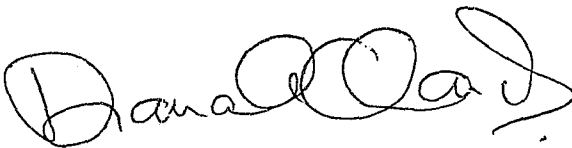
Diana Alexandria Chard

A research report submitted to the Faculty of health Sciences, University of the Witwatersrand, Johannesburg in partial fulfilment of the requirements for the Degree of Master of Science (Nursing).

Johannesburg 1998

DECLARATION

I declare that this research is my own, unaided work. It is being submitted for the degree of Master of Science (Nursing) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university.

A handwritten signature in black ink, appearing to read 'Diana Alexandria Chard', with a stylized flourish at the end.

Diana Alexandria Chard.

This 30th day of November 1998.

DEDICATION

In loving memory of my parents,
Alec and Connie Richardson,
who supported and encouraged my lifelong
desire to follow nursing as a career.

ACKNOWLEDGMENTS

All honour to my Lord and Saviour Jesus Christ

I wish to express my gratitude and appreciation to the many people who have encouraged me and assisted me in this study. In particular I would like to thank:

My husband, Richard, and my children Alex and Debbie, for encouraging my interest in "Women's Health" and nursing, and for tolerating my demands when I commandeered the computer .

My supervisor, Barbara Robertson, who encouraged me, coaxed me from the depths of researcher's despair and who waited patiently for this work.

My friends and colleagues; in particular Sharron Robertson for her unwavering support, and to Gayle Langley who shared her fascination for qualitative research with me.

To Cathie Potgieter, who performed the final editing and printing with awesome patience and longsuffering.

The women I worked with in various communities who sparked my particular interest in Women's health.

The participants who were kind enough to entrust me with their experiences and perceptions.

ABSTRACT

The purpose of this study was to examine, from a subjective point of view, the experiences and meanings of menopause by black nurses.

In South Africa the biomedical model of menopause, which portrays menopause as a deficiency disease requiring medical treatment, is the model that dominates the media, and medical thought. The narrow confines of this model leave no room for any explanation for the richness of experiences that women may have at this time, nor does it have any scope for the contributions of the socio-cultural, psychological and spiritual influences that may impact on a woman's life at this time.

This study aimed to explore the actual experiences of women at this time - in this instance black nurses. Eight respondents were interviewed and the transcribed interviews were analysed in order to extrapolate categories, themes and sub-themes. These were then cross-analysed for similarities and disparities. Themes and categories were illustrated by means of verbatim excerpts from the transcribed interviews. A literature search was undertaken to validate the results and findings.

Bodily changes, psychological aspects, social relationships and "becoming" emerged as the central themes; cessation of menses, discomfort, health seeking behaviour, seeking knowledge, anxiety/fears, emotional tone, relationships and existential and spiritual aspects also were apparent. These were explored for their impact on the experience of menopause.

The experience of menopause as described by the respondents does not fit neatly into the biomedical model. Rather, there emerges a richness of experience that is expected to lead to a fulfilling future, although this is tempered by fears and anxieties related to marital abandonment, feeling "less than a woman" and of cancer. Social relationships were important at this time, and difficulties with partners were highlighted, as was irritability with children, and to a lesser extent, with colleagues. However, while it was culturally unacceptable to talk to their mother's about menopause, respondents talked to colleagues, and these and other friends were perceived as generally being more helpful and supportive than husbands and partners.

One of the most important findings to come from this research is that there is a great need for accurate information about menopause to be made available to women. While the sample is too small for generalisation, confirmation of these findings by other studies would have implications for health service policies.

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CHAPTER ONE

INTRODUCTION

1.1.OVERVIEW

"Women's Health too often focuses on the reproductive aspects of their life cycle, thus decreasing the potential for understanding of, and attending to, the critical needs of women...beyond conceiving and delivering a healthy baby "(Meleis and Ferial, cited in Women's health: Nurses pave the way: 1995:1). This narrow perspective has not only marginalised many women but has also led to the neglect of women's health throughout the lifespan. Jones, (1994:43) states that " Constructions of women's bodies have changed throughout history but since the Enlightenment and, with it, the hegemony of science, they have been determined primarily by a biomedical perspective. This perspective results in a master medical narrative which reduced women's bodies in general to a biomedical reality; and their experience of menopause, specifically, to a biological event representing deterioration and decline". If women's health in general has long been narrowly defined and usually neglected, the health of midlife and older women has received very scant attention, and that of women of colour even less. Until recently most studies related to the experiences of menopause have been conducted on samples of middle-class white women, although there are some indications to suggest that the experiences of women of colour differ from those of white women (Glazer, 1992). Moreover there are few studies that consider menopause both within the context of a women's current life experiences at this time and her own culture (Buck & Gottlieb,1991).

Against this background the researcher decided to investigate black women's experience of menopause, seeking to elicit from participants their own experiences of this stage of life. The researcher hoped that by so doing she would assist in equipping the nurse to better understand menopausal women and thus enable her to care for her clients in a more purposeful way. The results obtained will also contribute to the body of knowledge related to menopause in South Africa.

Lesley Doyal, a British health theorist, speaking at the 1994 Women's Health Conference in Johannesburg said "...a new idea is beginning to emerge which we can call a social, rather than a medical, model of women's health. This approach does not concentrate on the inside of women's bodies, as doctors so often do. Instead it looks at their living and working conditions; what labours they perform, and how; what their responsibilities and duties are, and how they are rewarded (or punished) for carrying out these tasks" (Doyal, cited in *The South African Women's Health Book*, 1996:2) A definition of women's health must therefore recognise the particular health needs of women at each different life stage and also take cognisance of the social, economic and political contexts in which women live and work. It is for this reason the researcher has chosen this particular area as her focus. The International Roundtable on Women's Health, 1994, concluded that it is vital to establish a comprehensive, woman-centred vision of women's health, especially in regard to defining service needs, that is respectful both of women's autonomy and of individual rights.

The nurse is, in the new Primary Health Care approach to health, the most accessible member of the health team. It is she who has first contact with women who come to a clinic, and because of her work she is the most likely person to have access to women in their homes and communities. It is the nurse who is thus in a position to care for women at all stages of their lives, and in particular to promote and maintain the health of all women. Nurses can assist women towards optimal health.

Reid, (1994) cited in the International Council of Nurses' Policy document, (1995) suggests that by listening more to what women are saying, questioning existing

practices and knowledge and building up their own skills and expertise based on their experiences of caring for women, nurses can become a valuable resource in efforts to raise the standard of women's health.

1.2. MENOPAUSE - definitions and models.

In most cultures around the world menopause has usually been a topic that has been veiled in secrecy, as well as being accompanied by myths and superstitious practices. In some cultures menopause has been synonymous with ageing and the onset of degenerative diseases; in others, women who have passed through menopause are accorded increased status and in some respects are liberated after menopause. In most developed or "Westernised" societies, which are frequently obsessed with youth orientation, menopause is perceived as loss and deterioration, and increasingly as a disease that requires treatment. Primarily, the value of the experience of menopause is determined by, not only the level of knowledge of bodily functions, but also by the value women in general have in society.

While different "models" and definitions of menopause have been postulated, none can give a complete "picture" of menopause, nor can any one model be universally applicable to all cultures around the world. Different cultures interpret events into that which is determined to be congruent with the beliefs of the group. For example, Mexican Mayan women do not associate menopause with either physical or emotional symptomatology, but rather view the post-menopausal years positively, as a time of freedom regained (Beyene, 1986, cited in Richters, 1997).

A brief overview of the different models of menopause will clarify the perspective of the research.

1.2.1. Biomedical model.

The biomedical model is the most widely promoted in South Africa. It reflects perhaps the power of both the medical profession and the pharmaceutical industry.

Barile (1997:37) defines the aetiology of the biomedical model as a metabolic or endocrine disorder characterised by oestrogen deficiency caused by cessation of ovarian function. This perspective is supported by the World Health Organisation that describes menopause as an oestrogen deficiency disease. This disease is purported not only to lead to physical decline, but also to psychological and mental deterioration as well. Various symptomatology has been ascribed to menopause: hot flushes (or flashes); vaginal atrophy; general urogenital symptoms; osteoporosis; and an increased risk of cardiovascular disease. Utilising the biomedical model as a framework for managing menopause entails the acceptance of menopause as endocrinal pathology. This view was entrenched with the discovery of synthetic hormones. Bell, (1986) cited in Lewis, (1993:41), states "physicians could not have been successful in medicalizing menopause without sex endocrinology, the ethical pharmaceutical industry and the state".

This biomedical model of menopause is that which has given rise to the massive advertising campaigns that not only promote the use of exogenous hormones for treatment of this "disease", but which also actively prey on a woman's fears of ageing and disease in a predominantly youth orientated society, such as is the case amongst much of the South African population.

Many of these advertisements that promote the use of hormones, also portray women as aged and unattractive without use of the products, and as graceful and attractive after use of the recommended medication. (See Appendix I). The ethics involved in preying on fears of the general population are perhaps questionable. The biomedical model has drawbacks in that it not only recommends the mass medication of healthy women with powerful drugs, but it has no place for other experiences that a woman may have at this time, and cannot attach any meaning to them.

1.2.2. Socio-cultural model

Barile (1993:37) states that the "socio-cultural views towards women and ageing are responsible for menopausal symptoms. The socio-cultural model of menopause views the menopausal woman in relation to the cultural expectations and the social context in which she lives. Flint (1975, cited in Dickson, 1993:41), whose work was instrumental in the development of this model, describes how a woman's social standing at menopause appears to be related to her positive or negative experiences of it. Orner, (1996:9) cites Bowles as describing women's experiences of menopause as being rooted in the prevailing socio-cultural framework which consequently influences and shapes the experience for her as either favourable or unfavourable.

1.2.3. Psychological Model

This framework encompasses the view that menopause is part of a normal developmental process and is not pathological per se. However, Barile,(1993:37) describes this model as looking for underlying psychological causes of symptomatology. Bell (1975), cited in Orner (1996) describes this model as basically contradictory in that while it pursues an explanation for problems beyond that of the biomedical approach, it ultimately places responsibility for any negative experiences with the individual. In other words, it does not view the woman in the context of her life-experiences and social and cultural setting. It may thus assign blame to the woman, and place sole responsibility for any symptoms on her (Barile, 1993:37). It implies treatment for mental disorder is sufficient in terms of offering solutions and is thus extremely limited in its effectiveness to offer to women any understanding of menopause.

1.2.4. Feminist model.

Barile (1993:37) suggests that from a feminist perspective menopause is a natural developmental process, a transition or life passage. It would, however, appear that while there is no specific feminist model of menopause, there are opinions of menopause and research into menopause by feminist writers and researchers.

Lewis, (1993:38) suggests that late twentieth century feminism has generally been very critical of the medical profession and medical care. She says that, in the main, modern medicine has exerted patriarchal control over women's bodies and has expected them to be passive recipients of care. While she challenges the biomedical model of menopause she describes the development of Hormone Replacement Therapy for women as a dilemma; in one way, its availability legitimised women's menopausal complaints, but at the same time it also gives vastly increased powers to the (predominantly male) medical profession and increased traditional perceptions of menopausal women as being "beset with psycho-social complaints, losing cultural significance, showing regretfulness and depression, and generally being a burden on medical care" (Lewis, 1993:38).

The feminist researcher MacPherson,(1981), emphasises that menopause cannot be viewed as a disease; and Lewis,(1993:41), suggests that the aims of both the "management" and experience of menopause should be empowerment. This perspective promotes the normality of the menopausal transition and views it as a challenge within the control of the woman (Barile, 1993:38). It emphasises the value of learning coping strategies and the use of non-allopathic treatments. The advantage of this perspective is that it empowers women to take control of their lives and to participate in maintaining their own health.

In its extreme form the feminist approach to menopause would deny that doctors have any role to play. This view may in fact be disempowering to those women who have physical problems and may need medical help. It could in fact lead to these women experiencing guilt and shame for actually needing the assistance of the medical profession.

All these models of menopause have some merit. However, each of them has its drawbacks and leads to a narrow and limited view of the experience of menopause. Barile (1993:38) suggests an inclusive theory that "would broaden viewpoints and reduce misunderstandings, myths and misconceptions". She purports that an inclusive theory would allow for a more integrative research agenda; topics such as diet, genetics, culture and attitudes as well as alternative treatment strategies including exercise, herbs, homeopathy and natural hormones would be researched and would be utilised where appropriate.

1.3 PROBLEM STATEMENT

While many women around the world are living longer than ever before and there are superb role models of older women who have accomplished much in their post-menopausal years, women today are increasingly exposed to advertisements that are designed to engender fear of menopause in particular and ageing in general. Pharmaceutical companies distribute brochures to doctors' waiting room that promote the idea that menopause is a disease that needs medical and pharmaceutical interventions to prevent the menopausal women from physical deterioration and mental disintegration (Glazer:1992). Advertisements for Hormone Replacement Therapy include photographs of young women needing exogenous hormones to prevent bone loss. A study of advertisements for Hormone Replacement Therapy (Mintzes, 1997) describes the use of women of about 10 years younger than the average menopausal age to promote the use of hormones for all menopausal women. One pamphlet is called "Health, Happiness and Hormone Replacement Therapy", thus promoting the idea that health and happiness are dependent on the taking of medication!

Additionally a woman's problems at mid-life are frequently tossed into the "catch-all" basket of menopause, while real physical and emotional issues go undetected and neglected. The context in which mid-life women are living is largely ignored - they may

be coping with ageing parents, adolescent children and partners who are having their own mid-life crises.

Increasingly however, medication is being promoted as a cure for any and all of the issues women face at midlife. Pamphlets for women uses a headlines which states "Menopause - how hormone replacement therapy can help", again promoting the somewhat biased, biomedical view that menopause is a pathology that needs treatment (See Appendix 1). Additionally, both international and local medical journals related to menopause carry massive advertising of hormones as the main "treatment" for menopause.

To a great extent this is being done with little consultation with women who could identify what they require from health service providers at this time in their lives.

Whilst menopause is being promoted as a new disease that needs treatment, menopause in fact, merely means the cessation of menstrual periods. There are however, specific physical symptoms, such as hot flushes, irregular and heavy menses and vaginal dryness that may or may not accompany this, and some women may seek health care at this time. To equip nurses to promote optimal self-care for menopausal women and to offer specific assistance when appropriate, more knowledge as to how women experience menopause is required.

1.4. RESEARCH QUESTION

The research question is therefore "What are black women's experience of menopause?"

1.5. RATIONALE FOR THE STUDY

1.5.1. The Changing Role of the Nurse

The National Health Plan, (African National Congress, 1994) with its commitment to Primary Health Care, has highlighted the changing and expanding role of the nurse in South Africa. The nurse has been identified as the key practitioner in Primary Health Care services in South Africa (South African Nursing Council, 1992:4).

Given the overcrowding of outpatient departments and their inaccessibility for the majority of the population, it is axiomatic that the nurse at clinic level will be required to competently provide health care and education to mid-life women. In nursing, the ability to view the client as a whole (biologically, socially, psychologically and spiritually) is emphasised. The recognition of such factors as nutrition, work, relationships and stress in the context of culture, beliefs and attitudes enables the nurse to give relevant and appropriate health care. This is particularly important when related to such a time as menopause, which is infrequently discussed and is often shrouded in cultural beliefs and practices (Matthews, 1992; Quinn, 1991). The quality of available health care and information can greatly influence the way women cope with this time of life.

1.6. PURPOSE OF THE STUDY

The researcher has noticed that in this country there is little informed, accurate information available to women at mid-life, particularly about menopause and any associated problems. Jones,(1994) notes that there is a general lack of information for women, about both the physiology of menopause and their own bodily processes. She comments that unless women understand these they have no basis for making informed decisions and may consequently be subjected to the medicalization of normal physiological functions and the unnecessary imposition of dangerous and expensive

treatments. Nursing and medical text books have little reference to either the non-medical management of the menopausal woman, or more importantly, how to assist her to obtain optimal health at this time (Greendale & Judd, 1993). There is little emphasis on the care of women of this age group in nursing curricula, except in terms of gynaecological problems and their nursing care. Personal teaching experience indicates that younger nurses in particular have difficulty in assisting older women. With the change to community based care, nurses will be required to manage menopausal women in community clinics. In order to do so effectively, the nurse will require knowledge, guidance, support and supervision. Education in the manifestations of menopause, as well as an understanding of the psychosocial and cultural dynamics of menopause will enable the nurse to provide optimal care and information to her clients. Maintenance of optimal health for communities is not an option - it is an integral part of primary health care, and the health of mid-life women is a part of this.

It is therefore postulated that a better understanding of how black women experience menopause would enhance the nurse - clinician's therapeutic management of menopausal women. A knowledge of the client's subjective reality would, it is believed, facilitate and foster understanding and empathy. An increased knowledge of the type of care desired by menopausal women would enable the nurse to give accurate information to her clients and to confidently provide appropriate care.

To this end the researcher investigated and described the subjective viewpoint of black women's experiences of menopause.

The purpose of the study therefore was to examine, from the participants' point of view, how black women experience menopause. The study also sought to explore perspectives that might more accurately reflect the "lived experiences" of menopause from a previously little researched group - black women. In terms of their menopausal experiences their voices have, until only recently, been largely unheard.

1.7. OBJECTIVES OF THE STUDY

- * To identify and document participants' experiences related to menopause.
- * To identify and document participants' thoughts, feelings and emotions related to menopause.
- * To identify and document participants' physical manifestations of menopause.
- * To describe the subjective experiences of menopause of black women that will provide data for further research.

1.8. DEFINITIONS

The following are used as operational definitions:

- * **Black** : this term is used solely to define those who participated in this study. The term was defined and delineated by previous government legislation. The use by the researcher in no way indicated acceptance or support of previous apartheid categorisation of persons, nor of its accompanying legislation. The term is used only for clarity.
- * **Peri-menopause** : the time around menopause when menstrual cycles first begin to be irregular; this may or may not be accompanied by other manifestations of menopause.
- * **Menopause** : The cessation of menstruation
- * **Post-menopause** : either having experienced menopause or referring to events that occur after menopause has taken place.

* **Primary Health Care** : In this context Primary health Care refers to the first level of contact of individuals, the family and the community with the national health system; it brings health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.(Strategy for Primary health Care, 1992:2).

1.9. SUMMARY

In this chapter the term "Menopause" was discussed , as were changes in the South African Health Care system that have particular relevance for the nurse. The rationale for the research and the purpose and objectives of the research were described.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1. OVERVIEW

In this chapter the researcher will discuss the research methodology utilised and motivate it's use in the study. Sample selection, reliability and validity will be discussed with specific reference to phenomenological research.

The method of data collection and analysis will be described.

The limitations of the study will be identified.

2.2. PHENOMENOLOGICAL RESEARCH

Nursing finds its true expression in the holistic care, both of people and communities. It seeks to avoid a reductionist approach that has as its focus one aspect or area of a person's life or body, or parcels out solutions to communities while ignoring the context in which people live and work. The discipline of nursing, a relative newcomer to research, has less than a century of research enquiry. It is, therefore, crucial to increase the body of nursing knowledge, which is the foundation for nursing practice. There is an urgent need for new knowledge which will contribute to the holistic approach to care. However, the pursuit of knowledge that is not contextualised in human experience is to pursue knowledge that will be divorced from the realities of

practice (Streubert and Carpenter, 1995:ix). It is for this reason the phenomenological method of research was chosen.

Phenomenology is derived from the Greek word *phenomenon*, which means a thing which appears or is perceived, or "shows itself" (Heidegger, 1962:5, quoted in Morse, 1994:118). The phenomenological method of research seeks to examine "phenomena" or the lived experiences of people in the context of their lives. It is in this sense congruent with nursing philosophy, in that it utilises a holistic approach to the phenomenon under study. Streubert & Carpenter, (1995:31) state that "Phenomenology is a science whose purpose is to describe the particular phenomena, or the appearance of things, as lived experience". Additionally Field and Morse (1985:28) describe the goal of phenomenology as "to describe accurately the experience of the phenomenon under study and not to generate theories or models, nor to develop general explanations".

There are two main schools of phenomenological enquiry, namely Eidetic (Descriptive) and Hermeneutic (Interpretive).

Eidetic Phenomenology seeks "to describe the meaning of the experience from the perspective of those who have had the experience - that is, to describe the meaning of an experience from the worldview of those who have had the experience and as a result now have meaning attached to it" (Morse, 1994:148).

Hermeneutic Phenomenology "rests on the ontological thesis that lived experience is itself essentially an interpretative process" (Morse, 1994:148). The Hermeneutic approach focuses on the interpretations of meaning, which are understood to occur in context (Morse, 1994:148). Both these methods are frequently combined, that is, features of both descriptive and interpretative phenomenology are utilised. This lends depth to the enquiry and is the approach that was utilised in this study.

In summary, the phenomenological method was chosen for the study as the method that would provide the richest and the most descriptive data.

"Phenomenology as a research method is a rigorous, critical, systematic investigation of phenomena." (Streubert & Carpenter, 1995:36). It has clearly defined characteristics and well identified steps in the research process.

2.2.1. Role of the researcher

The phenomenological design requires the personal involvement of the researcher in the data collection. This includes the "researcher as instrument" in the research process. In effect the researcher "becomes the tool for data collection and listens to individual descriptions of quality of life through the interview process (Streubert & Carpenter, 1995:37).

Additionally the researcher must utilise the following processes:-

2.2.2. Bracketing:

The researcher engaged in a phenomenological approach utilises "... discipline and systematic efforts to set aside prejudgements regarding the phenomenon being investigated (known as the Epoch process) in order to launch the study, as far as possible, free of preconceptions, beliefs and knowledge of the phenomenon from prior experience and professional studies - to be completely open, receptive and naive in listening to and hearing research participants describe their experience of the phenomenon being investigated" (Moustakis, 1994:22). Epoch comes from the Greek meaning to pause, stay away or refrain from judgement. This process of identification of any existing knowledge or preconceived ideas held about the phenomenon under study, and the putting aside of such information for the purpose of the research is also known as 'bracketing' and 'reduction' in this context. Once identified, existing

knowledge or bias must be removed from conscious thought or "bracketed" throughout the investigation.

This is to prevent any existing knowledge from interfering with the research process and the identification of pure description of the phenomenon (Streubert & Carpenter, 1995:33). The process must be continuous throughout the investigation.

2.2.3. Intuiting:

" A process of thinking through the data so that a true comprehension or accurate interpretation of what is meant in a particular description is achieved" (Streubert & Carpenter, 1995:316), or "The process of being totally absorbed with the phenomenon under study" (Oiler, 1982:179). This leads to increased awareness of the phenomenon and insight into the data collected, and results in accurate interpretation and description of the phenomenon under investigation (Streubert & Carpenter, 1995:32).

Through this process the researcher begins to understand the phenomenon as described by the participants. It is in this sense that the researcher thus becomes "the instrument" in the interview process. Through immersion in the interview process the researcher acts as the tool for data collection; this process of data collection includes not only the actual interview, but also the collection of observational notes and field notes. Through the process of repeated review of the data the researcher is able to describe the phenomenon under study (Streubert & Carpenter, 1995:37).

2.2.4. Analysing:

Comparing and contrasting descriptions contained in the data about the phenomenon under study - themes and relationships between themes being identified (Spiegelberg, quoted in Brink & Wood, 1989:167). The reiteration of certain themes and ideas by the

respondents are taken as signs of reliability and validity from a qualitative research perspective (Leininger, 1985:57).

" Saturation " occurs when no new themes or ideas are extrapolated from the data and repetition of themes and concepts is apparent (Strauss, 1987:21). Denzin & Lincoln, (1994:230), describe saturation as having occurred when repetition of information already obtained occurs, as well as confirmation of previously collected data.

Phenomenological research seeks to identify people's lived experiences and their thoughts, perceptions and feelings at the time of discussion. Therefore minimal manipulation of the environment is undertaken.

2.3. SAMPLE SELECTION IN PHENOMENOLOGICAL RESEARCH

Theoretical sampling or convenience sampling is used most commonly in phenomenological research. This method of sample selection elects individuals for inclusion in the study based on their knowledge of the particular phenomenon. The ability and willingness to share this knowledge is also an essential criterion in theoretical sampling (Streubert & Carpenter, 1995:43).

Samples in qualitative research are not necessarily identified before the start of the data collection - initial respondents can lead the researcher to others who meet the criteria of selection. This is known as snowball sampling (Miles and Huberman, 1994:27). However, the sampling should be "planned rather than haphazard, while still retaining some degree of flexibility" (Strauss & Corbin,1990:179).

Theoretical sampling is the weakest form of sampling as it entails utilising the most conveniently available persons who meet the criteria. It is however commonly used in research in the disciplines of humanities and social sciences.

There are, however, specifics related to theoretical sampling that must be identified before commencing the research. These are:-

2.3.1. Identification of the study group.

This is related to the main research question: for the purpose of this study it is black nurses in the 45-55 year age group (Vide p.25 for sampling procedure).

2.3.2. The type of data required

Observations, interviews, audio or videotapes, or some in combination.

2.3.3 The length of the study.

A number of people followed over time, or people at differing points in time.(Strauss & Corbin, 1990:179).

There is considerable risk of bias in theoretical sampling. However, phenomenological research neither aims to predict nor to generalise, but seeks only to explore and describe the lived experiences of the respondents. Additionally phenomenological research is less concerned with issues of control, but focuses on "a holistic experience and the individuality of human experience" (Polit & Hungler, 1991:58).

Measures utilised by the researcher to limit any unnecessary bias will be discussed later in the chapter (see p23).

2.4. VALIDITY AND RELIABILITY IN QUALITATIVE RESEARCH.

These terms are not applicable to qualitative research and have been supplanted by alternative terms which demonstrate the rigour of qualitative studies.

Guba's model of Trustworthiness in Qualitative research is used. Guba's model(1981), cited in Krefting (1991:215), is based on four aspects of trustworthiness that are applicable both to quantitative and qualitative research. These are truth-value, applicability, consistency and neutrality.

2.4.1. Truth value/credibility

In quantitative research the truth-value or internal validity may be supported when the research design minimises the confounding variable. In qualitative research the truth-value is usually obtained from the discovery of human experiences as they are lived and perceived by informants (Krefting,1991:215). Lincoln and Guba (1985), cited in Krefting (1991:215), state that in quantitative research internal validity assumes a single reality that can be measured. In qualitative research this assumption becomes one of multiple realities with the researcher expressing these as comprehensively and as accurately as possible.

Truth-value therefore, is not a pre-existing definition, but arises from the study of the human experiences of the respondents. It can also be defined as credibility. Sandenowski (1986). cited in Krefting (1991:216), states that a qualitative research study is credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would also recognise its descriptions. Truth-value is the most important criterion of assessment.

To increase credibility two interviews were undertaken with each respondent. Additionally they were asked to keep a daily diary . This is known as data triangulation. Data triangulation in qualitative research aims to corroborate or validate information by using more than one source of information (Denzin & Lincoln, 1994:214-5).

Member checking was also undertaken, whereby initial interviews were transcribed, analysed and content confirmed with the participants (Brink, 1993:37; Silverman, 1993:156).

Expert validation was also used whereby an expert in the field independently analysed the data (Brink, 1993:37).

2.4.2. Applicability

Applicability refers to the application of the research findings to other contexts and populations, i.e. generalisation.

In phenomenological research each exploration of human experience is different with a unique context and interaction between researcher and respondents. Application or generalisation is therefore not seen as appropriate in qualitative research. Yin (1989) comments that in qualitative research it is more appropriate to focus on generalisation to a theory, rather than on generalisation to a population.

However Guba (1981), cited in Krefting (1991:215), presents an alternate concept of applicability, namely transferability. Research meets this criterion when the findings fit into new contexts outside the study situation that are determined by the degree of similarity between the two contexts. Although this is not the responsibility of the original researcher it is argued that, if she/he submits data adequate to demonstrate comparison, the problem of applicability has been addressed. (Adequate data is also sometimes termed "thick description").

2.4.3. Consistency/Dependability

Consistency (or reliability) is demonstrated in quantitative research by replication of the study (of one reality) in a similar context.

In qualitative research there are multiple realities and the uniqueness of the human situation is fundamental to the study. Thus identical replication is inappropriate. What are sought are variations in human experience rather than identical repetition (Field and Morse, 1985).

2.4.4. Neutrality

Neutrality refers to the degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivations and perspectives (Guba, 1981, cited in Krefting, 1991:216).

In quantitative research this is achieved by rigorous methodology and the objectivity of the researcher which puts distance between the researcher and respondents.

In qualitative studies researchers aims to reduce the distance between respondents and themselves through periods of extended contact. Therefore the emphasis of neutrality is transferred to the data. Lincoln and Guba, 1985 cited in Krefting (1993:217), suggest that "confirmability is the criterion of neutrality [and that] this is achieved when truth-value and applicability are established".

The criteria used to measure the trustworthiness of this study are therefore credibility, transferability, dependability and conformability.

2.4.5. Identification of Problems

Polit et al, (1991:366) state that there are many problems that contribute to errors in data collection. Among the most common are :

2.4.5.1. Situational Contaminants

- the subject is aware of the interviewer's presence (reactivity factor) (Schurink, 1987:15).
- environmental factors-temperature, noise, lighting and other disturbances.

2.4.5.2 Response set bias

- existing personal characteristics of respondents can interfere e.g. social desirability of response, extreme responses and acquiescence.

2.4.5.3. Transient Personal Factors

- Temporary states of the respondent that may influence her responses e.g. hunger, fatigue, anxiety.

2.4.5.4. Administrative variations

- Alterations in the method of data collection from one participant to another. In this research use of unstructured interviews was made: questions and probing were not in any specific order: the interviewer asked for clarification of certain themes as the subjects arose.

2.4.5.5. Instrument Clarity

The use of the unstructured interview can lead to ambiguity on the part of either the researcher or respondent.

2.4.5.6. Instrument Design

The use of the unstructured interview may elicit different responses from the use of a specific interview schedule.

2.4.6. Limitation of problems

To limit the above problems the following precautions were taken:

2.4.6.1. Participant Selection

The selection of unfamiliar respondents: the respondents were previously unknown to the researcher.

2.4.6.2. Bracketing

Vide p 15.

2.4.6.3. Interview technique

The interviewer maintained a neutral and non-judgmental manner: this was achieved by the use of open-ended questions which allowed the respondent to express her own feelings and point of view (Leininger, 1985:57; Langley, 1993:24).

2.4.6.4. Research Supervision

After content analysis transcripts of the interviews were submitted to an independent expert in the field phenomenological research in nursing. Comment was given both on content analysis and on categories and themes extrapolated. Polit et al (1991:383) and Field et al (1985:121) both recommend this "Triangulation" as a means of validating the selection of categories.

2.4.6.5. Interviews

The researcher's use of open-ended questions, clarification and focusing assisted in eliciting the subjective viewpoint of the respondent. Summarising primarily took place toward the end of the interview. This avoided the temptation for the respondent to agree with the summary, rather than continue to describe her experiences (Field et al, 1985:71).

2.4.6.6. Data Triangulation

This refers to the use of multiple data sources, for example multiple informants. It also refers to the use of more than one episode or method of data collection (Crabtree and Miller, 1992:87). In this study an initial in-depth phenomenological interview was undertaken with each respondent, and later a follow-up interview (member checking) was conducted (Brink, 1993:37). Participants were also asked to keep a diary for one month.

2.4.6.7. Convergence

The affirmation by different participants of certain themes or categories during data collection leads to the "convergence" of information. "When this occurs, the researcher knows that validity and reliability in qualitative ways are occurring" (Leininger, 1985:57).

2.4.6.8. Validation in Literature

A literature control was utilised to examine whether categories, themes and concepts extrapolated from the data could be verified by literature. In accordance with recognised methodology in qualitative research this followed data analysis. The rationale for postponing the literature review until after data analysis, is "the

fewer ideas or preconceived notions the researcher has about the phenomenon under investigation, the less likely the researcher will be influenced by his/her bias" (Streubert and Carpenter, 1995:46).

2.5. SAMPLE SELECTION

" Qualitative researchers usually work with small samples of people, nested in context and studied in depth" (Miles and Huberman, 1994:27).

Eight respondents were selected by means of purposeful sampling. The sample chosen met the required profile. The total population for the research was all registered black nurses in the age group 45-55 years of age.

Respondents were selected by means of purposive sampling, i.e. respondents were black registered nurses in the age group 45-55 years, and were competent in English. They were asked to participate in their private capacity as nurses and citizens. They were chosen for their ability to describe their experiences of menopause with regard to feelings, attitudes, emotions, role changes, problems and benefits. Interviews with respondents (two per respondent) were undertaken until no new data was generated.

2.6. PERMISSION FOR RESEARCH.

Permission for the research was sought from the Ethics Committee of the University of the Witwatersrand. (See Appendix 2).

2.7. CONSENT.

Written informed consent was obtained from each of the participants. Included in the consent form were the assurances that the information would be kept confidential and that each interviewee could withdraw from the study at any time. Permission was

also obtained from respondents to audiotape the interviews.(See sample - Appendix 3).

2.8. DATA COLLECTION

Informal, unstructured interviews were utilised in order to minimise researcher influence. Respondents were encouraged by the researcher's use of an unstructured interview format, open-ended questions and minimal verbal response. Where clarification or further explanation was required the researcher probed to elicit further information. Interviews were conducted in private and were audiotaped. Initial interviews were all conducted in the same room in the Department of Nursing Education at the University of the Witwatersrand. Three follow-up interviews also took place in the same venue. The remaining were conducted telephonically. This was because the respondents were no longer students in the above department and the prevailing violence at the time made unsafe for the researcher to visit respondents in their homes.

2.9 FIELD NOTES.

In order to enrich the taped interviews, the researcher made use of field notes: these include observational, personal and theoretical notes (Polit and Hungler, 1991:324). These are defined as follows:-

Observational notes - objective description of events, behaviours and conversations that took place; this included time and place, and also any external distractions that may have occurred. The researcher also noted the respondent's behaviour whilst being interviewed. This included body language and other non-verbal behaviours.

Personal notes - describe the researcher's reactions during the interview.

Theoretical Notes - are interpretive attempts to attach meaning to observations.

2.10. DATA ANALYSIS

2.10.1. Transcription

The audiotaped interviews were transcribed verbatim and field notes added where appropriate. Transcriptions were checked against tapes for accuracy.

2.10.2. Content Analysis for Themes, Patterns and Categories

Transcripts were analysed individually. Significant words, phrases and statements were extrapolated. These were noted for each respondent. Emergent categories, patterns and themes were noted. "Creating categories for coding is the first step of analysis. It is vital to the process of organising the naturally occurring stream of behaviour into manageable units" (Le Compte & Goetz, 1982:39). The scripts were analysed incrementally, utilising the process of constant comparison. This procedure enhances the technique as "...the researcher seeks to develop an understanding that encompasses all instances of the process, or case, under investigation" (Denzin et al, 1994:202).

Once tentative themes and categories had been identified, data was analysed quantitatively to validate the theme or concept. This was done by counting words, phrases and sentences which fitted each theme or category. Sometimes new themes emerged and others were telescoped and data subsumed into single categories. Transcripts were then cross-analysed for similarities and disparities in the developing themes and patterns. The process of refinement was continued until the themes and categories were clearly defined.

2.10.3. Review and Confirmation of Analysis

To establish the truth-value and credibility of the content analysis, unmarked scripts were submitted to an independent expert in the field of phenomenological research in nursing. Also submitted to the external expert was a protocol describing the steps taken in analysis.

A final discussion was arranged with the independent expert where the outcome of her analysis was compared with the results of the researcher.

Decisions as to whether suggestions and changes should be included were taken.

2.11 SUMMARY OF RESEARCH PROCESS

Initially the prospective participants were identified and invited to a short (individual) interview where the researcher introduced herself and explained the purpose of the research study. Participation in the study was requested and an appointment made for the first interview.

These were audiotaped and field notes written up immediately after the interviews. The interview tapes were then transcribed and field notes added where appropriate. A content analysis of the transcribed interviews was undertaken and initial themes and patterns identified. Categories and sub-categories were then organised to include themes and patterns.

Follow-up interviews were completed, with member checking. Only one participant managed to keep a diary and no additional information was obtained through this.

An independent expert studied unmarked transcripts and discussion ensues regarding analysis. After discussion with supervisor, comments were included where deemed appropriate, and the final draft prepared.

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CHAPTER THREE

FINDINGS OF RESEARCH AND DISCUSSION OF RESULTS

3.1. OVERVIEW

This chapter reviews the operationalization of the research and presents the findings. These will be presented with categories extrapolated from the interviews and the sub-categories and themes subsumed under each. Edited excerpts from the interviews will be included in the text to illustrate the delineation of categories. The researcher's observational and theoretical notes will also be included.

3.2 OPERATIONALIZING THE RESEARCH.

3.2.1. Sample

Eight respondents were selected by means of a convenience sample. All were Registered Professional Nurses who met the criteria set out in chapter two of this report. None of the respondents were known to the researcher.

3.2.2. Consent

Written informed consent was obtained from each of the interviewees. (See consent form, Appendix 3).

Participants were assured both of confidentiality, and of the right to withdraw from the study at any time should they wish to do so. This latter eventuality did not however arise. If any adverse reactions to the interview arose participants were to be referred to an independent counsellor.

3.2.3. Interviews

Respondents were interviewed on an individual basis. With one exception the initial interviews were conducted in a private venue in the Department of Nursing Education at the University of the Witwatersrand. Three follow up interviews were done in the same department, while others, because of issues regarding safety, were completed telephonically.

First interviews were audiotaped. Initially, some of the respondents found this distracting but were soon able to ignore the tape recorder. The researcher does not believe the tape recorder affected the overall quality of the interviews.

The researcher attempted to maintain a non-judgmental neutral and objective stance. This was done by "Bracketing" (see chapter 2.2.2) and by asking open-ended questions to facilitate the expression of the respondent's perceptions (Leininger, 1985:57).

Throughout the interview, the researcher assisted the respondent to reflect on statements made by the use of such communication and interviewing skills as reflection... probing...clarification and focusing. This eliminated the researcher prematurely ascribing meaning to the respondents' answers. The researcher did not make use of a formal structure when questioning the respondents. Frequently the respondents dictated the sequence and form of the interview. This approach allowed the respondent to describe her own perceptions and experiences without being

confined to a formal interview schedule, and this consequently elicited rich, complex data. It also meant that respondents were not subject to the same order during interview.

Applicability was confirmed through member checking, confirmation of categories with an expert in the field of nursing research and phenomenology, and by confirmation with literature.

3.2.4. Field Notes.

To enrich the audiotaped recordings of the interviews use was made of field notes. These were written up immediately after the interviews and were then inserted into the text during transcription of the tapes.

Field notes will be indicated where appropriate throughout the text.

3.2.5. Data analysis

The audiotaped interviews were transcribed verbatim. This included all hesitation, repetition and any incorrect use of language. Verbatim excerpts (i.e. including hesitation etc) are included in appendix 4.

Themes were identified, a further content analysis undertaken in order to quantitatively validate emergent themes or concepts. The number of words, phrases or sentences that fitted each theme or category acted as quantitative confirmation. During this analysis additional themes or categories were added where necessary, and others were collapsed where appropriate.

Transcripts were further cross-analysed for similarities and differences regarding the emerging themes and categories. Again some themes were expanded if this was deemed necessary and others collapsed to achieve homogeneity.

Transcripts were submitted to a nurse-expert in qualitative research for confirmation of findings.

3.3. CATEGORIES EXTRAPOLATED FROM THE INTERVIEWS.

Analysis of the data revealed the following categories:

3.3.1. Biological:

- 3.3.1.1 Bodily changes
- 3.3.1.2 Discomfort
- 3.3.1.3 Health Seeking Behaviour

3.3.2. Psychological:

- 3.3.2.1 Cognitive
- 3.3.2.2 Emotive:

3.3.3. Social:

- 3.3.2.1 Relationships
- 3.3.2.2 Status/roles/responsibilities

3.3.4. Existential/Spiritual

3.3.5. Cathartic/Therapeutic effect of interviews.

3.3.1. BIOLOGICAL

3.3.1.1. Bodily changes

- cessation of menses
- reduced libido
- increased weight

Cessation of menses

Without exception all respondents stated they were pleased that their menstruation had ceased with the advent of menopause. All aspects of menstruation were highlighted, from feelings of freedom to a reduced cost for sanitary protection, especially if there was more than one person in the household menstruating.

These diverse aspects of menstruation are illustrated by the following quotes:

Cost:

"...no buying of sanitation, it is cost effective in that way".

" When there are two or three of you menstruating in one household it is very expensive. So even one less is helpful"

Dislike of sanitary pads:

"...I'm quite comfortable, especially as I didn't like the idea of wearing pads and all that".

"I'd be a happy woman- no using of sanitary towels".

"...on my side I hate menstruation, I hate it, I don't like it. So having stopped it helped me a lot. it helped me a lot-you don't need to put in a pad, you are not afraid that one day you are among friends you are uncomfortable".

"...now I don't need a pad"

Cleanliness/freedom:

"..I'm clean, I'm clean".

"...you're dry right through and your panties are clean".

"I am so happy at this stage...I go to Woolworth's and buy nice white panties; I don't like any more black panties - because I used to bleed so much I was putting on these pants; now I am so clean I even walk with confidence".

" ...now a very happy life with no menses - just going to be nice and free".

"You can have your sexual relations at any time".

However, in marked contrast to the statements by all respondents that they were pleased menstruation had ceased, three respondents expressed anxiety that cessation of menses was problematical in terms of their marital relationship. This was particularly related to their cultural context. One actually sought assistance from a traditional healer to bring back her menses. The rationale stated by both these respondents was that after the first wife had experienced menopause it was culturally acceptable for their husbands to take a younger wife. This elicited feelings of fear and anxiety at the thought of being rejected for a younger woman.

"Your man is allowed, and you know, once you get older he must get somebody else who's going to keep him young....there is that feeling that he can go and find somebody else because in his mind he says 'No, this woman is old, I can no longer go with her' ".

" When you are no longer menstruating you are old now: [he] cannot have anything to do with you, so they must have a younger wife who is still menstruating".

"You are afraid, deep down, that he can go away and leave you".

Two respondents stated that once a woman reached menopause it was culturally inappropriate for her to have sexual relations any more anyway.

"We don't go and do sex any more, it is for the young ones...because you are menopausal you don't need a man any more.

"...they [friends] want to know what you are going to do with a man because you are menopausal, you don't need a man now".

Two women experienced post-menopausal bleeding. This elicited dichotomous feelings. There was a marked fear of cancer.

"I had the staining, as if I was menstruating, for about a week. I started thinking...maybe this period [was] a cancer or what".

"I got a brown patch once a month maybe for just a day or two; sometimes it's actually bloody. The other day I was worried so I went to the family planning clinic and I had my first Pap smear ever done".

Set against this fear of pathology was the pleasure of what the return of menstruation might mean in terms of their cultural perspectives and marital relationships.

"...the doctor gave me those Triphasil and then I used to menstruate...then I used to feel good, thinking that oh, I've gone back".

"I felt to myself that...it's becoming you know, part of the woman".

"It made me a little bit happy, yes, [like a young woman again]".

OBSERVATIONAL NOTES

The respondents used explicit body language to demonstrate their relief at the end of menstruation. They used eye contact, smiled and demonstrated their delight at being "clean".

The researcher noted that several respondents demonstrated a "pride" in having reached this stage in their lives by "preening" themselves and sitting more erectly.

However, the researcher also noted that while describing their fears, both of cancer and of marital abandonment, respondents avoided eye contact. Also noted was the observation that whilst talking about the taking of a second wife, respondents appeared anxious and fearful.

THEORETICAL NOTES

In this category it was evident that respondents viewed cessation of menstruation in a positive light and were pleased that the associated problems of menstruation were over.

However, there appears to be a dichotomy in this regard. Also displayed were anxiety regarding marital relationships and fears of cancer. These latter fears were however tempered by the expressed feelings that post-menopausal bleeding could be regarded as the return of young womanhood - a culturally desirable event. Not only does this belief go against respondents' training and knowledge of normal bodily processes, it also contradicts participants statements that they viewed cessation of menses in a positive light. It would appear that cultural beliefs and expectations can override cognitive knowledge.

PERSONAL NOTES

The researcher was concerned that beliefs appeared to override professional knowledge. She felt concern about respondents with post-menopausal bleeding and the need to ensure that those with symptoms should receive adequate medical investigation. This posed an ethical dilemma in that permission from respondents had been obtained to discuss their experiences of menopause but not for any medical advice or interventions.

Reduced libido.

Two of the respondents cited reduced libido as problematical.

"I struggle to get aroused....it takes some time for me to participate...really I cannot respond"

"In Zulu they call it 'you are cold to your husband'"

"I don't like sex much"

This led to deceit on their part in their relationships with their husbands.

"You make pretend to your husband that you really feel good about it...but you cannot show him or tell him because you are afraid he can go away and leave you".

"...he will keep pestering me and doing all those things until I give up and I say let me give it to him so that I can sleep".

Another respondent found there was no change in her libido but she did need an oestrogen cream for comfort.

OBSERVATIONAL NOTES

Respondents were quite open in discussing the dishonesty that had arisen in their relationships with their husbands. The researcher speculated on the long-term effect this would have both on their relationships and also on the self-esteem of those concerned.

Increased weight

Two respondents cited increased weight as a problem that appeared to be associated with menopause. This caused considerable distress and also embarrassment.

"I'm just bothered by weight, I think I've got to control it".

"I don't like this weight...it makes me sometimes uncomfortable...at least if I was (size) 38 or 40 I would feel comfortable with that. But when it's going up to 40 or 42 I am becoming worried with that weight".

Contrasted to this is the attempt to rationalise overweight.

"...it's hereditary - my father was a big man and my aunt was a relative from my father's family, they are huge, they are fat".

3.3.1.2 Discomfort

- Hot Flushes
- Aches and Pains

Hot Flushes

All respondents stated that they experienced at least some degree of hot flushes. Some experienced greater discomfort than others.

Quotes to illustrate this are:

"...sometimes I got these hot flushes...this heat...very, very hot. It was sort of extraordinary...it was very abnormal on my part".

"I'm feeling a hot feeling on the whole body, then I sweat a lot".

"I experienced that something very hot has affected the whole body. I sweat for that period, it lasts for five minutes, I even want to faint. The sweat was running on my face".

"Hot flushes were my problem. I was terribly affected by the hot flushes".

"I am so hot, I want the lightest things. No bra, I can't stand the heat".

"I was sweating profusely and then I was becoming tired".

Some found them more troublesome at different times of the day.

"During the day it was terrible".

"In the morning, especially after washing"

"They kept me awake so much"

Coping strategies

Respondents used a variety of coping strategies to deal with the discomfort of hot flushes.

"At work I have a fan in my office, I just put in and then I feel better".

"The only thing I could do [at work] was to sit next to a window so that

when they come I just open the window".

"If it's raining I go out for a short period".

"Sometimes when I'm in theatre there is a basin of water...I'm always putting my hands in it. And sometimes I feel the need to go away because it's just a short spell".

Coping with hot flushes is easier at home.

"When I have hot flushes I just relax, take off my clothes , maybe go for a shower and the just dress lightly".

"I take off my night-dress and throw it away".

OBSERVATIONAL NOTES

All respondents demonstrated with body language some degree of discomfort associated with hot flushes. Coping methods were adapted to the context of the experience, i.e.what was manageable in the situation respondents found themselves in, with different coping mechanisms used at home and work.

THEORETICAL NOTES

Follow up interviews showed that the initial interview had acted as a catalyst for increased awareness and self-care in this respect. Interviewees began to dress appropriately to stay cool and comfortable, and to recognise the place of exercise in both reducing the incidence and severity of hot flushes.

Aches and pains

Four respondents said they had problems with generalised aches and pains and

with fatigue. There were different attitudes to these discomforts.

"...pains you cannot account for, pains in the legs...I have had problems in my joints".

"I don't think I mind becoming old but I don't want to be feeling pain".

"I have got on and off pains in my knees, I don't know is this old age".

"...my knees are so painful; and my shoulders, it's so painful".

"It's embarrassing when you are with young children and you've got pain. You have to pretend that you didn't be aware of it".

"I am a very, very active person and I don't like sitting down. I was very disappointed".

THEORETICAL NOTES

Respondents, while accepting that aches and pains may be part of ageing, also appeared to feel betrayed by their own bodies which they perceived as having let them down. This was also something to be ashamed of and to hide from others.

3.3.1.3. Health seeking behaviour/medical intervention

"I think you need acceptance more than medical intervention".

Four respondents went to their doctors at this time. One participant went to see her doctor because of excessive bleeding, and she subsequently had a hysterectomy.

"I couldn't take it any more. The bleeding was worse now...he operated on me last April. The operation was successful, I did not have any problems. The doctor told me she just removed the uterus and the ovaries are left in. So I did not get any treatment, hormones or whatever".

Two participants were given some form of Hormone Replacement Therapy for control of hot flushes, but no longer saw the need for this medication.

"When he gave me those tablets it(the hot flushes) started to subside...I took them for three years...then from there just left them".

"They (hot flushes) kept me awake so much I had to see a physician who prescribed for me oestrogen...but I am no longer taking the oestrogen".

One respondent sought information from her doctor who dismissed her fears and symptoms as normal.

"I thought I'd go to my gynaecologist and talk about it...he told me it's normal...these things happen".

This participant went on to say:-

"They think I am psychosomatic, so I said from now on maybe I can try the traditional healer, (she) will listen, maybe she understand what it is".

The remaining participants felt no need to seek any form of medical intervention.

"I'm not sick, I have no need to go to a doctor for this".

"I haven't gone to a doctor, I'm a very active person".

"I don't need any medical intervention...there is no need for it".

"There is nothing that would make me (see a doctor). There is no problem. I have had no problems".

"I am all right-I need nothing expensive...I would advise people to accept it...not to rush for drugs".

"I think you need acceptance more than medical intervention".

OBSERVATIONAL NOTES

Participants who sought medical intervention were quite open about their need for it at the time. The one who sought the help of a traditional healer also discussed this quite openly, whilst maintaining eye contact.

Those who saw no need for any type of intervention were demonstrative in their body language that this was unnecessary, using hand movements to "brush" the idea aside.

THEORETICAL NOTES

The researcher speculates on the fact that while some participants sought medical intervention, none followed through with prescribed medication for any significant length of time.

It is also interesting to note that the participant who sought the help of a traditional healer did so, not for medical assistance, but for someone to listen to her fears and problems.

The respondent who said that understanding was needed rather than medical intervention reiterates this need.

It would appear that overall, participants do not view the menopause as a time of ill health that specifically needs medical intervention, but rather as a normal process that needs understanding and support by others.

3.3.2. PSYCHOLOGICAL

3.3.2.1 Cognitive

Knowledge/Seeking knowledge/ignorance

Participants were unanimous in that there is a great need for information about all aspects of menopause. A lack of knowledge gives rise to fear about menopause.

"...to say OK now menopause, tell you what to expect, what to see, how to go"
 "We don't know. If someone has taught us then we will look forward to that thing".

"Life would be better (with knowledge)...then you would know. Now you just go into the dark".

"If someone had taught us then you would look forward to that thing".

"As far as the whole body's physical changes, what happens inside my body, that bothered me a little bit because I did not know what was going to happen...how it was going to affect my relationships".

"We need knowledge about what will happen at menopause...we don't know what will happen. A lack of information means fear".

"...wanted to speak to someone to find out what was happening".

"It is very difficult ...menopause and those changes...I did not know when they were happening to me that now this is the menopause".

"A person who is not knowledgeable actually feels she is sick, she seeks medical intervention".

"For those who have not been exposed they have that fear of the unknown".

In spite of this great need for knowledge it is usually culturally unacceptable for mothers to discuss such matters with their daughters and also between themselves. Quotes to illustrate this are:

"I don't even discuss that with my mother-we don't discuss that".

"My mother never discussed these things with us".

"In our culture it is taboo to talk about menopause".

"In our culture we are secretive...even if we know something we don't want to part with it...still got the old ideas, but then, it is our culture".

However, whilst talking about menopause is taboo, there was a perceived need for sharing experiences among peers.

"...maybe they share together with us...the one who experiences this. Then together we can balance and share and have knowledge".

"My colleagues... we can share...then maybe we can understand".

"In terms of our menopausal troubles, when they strike they must be shared".

OBSERVATIONAL NOTES

Of note is the manner in which all respondents freely described their lack of knowledge; participants used body language, particularly hand gestures and facial expression to demonstrate the anguish and fear that is generated by ignorance in the face of developmental changes.

THEORETICAL NOTES

The researcher notes with interest that although all participants are professional nurses they do not appear to have the necessary knowledge to cope with menopause on a personal level. Also of interest is that participants shared freely with the researcher, a white professional nurse and academic. It would appear that cultural taboos are not applicable in a nursing professional context.

3.3.2.2. Emotive

Anxiety/fears

Marital abandonment/loss of marital status/cancer

As mentioned in 3.3.1.above there was unanimous relief at the end of menstruation - relief at the release from the tedium of menstruation and the concomitant expense, feelings of being unclean and freedom from the embarrassment. Related to this, in apparent dichotomy, was the perception that post-menopausal bleeding was culturally advantageous in terms of "womanhood" and led to a reduced risk of either marital abandonment or the taking of a second younger wife and a reduction in related

anxiety. This in spite of well articulated fears that post-menopausal bleeding could be indicative of cancer.

"When...bleed after menopause it is not regarded as this could be illness and things like that...feel quite comfortable...think that it is the return of menstruating...that's why some never find out in good time what they have got".

"Being diminished"

Three respondents described how in some cultures there is a perception that to have had one's uterus removed means that one is now somehow less than a woman and it will cause marital problems.

"I had such a fear of the operation...there was a myth that if you have a total hysterectomy your husband is going to run away from you".

"If you have done this operation you are going to have problems".

"People who have got husbands usually feel if uterus is out then you are no more a woman".

"A woman without a uterus is no more a woman".

One participant said that educated men do not have these perceptions.

"Men who are learned, who understand, have actually said it is nothing of the sort. If one part of you has been removed you remain yourself".

THEORETICAL NOTES

It is of interest to note that, although the respondents were educated women, cultural beliefs about hysterectomy diminishing one as a woman were still of importance. This in spite of the overt acknowledgement that education negated such beliefs.

OBSERVATIONAL NOTES

The researcher noted that talking about these aspects and the feelings evoked by them caused participants to become upset and tearful.

PERSONAL NOTES

The researcher mirrored the feelings of the participants when these obviously distressing aspects were discussed and found herself anxious to intervene in a therapeutic and counselling mode.

Body/mind changes

There was marked anxiety by participants regarding deterioration of and a reduction in appearance and functioning of their bodies.

"I am looking to the time when everything will start falling apart"

"One thing I always fear...it's a major disadvantage for a woman to have falling breasts. When all your life you have had breasts nice and full and all of a sudden they fall. It is unavoidable. It is going to come".

"My knees and my shoulders...it's so painful... and then you have to go slowly. I am very, very active and I don't like to be sitting down".

"My body image is changing...pains you cannot account for, pains in the legs, in the areas here; otherwise I have problems with my joints".

"I wish I couldn't be feeling that (the pains); I don't think I mind becoming old, but I don't want to be feeling pain and all that".

A perceived loss of memory is also feared and regarded with anxiety.

"I have noticed I have a high rate of forgetfulness. You know I forget so much...it's so distressing".

"It's a strain telling me don't forget, don't forget, don't forget. Anything that someone tells me I must write it down. I keep on writing down so I don't forget".

"I just had to take it. I couldn't even concentrate".

OBSERVATIONAL NOTES

The researcher observed that while participants were describing anticipated deterioration of both body and mind considerable emotion was demonstrated. In particular verbalisation around the issues of memory lapses and abstraction generated marked distress.

THEORETICAL NOTES

Once again a dichotomy is encountered during this discussion. Although for some getting older is viewed as positive the respondents verbalise their underlying fear and dismay at what is happening to their minds and bodies.

PERSONAL NOTES

Once again the researcher felt the need to demonstrate empathy to the participants and to offer therapeutic intervention.

Emotional Tone

Some degree of variation in emotional tone was a factor for all participants. Without exception participants described irritability as a problem at this time. In particular this affected relations with husbands, children and colleagues.

"Another thing that I've noticed...that someone becomes sort of irritable at times...I don't know if it's my nature or what. But I think there is a connection with the menopause".

"I am irritable, and funny enough I don't know if it is old age or menopause".

"I used to be very patient but nowadays I'm not very patient any more. I don't know if perhaps it's related to menopause".

"When I'm irritable he (my husband) does not like it; sometimes he'll say to me 'you are not like this before'".

"I am irritable"

"When I'm alone I want to correct this behaviour (irritability), but I'm on and off; the next minute I just lose my temper and talk".

When I am stressed I become irritable".

Quotes to describe how their irritability affected their relationships:

"The kids would say `Mama, why are you short tempered? It is not good'".

"...I took his head off...he couldn't stand my irritability, he got fed up too. At times he even went to sleep out".

Coping Strategies.

Different coping mechanisms were used to cope with the irritability.

"I usual(ly) avoid my husband".

"Sometimes when I see this thing (irritability) is going to make me talk I go to my bedroom...I just watch T.V. or else I read my book".

"I just abstain from that thing that is going to make me irritable".

"(I go) away from the environment that is causing me the problem. Yes, that's how I decide to cope with it...I just go to my bedroom, then I feel O.K".

"I just get away from whoever is making me cross".

I have to do something else...I try to maybe visit".

OBSERVATIONAL NOTES

Participants willingly discussed their different coping mechanisms and appeared confident in the ways they had chosen to manage their irritability.

3.3.3. SOCIAL

3.3.3.1 Relationships

With Husbands/partners

Relationships with husbands and partners were varied. As discussed above irritability had significant impact on the relationship for some, but others were supportive.

"I am irritable with him".

"I lie to him (that I am menstruating)...just to be alone".

"...sometimes nothing, nothing happens (sexual response), I just have to continue making my husband think I am enjoying it".

Others were more fortunate.

"(I say to him)...please bear with me. He understands me".

"He can see...that you are really getting old. He understands me with my behaviour".

"Mine was a dear one. One in a million".

The unmarried lady with a partner spoke of "a lover, a friendship, a partnership, someone to share things with".

With children

"I am irritable (with her children)...but you know I just keep quiet, just keep a listening ear".

"I become sore after, to tell the truth, after maybe shouting at my child I become sorry".

"I try to explain to them, maybe I am getting old. And then they go with me, they understand me".

"The kids say 'Mama, why are you short tempered? It is not good'. But I try, you know, to control myself".

"When they see the changes they say 'mummy won't like it' and that's how they manage with it".

After an argument "a knock at my (bedroom) door might be my family, then they bring me a cup of tea or a cold drink or whatever, then it's OK They come and say 'peace' and then we talk".

With friends and colleagues/work

Without exception all participants said they needed the support of friends and colleagues at this time in their lives.

"(My colleagues)...they were understanding".

"Because I am an old lady they understand me".

"I visit my friends...talk, they always understand"

"I have to do something else. I try maybe to visit (friends)".

"I'm always involved...I never stay at home".

"They (my colleagues) were aware, they were actually laughing, say 'it's your

turn now' because they had gone through. It was a sort of joke with everybody - they helped".

Sublimation through work was also viewed as positive.

"My work, I have always liked my work...I think that was another way that used to get me out of the mood was to spend long hours at the office".

"Being a working mother helps me a lot- I've no time for self-pity".

THEORETICAL NOTES

It would appear that while support from, and relationships with partners was variable, all participants tried to maintain good relationships with their children. Also support from friends and colleagues was of vital importance at this time.

3.3.3.2 Status/roles/responsibilities

Positive Aspects

Respondents appeared overall to view menopause and beyond in a positive light. For some this was a time of changing values. This time offered increased status, changing roles and different responsibilities.

Quotes that show changing values are:

"You become older...you see things in a more natural way".

"When you are an older woman you don't have much worry about the things like being rich".

"I realise by being older I have wasted money by buying these things (clothes)".

And to show increased status:

"Yes, in our culture we always respect the elderly".

"The more you grow older the more you are respected. Even at work they respect you more than the time when you were young...sometimes they even call you 'Mama' , meaning old thing, because they respect your age".

"In our culture, yes, they respect the people that are growing old".

"You become important, you are a gran to somebody, a mother-in-law to somebody, you are an aunt. They make you feel special...anything they want to do they involve you".

"The respect that is displayed makes me feel special".

A counselling/advisory role is accepted.

"Trying to advise them...tell (them) what marriage is... you have got to understand your husband".

"If they've got problems with the husband, sometimes I do try to give them advice".

"We should go and teach the young people, especially about sex".

"I'm often teaching them...on menstruation, and the boy as well on his side".

"They ask me questions and I explain everything to them... sometimes when I go to their houses I give them lectures".

Specifically, some participants perceived that they had an educational role amongst their peers regarding menopause.

"It is because you see yourself...able to give advice to other people if you want to, to be realistic and say your feelings to people...the hot flushes or whatever.

The experience is the best that I can say, the experience".

"I believe in teaching each other about the very hot flushes...the sisters I am working (with), she is having the hot flushes. I say 'My child, you must accept it as they come. There is nothing wrong, it is the changes in your body.' And she actually laughs".

"It gives me actually a great deal of pleasure ...I start explaining to them, teaching them exactly...so they must know it is time".

THEORETICAL NOTES

Generally participants viewed the time of menopause as a gateway to increased status both with their peers and within their communities. They felt they had much to offer both in terms of their knowledge and wisdom and also in sharing their experiences.

3.3.4 EXISTENTIAL/SPIRITUAL

In marked contrast to the generally accepted western stereotype of the menopausal woman as 'over the hill' and with little purpose left in life, the participants viewed the advent of menopause as not only a mainly positive event, but also as part of their normal development.

"It's part of my happening".

"To me it is one of those steps I am taking towards old age. I am happy with that because I know I must pass through. I feel so great, I know I am old. I am having another stage, I am comfortable".

"I am approaching the stage of being old now, elderly. It is a good thing because we come in stages. I am glad it has come".

"I am comfortable because I am not going to grow young. I am growing older and actually I am happy".

"It is better to be older...I look for groups my age...and learn more about them...so I have got full acceptance of the very stage (elderly) when it comes. I am learning patience as well because this is my patient time".

"With me it's a passage in my life; I'm beginning now to feel quite comfortable with it".

Acceptance of this time of life eases any difficulties or changes that may occur.

"Women should expect this to come...it is not painful. It is a step in life and they should continue with their life and take it as it comes".

"I must accept every thing as it comes that is preparing myself for the future".

"I am accepting it".

"My child, you must accept it as they come, the changes in your body, accept them".

THEORETICAL NOTES

This theme, of menopause as a significant stage of development, was apparent and clearly identified from the beginning of the data analysis - it is perhaps the overriding theme of the research - that menopause is a time of further development -

a time of integration of the personality to become a more mature and complete person. It is viewed as a time of self-development that leads to integration and acceptance of self as a mature, wiser woman who has much to offer to others.

3.3.5. THERAPEUTIC EFFECTS OF INTERVIEWS

The researcher noted with interest that during follow-up interviews it was apparent that the initial interview had generated moves toward the development of coping mechanisms for managing problems.

Quoted to illustrate this are:

"I'm feeling better now".

"I've learned to work through the irritability".

"I've talked about issues related to menopause; my husband is now very supportive".

"The headaches have now disappeared; the stress is less; my husband is now supportive".

3.4. CONCLUSION

In the next chapter the analysis of the results were subjected to a literature control in order to compare the perceptions of the respondents with those documented in the literature.

CHAPTER FOUR

DISCUSSION AND LITERATURE CONTROL

4.1. OVERVIEW

In this chapter the data analysed will be subjected to a literature control. The researcher will present the categories and themes extrapolated from the interviews with participants and will attempt to validate these with reference to existing literature. The categories tend to overlap and are not exclusive.

In order to expedite the juxtaposition of the information obtained from interviews (in chapter three), with that from the literature, the researcher will present a short precis of this information with each category in the literature control.

4.2. CATEGORIES EXTRAPOLATED WITH LITERATURE CONTROL

For ease of reference these are repeated below.

4.2.1 Biological

4.2.1.1. Bodily Changes

4.2.1.2. Discomfort

4.2.1.3. Health Seeking Behaviour

4.2.2. Psychological

4.2.2.1. Cognitive

4.2.2.2. Emotive

4.2.3. Social

4.2.3.1 Relationships

4.2.3.2 Status/roles/responsibilities

4.2.4. Existential/Spiritual

4.2.5. Therapeutic effect of interviews.

4.2.1 Biologica

4.2.1.1. Bodily Changes.

All eight respondents interviewed revealed that they had definite bodily changes at the time of menopause. It was apparent that whilst some of these were viewed in a positive light (cessation of menses) there was ambivalence about reduced libido and increased weight.

Cessation of Menses

All respondents, including the one who had a hysterectomy, viewed the end of menstruation in a positive light. The concept of freedom was linked to the end of menstruation as was the feeling of cleanliness. The latter was of considerable importance to the respondents as was the aspect of reduced expenditure on sanitary protection.

Datan and Antonovsky, cited in Notman (1990:154) report that while responses to the end of menstruation are shaped by culture and the balance of gains and losses are specific to each culture, she says that "cessation of fertility is welcomed by women in all cultures".

This view is endorsed in a study by Voda and Eliasson, 1983), which determined that the vast majority of women view the cessation of menstruation in a positive light.

Other studies support the concept of freedom that comes with the end of menstruation.

Flint (1975), cited in Flint (1997) did extensive work among the Rajput caste of North India, and discovered that the end of menstruation was in fact viewed as a liberation; the women were no longer subjected to "purdah", which had severely restricted their social activities, but were now free to embark on previously forbidden activities of talking, joking and drinking with the men.

Logothetis, (1993:128), found that most women placed menopause within the context of their menstrual and reproductive lives, and linked menopause to the end of menstruation. The majority of her sample viewed the end of menstruation as a relief from what they regarded as a monthly nuisance. Logothetis thus concludes that her findings support earlier evidence that healthy women express relief rather than regret over the cessation of their periods and that their loss of reproductive capacity is not an important concern to mid-life women.

These views are also reflected in a local study. Omer (1996:102), in her study of working class black and white women in Cape Town, describes how most women agreed "...that no more periods and no more babies were positive aspects of menopause". She comments on the fact that no participants expressed a feeling of loss that they had stopped menstruating.

These findings confirm those of this research yet appear to be at variance with the commonly displayed media images of menopause, where women are portrayed as regretting the inability to bear further children and who fall into depression because of the "empty nest" syndrome. Both the research and the above studies would support the view that rather than lamenting the end of menstruation, healthy women express relief.

Reduced libido

Three out of eight respondents said they had a reduced libido. Interestingly, this appeared to be a problem in those who had difficult relationships with their partners. Studies done in various countries support this view.

Chompootweep, Tankeycon, Yamarat, Poomsuwan & Dusitsin (1993), found that among Thai women the most striking effect of menopause was a dramatic loss of sexual desire.

Downes, (1996:109), says that as women get older their sexual interest is reduced. He also describes the changing nature of the sexual response in menopausal women, with vaginal transudate delayed and reduced, clitoral enlargement less marked, and thinning of the vaginal epithelium all contributing to a less intense orgasm. He also states that other factors are important in determining libido, especially cultural factors.

McCraw, (1991), in an American study, found that 58.8% of his respondents reported a reduced desire for sexual intercourse. He does however go on to say that there were many other associated problems, such as vaginal dryness, dyspareunia and other psycho-social issues. Additionally his sample was taken from women who self-selected in that they sought treatment at a menopausal clinic for already existing menopause problems.

However, four respondents in the research reported no change in sexual desire; moreover these contrasting findings are supported in the literature.

While Osborn (1988) found no apparent **relationship** between sexual function and menopause, Dennerstein, Smith, Morse & Burger (1994:59) found that the majority of women in their study (62.3%), reported no decrease in sexual interest.

However, in those that did report a decline in sexual interest (31.1%) a correlation with cardio-pulmonary symptoms and reduced sexual desire was established.

Greendale, Hogan and Shumaker, (1996:445), found that the majority of their sample of postmenopausal women (64%) were sexually active and reported moderate to high levels of sexual function. They also found that 84% of women in the 45-55 age group acknowledged current sexual intercourse.

Frock and Money,(1992:30) found that post-menopausal ratings of erotosexual ideation, imagery and practices indicated a non-deterioration markedly more often than they did deterioration. They conclude that the presence of androgens in the body maintains erotosexual functioning in post-menopausal women.

These latter findings again appear to be at variance with the common media image of the sexless post-menopausal old crone.

While there are differing findings, both of the researcher and others, it would appear that women of menopausal age should not automatically assume a reduction in sexual desire. Frock and Money, (1992:30), describe that even when anticipation of a reduction in sexual well-being at menopause was anticipated this was not inevitable. However Koster and Garde,(cited in Dennerstein et al 1994), found that a woman's prior anticipation of sexuality at menopause was a significant predictor of decreased sexuality at menopause.

Pierce and Haughton, (1996) state that it is important to clarify the exact features of the complaint, in that it may indeed be a multifactorial issue, with different aspects that need to be addressed. They suggest that aspects such as sexual interest, frequency of sexual activity, vaginal dryness and dyspareunia should not be the only factors investigated. Other issues to include are the quality of the relationship, sexual performance of the partner and individual self-image.

Despite the confusing evidence, it would appear that each individual woman needs to be considered in the context of other factors in her life that may diminish or enhance her sexuality at this time.

Increased weight

Only two of the respondents cited increased weight at this time as problematical.

This limited number of respondents stating that weight gain is a problem is perhaps reflected in the views of Reuben Andres (1985), cited in Doress-Waters and Siegal, (1994:48), who states that there are advantages for women in being a little heavier than previously thought and that gaining a pound a year is apparently healthy.

Jones (1994:43) found that many of the women in her study reported not only weight gain at the time of menopause but also a change in body shape as well. Like the women in this study this was found to be a source of concern.

Logothetis, (1993:126), describes 60% of the women in her study as having some form of menopausal symptoms; weight gain, although cited as a symptom, was not a predominating problem.

4.2.1.2. Discomfort

Hot Flushes

The eight respondents all stated that they experienced hot flushes to some degree. Even those who minimally experienced hot flushes found them to some extent disturbing, while among those who had severe hot flushes one thought she was sick, another "terribly affected", and others found that the hot flushes affected the whole body or that the "wetness lasted for months". Feelings related to hot flushes included disappointment, embarrassment, and expressions of abnormality. Hot flushes, or vasomotor symptoms, are well documented as one of the more common and problematical symptoms of menopause.

Voda, (1981) suggests that hot flushes may begin way in advance of the last menstrual bleed, and may also persist way beyond it. While some studies,(Greendale & Judd,1993; Punyahotra, Dennerstein and Lehert, 1997), indicate the strong association between hot flushes and menopausal status; others ,(Kronenberg (1990; Logothetis, 1993) specify that between 47% and 89% of women experienced hot flashes at menopause.

However, not all women regard them as problematical. Porter, Penny, Russell, Russell & Templeton, (1996), comment upon the fact that while 57% of their respondents reported hot flushes, only 22% defined them as a problem. They did however state that a combination of classic, somatic and psychological symptoms might indeed constitute a considerable problem.

Three of the respondents experienced hot flushes that were severe enough to disturb their sleep. This common effect of hot flushes has been well described in the literature.

Porter et al, in their study of pre, peri and post- menopausal women found that

night sweats and sleep problems occurred in 28-41% of their respondents, depending on their menopausal status and their use of Hormone Replacement Therapy, with a higher incidence of problems reported by those using hormones.

Bono, Neri, Granell, Genazzani & Facchinetti, (1995:120) comment on a positive correlation of headaches, musculo-skeletal pains and insomnia with night sweats, postulating on the relationship between these symptoms and the general level of anxiety.

It would therefore appear that while hot flushes are a common manifestation of menopause, not all women experiencing them regard them as warranting medical intervention. Additionally, these symptoms should be viewed in the relationship to any other physical and/or psychosocial problems that may exist. Women should not just be viewed as having problems with hot flushes; their total life-context should be considered.

Aches and pains

Three respondents identified aches and pains as problematical at the time of menopause. This figure of less than half the respondents appears to be reflected in some of the other studies.

Japanese women suffer from aches and pains at the time of menopause; in particular they have problems with stiff shoulders as part of their menopausal syndrome. However, they have a much lower incidence of hot flushes than reported by respondents in this study (Richters, 1997:76).

Dennerstein, Smith, Morse, Burger, Green, Hopper & Ryan, (1993), found that their respondents reported aches or stiff joints as a problem for between 42.09% and 51.55%, depending on menopausal status, i.e. pre, peri or naturally menopausal. They also identified that backache was a separate issue, with 34-38% describing this as a problem.

Porter et al found significant percentages of their sample reported aching/painful joints as problematical, with the lowest percentage in the pre-menopausal group. Apparently inexplicably, they identified current users of Hormone Replacement Therapy as having the highest incidence of aching and painful joints, while 30% of both peri-menopausal and post menopausal women cited this as problematical. However, they also state in their conclusions that both psychological and somatic symptoms cannot be causally attributed to menopause.

Bono et al (1995:120), describe in their findings that 36.4% of the women in Their study reported suffering from low back pain and/or joint-skeletal pain to a degree sufficient to impair their normal daily activities. They comment on the fact that these women reported the highest levels of stress and used avoiding behaviour as a means of coping. They postulate on the inter-play between these apparent menopausal symptoms and the effectiveness of daily coping mechanisms, and state that in fact an increased level of anxiety could explain all such symptoms.

Fox-Young, Sheehan, O'Connor, Cragg & Del Mar (1995:219), describe "aching bones" as being problematical for some women, but comment that the women themselves, whose experience of menopause was either positive or neutral, questioned the common attribution of such symptoms to menopause. The women stated that stress might be another likely cause for such symptoms.

Jones, (1994 p.56), found that only two of her sample of seventeen menopausal women identified general aches and pains as being associated with menopause, and that these were not necessarily regarded as being a major problem.

One could again reiterate that when working with the menopausal woman the

client should be viewed in relationship to other life situations and events that may accentuate or potentiate health problems. Woods and Mitchell,(1997) stress the importance of the "stressful life pathway" as an influence at this time. Coleman, (1993) emphasises that menopausal complaints should not be trivialised by clinicians. Thus, somatic problems reported by women at this time should not automatically be assumed to be menopause related, for this could lead to some problems not being identified or adequately treated.

Interestingly, some studies suggest that menopausal symptoms are a cultural expectation in some societies. Flint, (1975) cited in Dickson, (1993) describes the differing experiences between American women, of whom approximately two million suffer from severe menopausal symptoms, and Indian women, who have no incapacitation at the time of menopause. This would lend further credence to the view that menopausal women should be viewed in the context of their lives - a context which should include the prevailing socio-cultural beliefs.

4.2.1.3. Health Seeking Behaviour

Two respondents went to a gynaecologist. The first was comfortable with her experience and took her husband with her. The second was offered no understanding or explanation of her symptoms, and her fears were summarily dismissed. This respondent, after the bad experience with her gynaecologist, went to a traditional healer primarily because of her perceived listening skills. Remaining respondents felt no particular need for medical intervention because they said they were in fact not sick.

The dismissal of menopausal issues by medical practitioners is apparently not only a South African problem. Women both in different countries and of differing cultures have found that menopausal concerns are frequently viewed as unimportant by health-care providers.

McVeigh, (1996), in her study of culturally diverse Australian women, identified the dissatisfaction that many felt when their concerns about menopause were trivialised by their medical practitioners.

Habson and Hibbard,(1996), studying in the United Kingdom, comment on the findings of recent research which found that many women are dissatisfied with their interactions with their health-care providers regarding information about menopause and the options for menopause management.

It is not only their interaction with their physicians that women complain about. Logothetis, (1993 p 131) describes women in her research describing their physicians as "...know(jing) less about menopause than about any other part of medicine" and that "...there are far too many paternal physicians who would rather turn to the prescription pad than take time to educate their patients". It would appear that not only is there a lack of knowledge regarding menopause on the part of physicians, there is also a marked disinterest in assisting women to find an appropriate way of menopause management for the individual woman beyond that of prescription drugs.

The research findings are consistent with studies done in other parts of the world.

Diverse studies describe the reasons women seek medical attention at the time of menopause. Morse et al (1994) describe the idiosyncratic nature of the treatment seeking woman at menopause; that despite the widespread advocacy of prophylactic hormone replacement therapy and increased vigilance at this time many women see no need to seek deliberate intervention, again reinforcing the view that menopause itself is not pathological and is not necessarily perceived to need treatment.

There appears to be a significant relationship between the amount of social support a woman had at menopause and her seeking treatment for menopausal complaints (Montero, Riuz & Hernanadez, 1993). This study also recounts that women

who were employed outside the home had less need of treatment for menopausal symptoms. This is reflected in this research sample where all respondents were employed as registered nurses and were also furthering their education.

The particular impetus that lead women to seek medical care at this time appears to be actual physical discomfort.

Fox-Young et al, (1995:217) and Greendale et al (1993) all discuss the identification of physical symptoms associated with menopause as the reason women seek medical intervention.

Groeneveld, Bareman, Barenstein, Dokter, Drogendijk & Hoes,(1993) confirm that women's health-seeking behaviour at menopause is closely related to the identification of physical problems.

These findings also reflect those of the researcher in that the respondents do not view menopause itself as a disease in need of treatment.

Four respondents stated that they were not sick and did not need medical intervention.

This attitude is echoed in George's (1996:273) study of South Indian women who, although they experienced some of the typical physiological problems associated with menopause described in Western literature, none of them saw any need to seek medical attention.

Ferreira & Patel, (1996:14), in their study of Cape Coloured women, comment on the fact that generally "...the women did not regard menopause as a medical condition that required medical treatment" and that "...a large majority of the women accepted that menopause was a natural phase in a woman's life, even

though it brought discomforts, and that a woman should cope with the discomforts with forbearance".

Thus the attitude of the respondents, that menopause itself is not a disease, and consequently does not need treatment per se, is reflected in the literature, in both local and international studies.

It would be pertinent to question why, in the face of a significant amount of evidence to the contrary, the idea of menopause as a deficiency disease requiring treatment appears to be perpetuated in the media?

Interactions with health-care professionals appear to be fraught with problems, and the need for empathy, understanding, as well as the need for information is highlighted.

4.2.2. PSYCHOLOGICAL

4.2.2.1. Cognitive

Knowledge/seeking knowledge/ignorance

All respondents said that there was a great need for women to be informed of what happens at menopause. While two respondents said that it was culturally inappropriate for their mothers to talk to them about menopause, and that menopause itself was generally a taboo subject, they all nevertheless said that accurate information on what happens to women at menopause is crucial to their understanding of and preparation for this time of life. They also said that while they felt a great need for this information, it was in fact not readily available to women.

Bratt, (1993:x), states that "...most women possess little accurate information about menopause because stereotyped menopausal images and biased information about menopausal changes are a widespread and a persistent part of our culture". She also goes on to say that "...many women have few or no discussions with their mothers or older female relatives because of a shared reluctance to discuss this common experience in the lives of women". This reflects the view of the respondents who asserted that discussion of menopause with their mothers was unacceptable. Bratt also comments on the fact that neither the arts nor literature offer any assistance in the understanding of menopause because "... they contain only a few, usually negative images of and reflections upon, menopause".

Fox-Young et al, (1995:217) found that the women in their study thought that the topic(s) of menopause, as well as other pertinent issues, were not widely or freely discussed in the community. Their respondents asserted that lack of reliable, accessible and current information was a problem and they also identified the conflicting nature of the available information as an issue that needed attention.

Standing and Glazer,(1992), describe the paucity of information on menopause available to the public, and comment that most of what is available is in fact provided by pharmaceutical companies and gives a somewhat biased, biomedical view of menopause. They identify the expressed need for information and education related to menopause.

These studies are further confirmed by Chang & Chang, (1996) who describe Taiwanese women's inadequate knowledge of menopause, and by Ferreira & Patel, (1996:27) in a South African study, who describe women in their study as "fairly uninformed about the physiology of menopause and their own bodily changes". They go on to say that " [available] information was often limited", while Graziotti,(1996), affirms the need women have for help with menopausal problems, while commenting on the inadequacy of the information they receive from their doctors to be inadequate.

There appears to be a worldwide phenomenon of a paucity of accurate and reliable information available to women about, and related to, menopause. This confirms the findings of this research. Information that is available is perceived as biomedical in approach, and lacking in understanding for those who are experiencing menopause.

4.2.2.2. Emotive

Anxiety/fears

Marital abandonment/loss of marital status

Of significance was the fear of marital abandonment once the ability to conceive had passed. Respondents said it was culturally acceptable for their husbands to now take a second, younger wife in order to have more children.

Ferreira et al, (1996 p 28), highlight the concern of women regarding self image and retention of femininity. They comment that "The women sought to sustain a feminine role and status, and recognised that they 'faced competition from younger women'". The women in their study "...fought against a notion that change of life is the beginning of the end".

Cancer

Fear of cancer was verbalised by three respondents.
Such fears are not unfounded.

Porcino,(1991:254), states that "Cancer. .is the disease everyone fears most. It is the second greatest killer in the United States". She goes on to say that "Our fear of cancer is often so great that we disregard simple and important preventive measures".

Landau, Cyr & Moulton, (1994:149) report that breast cancer is the second leading cause of death for women with cancer in the United States of America. They go on to say (of breast cancer)"...during the menopausal years...we worry".

Doress-Waters & Siegal, (1994:347), say that..."while it is true that most of us will never get cancer some of us will...we have heard stories of painful, lingering death and of treatments that sound worse than the disease itself...we may worry that we will lose a breast or go bald and be less attractive, less womanly".

Fear of cancer appears to be universal, particularly fear of breast cancer. Breast cancer cannot just be viewed as cancer; it is accompanied by many emotional issues, including concepts of femininity and sexuality. The discovery of "Female" cancers are at best devastating forms of the disease; at worst they result in mutilating surgery and death. These fears and findings were confirmed by the researcher.

"Being diminished"(related to hysterectomy)

Respondents described the fear of being viewed as less than a woman after hysterectomy, and that it is less educated men who tend to adopt this view.

Fox-Young et al, (1995:218), describe the problems women in their sample had with issues such as self image after surgery, with one of their interviewees stating that "I didn't feel like me afterwards". They also described how others struggled with sexuality identification and the consequent inability to have children.

The removal of a body part that is so fundamentally allied to being female, and all that is inherent in this, can be devastating for many women. Many are unaware of

some of the related consequences, such as diminished libido and reduced sexual responses that may occur after hysterectomy. Loss of pleasure from uterine contractions, loss of pleasure from penetration, fewer sexual fantasies, slower arousal and loss of desire to be touched, as well as depression have all been cited as consequences of hysterectomy (Zussman, Zussman, Sunley and Bjorson, 1981, cited in Doress-Waters et al, 1994). These effects of hysterectomy may indeed contribute loss of womanly self-image and may give rise to the cultural beliefs of being perceived as "less than a woman" after hysterectomy.

Body Image

Sorell and Nowak,(1981, cited in Lerner & Rossnagel, (1981) describe how the middle-aged women are considered less attractive than younger women, and this affects the body image of ageing women.

Jones,(1994) describes how women in her sample felt less attractive as they aged, and that they generally viewed physical changes with regret. She goes on to describe the feelings articulated of being less attractive and the expression of deep sadness and loss at bodily changes.

These studies confirm the findings of this study in that women appear to feel betrayed by bodily deterioration, and that this degeneration may affect their feelings of self-esteem.

Cognitive Deterioration

The fear of cognitive deterioration in the form of memory loss was an important issue for three of the respondents. They found the forgetting of things as they performed their daily activities either at home or in the work-place upsetting and disturbing.

Fox-Young et al, (1995), comment on the distress experienced by respondents in

relation to their daily activities and the problem of short term memory loss. They describe that respondents exhibited a fear of Alzheimer's disease and additionally used coping strategies such as writing things down in order to remember.

Levels of difficulty with concentration varied according to menopausal status.

Dennerstein et al, (1993), note the difficulty with concentration that a significant proportion of their sample described, with the range from 18.31% in naturally menopausal women, to 27.5% in peri-menopausal women.

Taechakraichana, Nakornpanom & Lympaphayom,(1997) comment on the fact that forgetfulness was identified as a problem by women in their sample, but that it was more problematical for post-menopausal than for pre- and peri-menopausal women.

Forgetfulness or lack of concentration appears to be a common problem among menopausal women, and this study is in line with other findings. This may cause considerable distress during general activities of daily living, and in the work place. Aids to memory are commonly utilised; the keeping of notes, cited by respondents as a method of coping is apparently a frequently used strategy.

Emotional tone.

For all respondents there was some degree of variation in emotional tone. Without exception they all identified irritability with husbands, children and colleagues, and described how this affected relationships.

Porter et al, (1996:1027), cite the frequency of irritability as a menopausal symptom, with it being described as a problem by 24% of pre and peri –

menopausal women, the lowest incidence in those who have had a natural menopause, and describe the highest incidence among users of hormone replacement therapy.

Sukwatana, Meekhangvan, Tamrongterakul, Tanapat, Asavarait & Boonjitpimon, (1991), in their study of Thai women in Bangkok, comment on the frequency of irritability as a symptom described by women in their study, stating that many perceived emotional lability as a problem.

However, again one should reiterate that at the time of menopause many women may have other demands on their emotions, and cognisance should be made of this when working with menopausal women.

4.2.3. Social

4.2.3.1. Relationships.

With husbands/partners; with children and colleagues

All women in the study discussed the nature of relationships at this time of life. While some experienced difficulty in some areas at this time there was an emphasis on the need for supportive relationships. Those in the study who were currently in relationships, with one exception, commented on the fact that generally, husbands/partners were not viewed as supportive, although friends and colleagues fulfilled this role. (However after follow-up interviews two respondents said their partners were being more supportive).

Standing (1997), cited in Reynolds,(1997) confirms these findings in a study that notes that while respondents tended to view friends, daughters and physicians as supportive, husbands were not. Ferreira and Patel, (1996:19) comment on the fact that

the women had a need for understanding and support from their husbands, but found that in general the women felt their husbands to be "...fairly unsympathetic about their conditions and symptoms, perceivably because men don't understand it". The need for support and understanding at the time of menopause is apparently common, and the lack of these from husbands and partners equally so.

Fox-Young et al (1995), comment on the contributory nature of mood swings to relationship problems with partners. They go on to state that some women felt that their children were less than supportive - they did not demonstrate the anticipated respect or understanding. Alternatively, some women did find their children helpful.

The research findings support these views that while generally husbands were not viewed as supportive and understanding, children sometimes were, and friends and colleagues even more so.

4.2.3.2. Status/roles/responsibilities.

All the respondents in the study commented on their increased status after menopause, as a "wise woman", or in having an educational or counselling role among other women. Also of note was the apparent increased respect afforded to older women giving rise to an increase in status.

In marked contrast to most Westernised societies, many other societies accord older women increased respect and status in the community.

Brown, cited in Richters,(1997:76), describes three different changes ascribed to post-menopausal women, particularly in non-industrialised societies. Firstly, there is the removal of restrictions that apply to younger women and they no longer have to defer to husbands, mothers-in-law or other older persons; secondly the women have control over other women, such as younger family

members and daughters-in-law, and thirdly, following closely on the other two, middle-aged women are accorded age and gender related positions that vary from healers to positions of religious and political status.

In some eastern cultures, including both Thai and Korean, there are advantages in being an older woman.

Punyahotra and Dennerstein,(1997), comment on the changing opportunities for women in education and occupation and that in Thai culture there is increased power that comes with age.

Jones, (1994:61), describes "...a power that I haven't known before...an authority that I never would have dreamed I could speak".

Notman,(1990:151), who contextualises menopause as part of adult development, comments that women's roles are less constricted than in the past, before menopause.

Lee,(1997), in a study of Korean women, describes the differing status of menopausal women as changing from oppression to freedom, from being a good wife and mother to becoming a woman of increased status, and of moving from a life of production life to a life transformed.

Lee, (1997) postulates that these findings offer nurses a unique understanding of the menopausal woman that can not only enhance their appreciation of her, but also contribute to the quality of nursing care offered to older women.

The concept of increased status of post-menopausal women, identified by the researcher, appears not uncommonly in cultures other than the youth-orientated Westernised societies.

4.2.4. Existential/Spiritual.

In marked contrast to the views of menopausal women portrayed in the media, all respondents viewed menopause as a mainly positive event, with an emphasis not only on the liberation from menstruation but also on the increased status obtained. Additionally for many this was viewed as a time of personal development and exploration of "self".

Buck and Gottlieb,(1991), in their study of Mohawk women at midlife, comment on the way these women referred to time as a concept at this stage of their development, and that mid-life and menopause were a time of summing up past and present accomplishments along the developmental continuum. They describe these women as at last having time to spend on themselves, of being comfortable with where they were in terms of development, and of life now having increased meaning for them. They viewed themselves as on a developmental trajectory and valued this personal time to be spent wisely.

Jones, (1994), describes how the women in her sample were creatively reframing this time of life into a positive and constructive light, and that although disturbed by media images of physical and mental decay, were excited about the possibilities that awaited them as older women. They saw new and exciting futures.

Ferreira and Patel,(1996:29) comment on their findings that the change of life was a major event in the women's lives but they were not mourning the loss of youth and fertility; rather that they welcomed it for it gave them a new lease on life: some viewed this as a time of personal growth. They go on to say that "The menopause transition could in fact be a more meaningful life event for these women, if it were not medicalised, but promoted as a process within which they may be able to create new meaning". Finally, they conclude that, for their

respondents, menopause is not seen as the herald of old age, but rather an opportunity for women to confront their future ageing and that the lived experience of women is intrinsic to understanding menopause.

Beyene, (1989), cited in Richters, (1997), comments that Mexican Mayan women regard the post-menopausal years positively; they welcomed this life stage and equated it with being young and free again.

These confirmations of the confident approach by many women to the post-menopausal years are at variance with the negative images of older women not only portrayed by much of the contemporary media, but also exhibited by many of the medical profession. This could be explained in part by the fact that, almost without exception, images of menopause and ageing in the media are based primarily on a biomedical model; this view cannot accommodate a developmental approach to ageing, nor can it find anything of value in learned and lived experience.

The respondents in this research displayed an approach to menopause that, while acknowledging some physical and emotional problems, was rather a time for personal growth and opportunity. Additionally there was an expectation of new roles in families and communities. None of this could be accommodated in the prevailing biomedical model - it would appear that menopausal women have to pioneer a new model of menopause that will harmonise with their experiences.

4.2.5 Therapeutic effect of interviews.

During the second, follow-up interviews respondents volunteered that since initial interview they had a heightened awareness of the menopausal process, they now felt they were coping better and had actively taken steps to cope with some issues. This therapeutic effect of interviews is well known .

Kaplan, Saddock and Grebb, (1994:830), comment on this aspect of

interviewing. "The verbalisation of unexpressed strong emotions may bring considerable relief. The goal of such talking out is not primarily to gain insight into the unconscious dynamic patterns that may be intensifying current responses. Rather, the reduction of inner tension and anxiety may result from the expression of emotion, and its subsequent discussion may lead to insight into a current problem and objectivity in evaluating it".

For some of the respondents, the participation in the research lead to a level of insight that for them that was transforming.

4.3. CONCLUSION

For the women in this study the experience of menopause was far broader than that represented by a purely bio-medical approach. To them menopause had to be viewed in the context of their lives, with cognisance taken of psycho-social issues, that included a very positive approach to the post-menopausal years. Whilst a certain amount of knowledge of the physiological events at this time is helpful in knowing the bodily changes to expect, the failure of the bio-medical model of menopause to encompass the intricacy and resonance of the experiences of these women has encouraged them to create for themselves new meaning that will capture the richness of this rite of passage.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1. OVERVIEW

This chapter summarises the purpose of the study, the research methodology, the findings and literature control, and offers conclusions and recommendations.

5.2. SUMMARY OF PURPOSE OF STUDY.

The purpose of the study was to examine, from a subjective point of view, the experiences and meanings of menopause, by black women, in particular, black nurses. The study aimed to explore beyond the biomedical model of menopause.

5.3. SUMMARY OF RESEARCH METHODOLOGY.

Eight respondents were selected by means of a convenience sample. All were unknown to the researcher and were Registered Professional Nurses.

Written informed consent was obtained from each of the respondents, who were also assured both of confidentiality and of their right to withdraw from the study should they so wish.

Respondents were interviewed individually and, with one exception the interviews took place in the Department of Nursing Education. Three follow-up

interviews were also undertaken there, while the others, for reasons of safety of the researcher, were conducted telephonically. First interviews were audio-taped.

The researcher attempted to maintain a non-judgemental neutral and objective stance. This was done by bracketing and the use of open-ended questions. Throughout the interviews the researcher used communication skills such as reflection, probing, clarification and focusing.

Use of field notes, which were written up immediately after interview, was made to enrich the audio-taped interviews.

The audio-taped interviews were transcribed verbatim, including hesitation, repetition and incorrect use of language. These were individually analysed for content, and emergent themes and categories identified. Further content analysis, using numbers of words, phrases and sentences, quantitatively validated themes and categories. Themes were expanded or collapsed if necessary.

Transcripts were submitted to a nurse expert for confirmation of the findings.

5.4. CATEGORIES EXTRAPOLATED FROM INTERVIEWS

5.4.1. Biological

5.4.1.1. Bodily changes

5.4.1.2. Discomfort

5.4.1.3. Health Seeking Behaviour

5.4.2. Psychological

5.4.2.1. Cognitive

5.4.2.2. Emotive

5.4.3. Social

5.4.3.1. Relationships

5.4.3.2. Status/roles/responsibilities

5.4.4. Existential/spiritual

5.4.5. Therapeutic effect of interviews.

5.5. SUMMARY OF FINDINGS

According to the respondents interviewed, menopause is a stage of normal growth and development in a woman's life.

Participants experienced some bodily changes. There was agreement that the cessation of menses was welcomed; however, this was tempered by the cultural viewpoint that the return of some form of vaginal bleeding could be equated with the return of young womanhood.

Hot flushes were experienced by all respondents to some degree, and were managed in diverse ways.

There was some anxiety regarding bodily deterioration and the advent of aches and pains.

Most respondents felt they had no need for medical intervention, while one respondent sought the help of a traditional healer, primarily for their perceived listening skills.

Participants unanimously agreed that there was a great need for

knowledge and education around the issues of menopause and mid-life.

Fears and anxieties generated were centred mainly around the fears of marital abandonment and body/mind deterioration.

Whilst family relationships appeared to be negatively affected, participants drew support from colleagues and friends.

Social roles and responsibilities resulted in increased status and the according of the role of "Wise Woman" in the community.

There was an explicit existential aspect to the participant's experience of menopause; this time of life was seen as a definite part of their whole experience of 'being' and a part of the developmental process that led to new horizons.

The participation in the first interview appeared to act as catharsis and for some led to the generation of coping mechanisms.

5.6. LIMITATIONS

The limitations of the study are dealt with in detail in Chapter two.

1. In phenomenological research design the sample size is small. Due to this the results of this study cannot be generalised.
2. Due to the unstructured nature of the interview and the subjective viewpoints expressed by the participants the data extrapolated cannot be validated except by the methods already described in chapters two and three.
3. Inability to replicate the study due to the specific nature of the study and the highly specific data extrapolated from the interviews. Each woman's

experience of menopause is unique; this means the study cannot be replicated exactly, and thus affects the reliability of the study.

4. Five of the respondents were unable, because of various commitments, to re-visit the Department of Nursing Education for follow-up interviews. Additionally, due to the high level of political violence at the time of the study, the researcher was unable to do follow-up interviews in participants work-places or places of residence. Thus the remaining follow-up interviews were conducted telephonically.

5. Only one respondent kept a diary as requested. This hindered the recording of the daily experiences of the respondents.

6. Nurses are familiar with the bio-medical model and this may have influenced their responses.

7. The researcher's particular interest in the area of women's health and menopause and extensive readings around the subject area, and current involvement in practice in this field, must undermine even determined attempts to "bracket" the knowledge. Pre-existing knowledge must influence the researcher's viewpoint and consequently bias the research.

5.7. RECOMMENDATIONS.

While the research sample was small, and as already stated the information gained cannot be generalised, there is sufficient evidence from the literature to support the following recommendations.

5.7.1. Educational

5.7.1.1. Student Education.

The researcher recommends that nursing students at a basic level of training, and registered nurses studying towards registration in the field of community health nursing, be urged to acquire an extended knowledge of the issues pertinent to menopausal women; that stereotypes are eliminated and appropriate health care made available to mid-life women. This includes not only theoretical knowledge, but also interpersonal skills that encompass empathy, listening skills and a non-judgemental approach.

5.7.1.2. Lecturer education.

This would entail education of lecturers and tutors in a comprehensive approach to women's health and in particular a focus on the health of mid-life women and menopause.

5.7.1.3. Curriculum design.

A comprehensive approach to women's health and gender issues must be part of any nursing curriculum. In particular the promotion of optimal health for all women through the life-span should be incorporated. This must include, inter-alia, an extended knowledge about the important stages of development and possible health problems that may occur. This must be combined with experiential learning in interpersonal skills and the development of an empathetic approach. To quote one respondent, "We need understanding more than medical intervention".

5.7.1.4. In-service education.

In-service education should be offered to those currently working in situations where they may have menopausal clients.

5.7.2. RESEARCH.

The information extracted from this study cannot be replicated. In view of this the researcher recommends that:

5.7.2.1. A quantitative study of menopause be undertaken to determine, on a larger scale, what manifestations women have of menopause, and to determine what their real requirements are from the health services at this time.

5.7.2.2 To investigate the most informative and most appropriate way to conduct health education for women around the topics of menopause.

5.7.2.3. Quantitative studies.

In view of the fact that the sample number in this study is small, a quantitative study be carried out to validate the categories extrapolated from this study, to form the basis for a questionnaire.

5.8. CONCLUSION

An attempt has been made, to examine, from the client's point of view, the thoughts, feelings and experiences of black women at the time of menopause.

Eight respondents were interviewed twice and the interviews analysed thematically. The categories were submitted to an independent expert for validation.

On the basis of the information extrapolated recommendations for education, practice and research were made.

The researcher is of the opinion that the client's subjective experience of menopause is an essential contribution to the health of women at this time.

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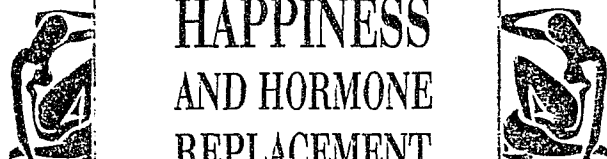
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So a woman
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Why use Progestova instead of ethynloestradiol in the new treatment?

Progestova contains Progestin, a synthetic progesterone, which is a natural hormone. It is a safe and effective way to replace the natural hormone that decreases after menopause.

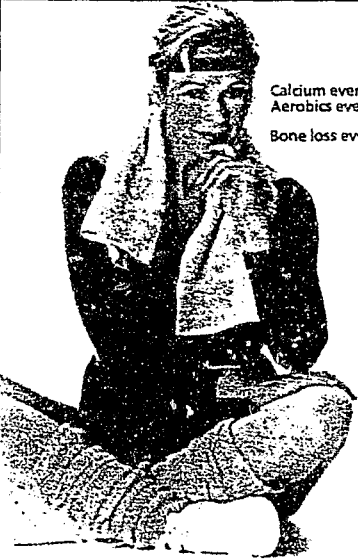
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CONFIDENCE



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50

Modern images of the candidate for hormones from Schering, CIBA-Geigy (above) and Ayerst (below): the woman in the Premarin advertisement looks 30 years old, at most.



Calcium every day
Aerobics every week
Bone loss every year

She needs PREMARIN to help
prevent further bone loss

Calcium and exercise are not enough to prevent bone loss. Premarin helps prevent bone loss by increasing the amount of calcium in the bones. Premarin also helps prevent bone loss by increasing the amount of calcium in the blood.

Early PREMARIN therapy
offers the best protection

The most important time to start taking Premarin is when you first become menopausal. Premarin helps prevent bone loss by increasing the amount of calcium in the bones. Premarin also helps prevent bone loss by increasing the amount of calcium in the blood.

Protection continues as long as
estrogen therapy continues

Recent studies show that women who take Premarin for 10 years or more have a 50% reduction in the risk of osteoporosis.

PREMARIN
(conjugated estrogens tablets)

Proven benefits
for menopause and beyond

Estrogens have been shown to increase the risk of osteoporosis. Premarin helps prevent bone loss by increasing the amount of calcium in the bones. Premarin also helps prevent bone loss by increasing the amount of calcium in the blood.

Division of the Deputy Registrar (Research)

Appendix 2

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)

Ref: R14/49 Chard

CLEARANCE CERTIFICATE

PROTOCOL NUMBER M 950213

PROJECT

A phenomenological study of the experiences of Black nurses through the menopause

INVESTIGATORS

Mrs D Chard

DEPARTMENT

Nursing Education, Johannesburg Hospital

DATE CONSIDERED

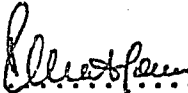
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DECISION OF THE COMMITTEE *

Approved unconditionally

DATE

950302

CHAIRMAN.  (Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

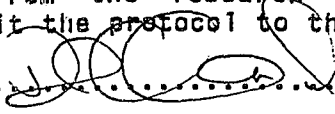
c c Supervisor: Professor B Robertson
Dept of Nursing Education, Johannesburg Hospital

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DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

DATE...14.2.95.....SIGNATURE 

UNIVERSITY OF THE WITWATERSRAND.

I, _____ hereby give my consent to being included in the study being undertaken by Mrs. Diana Chard.

I understand that I will be interviewed by Mrs Chard and I give my permission for the interview/s to be audiotaped. I will also keep a diary for her use.

I have been assured that everything I say and write will be held in confidence between Mrs. Chard and her University supervisors and that my name, place of employment or residence will not be mentioned in any research report.

I undertake this of my own free will and understand that I may withdraw from the study at any time if I choose to do so.

SIGNED: _____

DATE: _____

WITNESS (1) _____

WITNESS (2) _____

APPENDIX NO. 4: EXCERPTS FROM INTERVIEWS

The researcher has selected excerpts from the transcripts of the eight interviews. The examples have been selected to illustrate the findings of the research.

The respondents are designated using the letter R. The researcher by the letter I (Interviewer).

RESPONDENT ONE.

R. One thing I ... noticed which is very ...I noticed..unusual is that I...you know I find er that you know maybe the sex drive.

I. mm mm

R. After I have noticed with me I find that my husband really wants sex and I find that I'm not in the mood and I have to...you know to struggle to you know to er get aroused and maybe...when I think er I always think...oh it's because that have...maybe it's because, maybe some glands or whatever that have maybe, somewhere. So er, what I've noticed, what has happened to me is the sex drive. And it er er.... it really takes some time for me, to you know er to participate. And sometimes my husband will just do it...

I. mm mm.

R. because anyways is that to say this woman, now that I don't know what is happening.... I do my part....I don't...sometimes I don't even feel like it except er so this so what I have observed...for my part...I think it is connected with menopause....

I ...How do you feel about having sex with him when you don't really feel like it?

R. You know, I just feel that maybe it's my obligation. I have to give him sex, because er, if I don't, you know, women know, you make pretend to your husband that you really feel good about it, but deep down you feel, oh I'm not in the mood, but you cannot show him or tell him because you are afraid he can go away and leave you and go somewhere else. So if I'm not in the mood I do allow him and sometimes I tell him I'm not in the mood. I tell him "X, I really don't feel like it". But sometimes he goes on and goes on and sometimes I think it's the whole night I'll be arguing with him. Then I just go and give it to him. Because I feel I must go to sleep, I'm going to work tomorrow, then I must just give it to him.... because if I argue with him it will be one o'clock in the morning.

I. Are you really saying it's easier to have sex with him so that then you can get your good night's sleep than..

R. YES, rather than explaining and saying, Oh X, you must understand I'm not in the mood and he will keep pestering me and doing all those things, until I give up and say let me give into him so that I can sleep. Tomorrow is another day.

I. So does he understand some of the things that happen when you go through menopause?

R. Yes, sometimes he does understand, but other times he doesn't; you know he thinks very.... no he doesn't understand and then there's a problem.

I. mm mm

R. But he does understand, because sometimes when I say no, he does respect. And at times when I say no, he thinks I have some hidden agenda or what. Otherwise, he does. Although men, in our culture, when the woman has the um... menopause, the men will actually tell you, they have to get a younger woman, and you don't have to say no because you know he must get somebody younger than you. It's a tradition that he must get a young.... younger blood than you. But you are fortunate, because our men, sometimes they do understand. But if you are a younger woman, has already been.... no, you don't have to say no, because they just go.

I. So it's accepted practice for the men that once their women reach menopause...

R. mm mm

I. ...to find a young girl.

R. Yes, Yes.

I. Is that as well as...does he stay married to you?

R. Yes, to you.

I. But he still has...

R. Yes, he's still married to you, but he must get a younger wife. Then this younger one that he's got, in fact, they don't even pronounce it that you've got meno...they say it's because you are no longer going to give him kids to dress, so they take a younger one whose going to give this man kids. Now you become the elder one who's going to be the overall who is looking after this young wife of your

husband.

- I. So this is a negative side of getting older?
- R. Yes, I think in our culture, if you get older.... because really your man is allowed, and you know, once you get older he must get somebody else...who's going to keep him young. As you know men, they say, they never get old. But they do, themselves, but they don't know that.
- I. Is there this underlying feeling all the time, as you get older, that when you get to menopause, your husband will then go and find someone else?
- R. Yes, yes, there is this feeling that he can go and find somebody else, because, in his mind's eye he says, "no, this woman is old, I can no longer go with her".

RESPONDENT TWO

- R. I am 45 years old. I started having hot flushes from March, February, March. I can't remember the month, but February March 1994. At first I thought maybe it was too hot or what, but I experienced that something very hot, it affected the whole body. Then I sweat for that period, it last for five minutes. I even wanted to faint. The sweat was running on my face. It stopped five minutes, but for a whole day. But at night it was much better, but during the day it was terrible. So at times I thought maybe it was because of the activities but I could see that I have been doing this for years. Now it's a new thing - it lasted for two weeks. At first I wanted to go and phone the doctor, but I am not sick. I felt my BP is normal; is just this feeling that hotness was what I'm feeling. Then I get the feeling I was so irritable to everybody, but I was trying to control, especially my temper - it went. It was first at home I didn't like sex.
- I. So your feelings changed?

- R. My feelings, yes. I give even my husband a hard time, because I at times, I put a pad in, although my menstruals stopped. So I thought maybe at times I have forgotten is regular but I menstruate this month. I couldn't correlate exactly the time and the date but I missed my period for 4 months; it must be February, March, April, May, then in June I get my periods. It was normal. It went; I checked my dates that it was early days of the month; then the following dates it was the middle, then later than the last one. It went again; it stopped, so I did not have everything; but I did not have the hot flushes thereafter.
- I. How did you cope with the hot flushes?
- R. It was difficult because I'm in a working situation. I used to go to the fan and stay there for a few minutes. But because I am working in theatre, if I was scrubbing or assisting the operation it is very difficult. I used to ask permission from the doctor, "Can I have a break for five minutes?" But next to the operation, it was very difficult.
- I. Then it finished?
- R. I don't even remember if it was last week I didn't menstruate, but I still don't like sex that much, but I am better than that period of having the hot flushes. I am not irritable; maybe again I am trying to control my temper because I have got a teenager in the house. I am trying to make up for her, so that I don't shout at her, I don't do other things to her.
- I. How do you cope when you get really irritable? How do you cope with that?
- R. I usually avoid my husband. I took his head off, so that I can just lie to him that I am menstruating. I went to watch my T.V. - at times I am not even there - I am just thinking on my own, just to be alone. I am trying to cope, to be alone, so I want to change; maybe I become better.

- I So you feel the need to get away from people when you're feeling irritable?
- R Yes, I feel the need to get away from them.
- I You said you wanted to lie to your husband?
- R No, he didn't notice that I'm lying, but he couldn't stand my irritability, he got fed up too. At times he even went to sleep out.
- I It was very difficult for him.
- R . It was very difficult for him. It did affect him.
- I. Has it resolved now.
- R. It has, though I didn't tell him the truth that this has happened, but during the hot flushes he said I must go and see a doctor. I said "no". He said "Then you are going to be irritable. I said, you must go to the doctor", but at the same time he is shouting at me. It did affect him. It did affect our relationship.

RESPONDENT THREE.

- R. When you are an older person, you don't have much worry about the things like being rich. I'm just OK I don't have a costume like Winnie Mandela is using - you know the traditional dress; the very ones that I have got I think are O.K. I realise by being older I have wasted money buying these things, children of today don't wear them.

- I. Do you feel basically that your values change; that material things don't matter? is that what your really saying?
- R. Mm, mm. I think I will try to be an example. Unfortunately I haven't got more time because most of the time I am at work. And when I have the days off I clean the house and then work again...But sometimes, Sundays, weekends, I will be with my friends; we will chat and we will talk. Then sometimes we talk about our lives. And then my neighbours, unfortunately they are all younger than me so I always listen to their problems.
- I. So you have a counselling role?
- R. Ja, and trying to advise them. Men are all the same; you know when people get married, on the wedding day that's how people must talk. They tell you what marriage is. So I tell them you have got to understand your husband and black men are very proud. They don't want to be bossed. And then you tell them because some of the things you will find that you have also experienced, and you have to realise (you get older?)
- I. So you have a very useful role in that respect?
- R. Absolutely.
- I. Right at the beginning when we started talking you said no one had told you about menopause or what's going to happen. Would it have been helpful to you if you knew beforehand what was going to happen to you?
- R. If I had, obviously I would appreciate it and then I would have gone to the doctor to treat it. Like this overactivity; I sometimes say to myself, but am I normal? But there's nothing to stop me. Even at home, it's not just here. Even at home, I'm just working, working; you know, going round and round. Sometimes I feel, well it is menopause, because I don't think it is normal. But if I had somebody who told

me, you know like when I started menstruating; I got that from my mother. That is not an accident, she sit me down and told me everything. So I think the same thing should happen in menopause. You say, OK, now menopause, tell you what to expect, what to see, how to go.

I. So there is a great need for education?

R. Exactly. Because you might find the women - there are a lot of things we've got, whatever, we think it is normal, we don't know. If somebody had taught us, then we will look forward to that thing.

I. So then you can cope?

R. Life would be better. And then you would know, I have got to go and see a doctor or whatever. But now you just get into the dark.

I. If you know things then you know how to cope with them?

R. Exactly.

RESPONDENT FOUR.

I. Have you been to a doctor or anybody else for any help in coping with the sweats or the irritability? Any medicines or whatever?

R. No, I didn't. I am just coping. I am just using my own mechanisms, I did not think it was necessary to go to the doctor. It is for me to make a decision of how I am going to cope with the behaviour I am having.

- I. What do you think helps you cope with the behaviour? Did you know beforehand what was going to happen?
- R. Like when I was going to be irritable or whatever? What do you mean?
- I. Before you came to be having the irritability or hot flushes, did you know beforehand what was going to happen?
- R. I was not aware of it until it happened,
- I. So you didn't know beforehand what was going to happen at menopause?
- R. The menopause, I know it from my studies, but that it would happen to me one day and all that, maybe somehow I can see because I know that it is something like menopause that can happen to me at this stage that I am now, maybe made me feel it is a part of life. I have to be like that one day.
- I. Are there any positive aspect of growing older?
- R. There are advantages and disadvantages of getting old. I have adjusted because I was not like this before and now at times I become irritable and all that. It is part of my happening. In our culture, if I get old one day I have to be a granny and look after my two children and become a baby sitter for them you know. You become important, you are a gran to somebody, you are a mother-in-law to somebody, you are an aunt, you are a mother to children and all those things. They make you feel special.... You know the trust that have in me being their mother that just makes me feel special to them.
- I. So that's positive about being older. Is there any thing else you would like to add?
- R. Ja. At the beginning I had such a fear of the operation that's why I was

procrastinating to do it, because there was that myth that if you have a total hyst your husband is going to run away from you and all of these things. They made me to have that phobia that now I am messing up my marriage if I do this thing even if this man is saying I must go for it. Maybe he does not know and one day he will just turn it against me and then I am alone; and it is not my wish to divorce my husband because of instances that I could maybe have run away from. But it was impossible in my case. I had a problem with bleeding. I just had to do the op, to tell the truth. But otherwise after doing the operation people are saying if you have done this operation you are going to have problems. It's nothing like that, maybe it's psychological, I don't know, but with me my mind is so relaxed.

- I. You said people told you that your husband would run away. Does that happen?
- R. I don't know, it is just a belief, people will just encourage people from not doing things that will be of benefit to their health.
- I. Is it because it is culturally unacceptable to have part of what makes you a woman taken away?
- R. I think it is cultural because this type of myth we carried from our patients. We tell a patient, Mrs so and so doctor wants to do this type of op on you and all that. They say no sister; I am not going to do that, they say that when you have done that operation your husband will run away. You know the type of thing. And I mean we are human beings even you are natural when you have those things we don't just take them for granted. We look into each and say, what does this woman mean? Then I must sit down and try to analyse this, you are on your own and you get your own idea about this thing and how you perceive it. But with me, I did not have any problems, I just had it once and now I am going for it.
- I. May I ask you something very personal and if you don't feel like answering it that's OK. Has the operation or getting older affected your relationship with your husband?

- R. It did not. I am so happy at this stage. I was telling one of my colleagues that you know what, these days I go to Woolworth's and buy nice white panties. I don't like anymore black panties, because I used to bleed so much I was putting on these pants. Because the white ones would stain red with blood. So these days I am a happy woman, no discharge, nothing. I am so clean, I even walk with confidence.
- I. So that's really nice.
- R. Yes, I couldn't even walk around because I was worried that if the stain of blood in my back. Because I was bleeding that blood was running down my legs. It was terrible, so uncomfortable. But today, I am a happy woman.

RESPONDENT FIVE.

- I. You said you'd talk to me about how you feel about menopause.
- R. I have been menstruating normally right until now I could say but at the age of 47 that was in 1991 I started having the hot flushes now during the night, actually was sweating, that bedsheet and the mattress would be nice and wet. And on duty all the underwear would be nice and wet. I feel like removing practically everything. Now first I thought I was sick now, because I am may have professional I have realised it was that of menopause because already I was 47. It went on, it was on and off. Two days, three days, it is nothing. Fourth day, you see it is wetness. It continues for about three months, then it stops for about six months; then I thought all was that I had menopause. That was now in 1991. 1993 it continued, it was worse on duty practically every day. I think it was three full solid months of wetness. It can now cold, it can now hot but you feel like someone is splashing water on you. I live with that and because of the

experience I had from other people who had it before me I was comfortable with it because I knew I was menopausal. I did not see any doctors, I had no menstrual irregularity. I had my full four days right through and it was regular, monthly. 1993, I came to get, I still had those hot flushes but minimal. 1994, which was last year I had nothing, coming back from work. This year, 1995, I have had nothing, but I must admit the relationship is on and off. I can menstruate normally for four days for a month, next two months is nothing, next month is four days again, and I am comfortable with it; I am not on any treatment. I've got no other signs; I've got no problems.

- I. Nothing?

- R. Not at all, no other problems, except the irregularities now but I am comfortable with it, but I know I am definitely going into the full menopausal stage. As I've said I'm going to the fifty ages, so I am getting old.

- I. Are you quite comfortable then with going into menopause?

- R. I am very comfortable that I know it is time. It is here.

- I. How do you feel about being an older woman, being pre-menopausal and going past menopause?

- R. Actually I would be very comfortable if the menstruation would just stop and then I'd be a happy woman, no using of sanitary towels. I'd be a very happy woman. I know it is time, it has come, I must accept it. There is no regretting it.

- I. Are there any advantages, apart from not menstruating, are there any other advantages to being menopausal or post menopausal? That you can think of?

- R. No, those uncomfortable menstruations, I would say minor ailments of being

uncomfortable; that is if you are free from those at least you can lead a normal life. No buying of sanitation, it is cost effective in away. You feel that if you don't menstruate, all of you in the house, at least it is one minus in the house.

- I. It works out quite expensive.
- R. It is expensive. Until then your kids are still menstruating too, so you feel like if you don't do it they do it alone. You now decide to be a granny.
- I. Are there advantages to being a granny?
- R. I think it is advantageous and it's wise to be an older woman with experience, not an empty one. Because they are able to start teaching them and from where they are preparing them for their early childhood as well or for their early womanhood, is how it is. I think it's nicer of course, I've got that grandchildren. I enjoy them when they say granny and I feel good about it.

RESPONDENT SIX

- I. You were going to tell me more about how you feel about menopause. If you've had any changes or thoughts.
- R. I had nothing changed physically. I was fit as a fiddle. Until November.
- I. What happened then?
- R. No menstruation November and the hot flushes came back November and December, they came back. They are there now, but no menstruation for two months. Physically I am all right, I am fit.

- I. How do you feel about the hot flushes coming back?
- R. To me it is one of those steps I am taking towards old age. I am all right. I am happy with that because I know I must pass through, no we are not escape as people. Others don't have anything but I am one who is actually having those hot flushes. I am comfortable. I feel so great I know I am old. I am having another stage. I am comfortable, I know it will come again. I don't need any medical intervention.
- I. When you say the hot flushes have come back, I know you said that sometimes they were a problem when you were in a meeting or something. How do you feel when it happens in a meeting? How do you feel about other people's reactions and how do you feel in yourself when these things happen?
- R. Because is the second phase now of them coming back, I never had any problem I am comfortable with them because I know it must be that. Even if it is a meeting or a morning report I am always comfortable. It comes in, it goes away.
- I. Are you saying you just accept it?
- R. I am accepting it.
- I. You said just now that you're very happy they have happened because now you realise you're going into another phase of life. What does that mean to you, going into another phase of life?
- R. It means I am approaching the stage of being old now, elderly.
- I. And that is a good thing?
- R. It is a good thing because we come in stages. But I am glad it has come.

- I. And being older? How do you feel about being older?
- R. I am comfortable because I am not going to grow young, I am growing old and actually I am happy.
- I. You're happy about being older? Why do you say You're happy at being older; is it better to be older than younger?
- R. It is better to be older, young children never know where they are getting to. That is when you are, mature, that you know where you are getting to, and you know what phases you are in and you know exactly how to approach it. I look for groups of my age, groups of my phase, elderly, try and socialise with those very groups and learn more about them, so that I have got a full acceptance of the very stage, elderly, when it comes. I am learning patience as well, because this is my patient time. I must accept everything as it comes, that's preparing myself for the future. I believe in teaching each other as well.

RESPONDENT SEVEN.

- R. The hot flushes are coming just now, I had them some months back in class I just had to take, I couldn't even concentrate, but they come and go.
- I. When you had those hot flushes in class, what did you do?
- R. I take a blanket, and then I take something but I find my face is flushed and actually sometimes I get quite embarrassed. You know when you are among people and then you just get the need to take out the clothes that you are putting on. And those are the things that I have also had; and another thing I had the staining, as if I was menstruating, for about a week.
- I. Was it like a normal period? or not?

- R. It wasn't, it became dark, very dark as if old blood. But I started thinking that maybe I just be getting an attack, this period, a cancer, or what; but then it just went away. And not feel, like ...I hope to see him, maybe when we are on this one week. I just didn't know what to do.
- I. I know, it's a very difficult period.
- R. And the stress, what another thing I found, maybe I got tremendous stress, you know I actually become, my son says "I am sure Mama, because of your age", at the same time I always think that its maybe the menopause time, because sometimes I just snap about anything. And then the kids would say "Mama, why are you so short tempered, it is not good." But I did try, you know, to control myself. And this year, I haven't taken any? because I was controlling the hot flushes with Triphasil, but not this year I haven't because I haven't any. I think they are helping me to regulate you know, otherwise this stress and this sometimes I become temperamental. you know, especially not to anybody, to the kids, to my boys. They always complain that "Mama, I don't think this is right, so I always think maybe is a lot of work and together with this menopause.
- I. You said the triphasil controls the hot flushes. Does it control the mood variation?
- R. I think it was last year, it was not so very bad, but I think it did control my moods as far as you know, although maybe because I can see this year really I am going mad, bananas. So I am thinking that I must go back and take them again because the doctor has said I must actually use them for the last time. But some people say these things are dangerous. I am not sure how far true is that. Otherwise those are the things. The rest I told you. Sometimes I do respond and at times, nothing, nothing happens; just I have to continue making my husband think that I am enjoying it.
- I. Do you think that's just the menopause or do you think it's general tiredness and the heavy workload that you have.

R. I think it's a combination of this menopause and the workload. I think it's the menopause that's actually contributed to it. But I think maybe some might...you know, maybe it's the scar tissue, because I see why that I don't have the sensation, but my husband is not aware.

I. How does that make you feel?

R. You know, it makes me, you know, I feel bad, it feels I'm just a tool. I'm not living. And I had to think that maybe I know it was wrong to get that period in July. But I felt, you know part of this woman, but I could feel that it was wrong, because you cannot start again, to menstruate after you have stopped for a long time. But it made me a little bit happy.

I. Did it? You felt almost like a young woman again?

R. Yes.

RESPONDENT EIGHT

R. I think people in our culture, what happens in our culture, is that when people get menopausal they feel a bit of maturity, now that they have gone into a stage of adulthood, and they must behave in a particular way and there is more distance being menopausal than being young. So I think that from that point of view, to them it is a state of maturity and people could look forward to them to get advice about this and that.

I. So it's almost they are finally achieving maturity at that time?

R. Yes, at that time it is a sign of maturity, who can make decisions as opposed to the younger women about things. I don't even want to go on and say what they actually do, because I don't fit in the rural areas. I don't even discuss that with my

mother. We never discuss that.

I. If you know I would really like to hear it.

R. What I saying is because my mother never discussed these things with us . But I think what we would like to hear now is what happens. I think in our culture people always tend to show that once they start menopause you don't have to meet a man. That's what we think, but now they are quite elderly, so it is for the young ones. Actually you do find quite a lot of people who are married to do as say how do you enjoy yourself, we say oh, well, now we don't do these things.

I. It's a cultural expectation then that sexual relations come to an end.

R. I think it is a cultural expectation that now you are mature you don't have to do that because in our culture sex is actually for procreation. I remember like, talking of a friend in Durban, she says to me we don't go and do sex any more, it is for the young ones, sex is for the others. The other thing that I always think that if you are menopausal and I talk about having a lover, and if you are not married, and you talk about a lover, it always has sexual connotations, no talk of a friendship and somebody to share things with, it always has a sexual connotation. Because they want to know what are you going to do with a man, because you are menopausal; you don't need a man now you see. Actually, it is a partnership, when you are mature, but now you have got somebody to share with.

I. Would that be part of the reason why a lot of men take a second wife?

R. Yes, it is actually one of the reasons, because I think that when you are no longer menstruating you are old now and you cannot have anything to do with you, so they must have a younger wife who is still menstruating.

I. So the lack of sexual relations only applies to the menopausal woman, and not to an older man?

R. *Not an older man, yes, it would look like that.*

I. How does that affect a menopausal woman when her husband gets a second wife? Do they regard it as a release from having sex, or do they regard it as a loss in their lives?

R. I don't think so. I think we expect it to happen because it is culture; so you know our African culture is not revolutionary; it's backward, so we are inhibited to speak, it has been passed onto generations. So what your grandmother told you about that you expect that when you reach such an age, you are not supposed to meet a man, and things like that, because then you are old, and then he is going to look for a second wife. So it is an expectation, so I think we are psychologically prepared for it when it happens.

I. So it is regarded in a neutral fashion? It's neither good nor bad, it's just what happens.

R. It is expected; it is like waking up in the morning and sleeping at night.

I. So after you're fifty or so, a woman doesn't expect to have a sexual relationship.

R. Yes, that is the culture of our people.

I. *For some it is a relief and for some it's a loss.*

R. Actually it's to prove that women always want to feel that they are young, when they menopause; that is to say when they do bleed after menopause to them it is

not regarded as this could be illness and things like that. They feel quite comfortable because they think that it is the return of menstruating. So to them it becomes quite nice, that's why some of them never find out in good time what they have got.

- I. So the cultural expectations in a way can be damaging to health in the long term?
- R. Yes, because of the expectations because it is suppressed. They think, oh my God I'm feeling young now and they keep quiet and keep on changing their ages to feel comfortable, because it is not painful in any case.

Author Chard D A

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