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***Women's conception of the menopausal transition –
- a qualitative study***

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Abstract

Aim: To explore, with a qualitative approach, whether the conception of menopause varies between women seeking medical advice due to climacteric symptoms and, if so, to describe these different conceptions.

Background: For many women, the menopausal transition is a troublesome period of life, often associated with decreased well-being and a number of symptoms. Besides the hormonal changes, many other factors such as psychological, sociological and lifestyle factors affect how women perceive their menopause.

Method: Semi-structured interviews were held with 20 women after their first-time visits at outpatient clinics of gynaecology for discussion of climacteric symptoms. The interviews were audio-taped, transcribed and analysed using a phenomenographic approach.

Results: A wide variation of conceptions was revealed. Two main categories were identified including different physical changes with varying symptoms and both positive and negative psychological changes. The menopausal transition was also described as a natural process and as a developmental phase of life.

Conclusion and relevance to clinical practice: Women's conceptions of the menopausal transition were individual and contained both physical and psychological symptoms but also expressed a more holistic view of the menopausal transition. The transition was described as a natural process affected by endocrine and life-style factors as well as by the psychosocial situation and by aging *per se*. It is important that health care providers are aware of women's conceptions about the menopausal transition to be able to communicate optimally, support and empower middle-aged women in different health care situations and thereby optimise the result of care.

Keywords: Phenomenography, conceptions, menopausal transition, qualitative study, nurses, nursing.

Introduction

Worldwide, women's life expectancy is increasing together with the number of years women live after menopause and the number of women who experience menopause. The years around menopause constitute a period of life that is affected by hormonal, physiological as well as psychological and social changes (Mc Kinlay *et al.* 1992). A review identified three different ways to look at the menopausal transition (Olazábal *et al.* 1999). One is the biological/medical model looking at the climacteric as a deficiency state, a kind of disease needing life-long substitution treatment. The psychosocial model looks at the menopausal transition as a natural part of development, which should not be treated by medication such as oestrogens (Olazábal *et al.* 1999). This model can lead to personal development with new knowledge and self-esteem, but in women with severe climacteric symptoms this model may lead to a conflict and a feeling of failure and loss of self-esteem. The third model, the holistic perspective, describes the menopausal transition as a multidimensional process, which could vary between women due to a number of factors including her experiences and expectations. This perspective, adapted to the individual woman and her needs, could stimulate self-control and lead to empowerment (Olazábal *et al.* 1999).

In Western societies, up to 75% of the women experience vasomotor symptoms (hot flushes and sweating) around menopause. Vasomotor symptoms, as well as symptoms of urogenital atrophy, are the only symptoms that have been closely related to hormonal changes around menopause (Hammar *et al.* 1984; Mc Kinlay *et al.* 1992). It has been suggested that a number of other symptoms such as mood disturbances, palpitations and weight changes are related to hormonal changes around menopause (Collins & Landgren 1995)

Oestrogen substitution therapy, usually combined with progestagens, hormone replacement therapy, (HRT), is a well-documented therapy for vasomotor symptoms (McLennan *et al.* 2001). The use of HRT has increased rapidly, and, in Sweden, only 7 % of women used HRT in the early 1980s (Hammar *et al.* 1984) compared with nearly 50 % around 1998 (Ekblad *et al.* 2002). Oestrogens alleviate urogenital symptoms and prevent osteoporosis and fractures and may decrease the risk of colon cancer and Alzheimers disease (Birkhäuser, 2000). Oestrogens, however, increase the risk of thromboembolic disease and, especially in combination with progestagens, may cause breast tenderness, unwanted vaginal bleedings and, sometimes, depressed mood. Long-term therapy has been associated with increased risk of breast cancer (Writing Group for the WHI investigators 2002; Writing Group for the Million Women Study 2003). Epidemiological data collected over more than a decade have indicated that HRT prevents cardiovascular disease (e.g. Barrett-Connor & Bush 1991; Ettinger *et al.* 1996), but recent prospective, placebo-controlled studies have been unable to confirm these cardiovascular advantages in primary (Writing Group for the WHI investigators, 2002) and secondary (Herrington *et al.* 2002) preventive trials. Data from these studies even showed an increased risk of cardiovascular events during the first years after initiation of HRT. Also, preventive effects on Alzheimer's disease and cognition have been questioned (Shumaker *et al.* 2003). These conflicting and sometimes contradictory findings on risks and benefits from use and non-use of HRT probably make it difficult for many women to decide about their personal use of HRT. Many women turn to alternative, non-hormonal therapies, which are usually far less well documented (Stadberg *et al.* 1997; Kronenberg & Fugh-Berman 2002). Many women refrain from therapy because of fear and misconceptions (Stadberg *et al.* 1997).

It has been reported that womens' conceptions of the menopausal transition vary in relation to menopausal status and the symptoms they have experienced associated with this period of life. A Swedish study (Ejeby *et al.* 1997) showed that there was a large discrepancy between

women's attitudes and those of their doctors towards the menopausal transition. For example, almost 90% of the doctors (n=32) thought that women after menopause experience a feeling of loss whereas only 30% of the women (n=59) actually reported such feelings. Instead, half of the women reported a feeling of relief, something believed by only 27% of their doctors.

Consequently, to meet the needs of menopausal women, it is important that the nurses and physicians counselling these women in everyday practice have evidence-based knowledge of the menopause. They should also be able, and have time, to inform the women in a skilful, objective and balanced way and be aware of the conflicts and ambivalence probably associated with the women's decision about HRT. Women's interpretation of information is always affected by their own knowledge, experience, expectations and attitudes. It is thus important to learn more about a woman's conception of her menopausal transition, to be able to give information and support in an understandable way and to respond to the questions asked by the individual woman. There are a number of quantitative studies on menopause from Scandinavia but fewer qualitative. We therefore wanted to study the conceptions in Swedish women set against available data from Europe, North America and Asia. Research on the menopausal transition from a holistic point of view should be undertaken both at the quantitative and qualitative levels and should be multidisciplinary (Olazábal *et al.* 1999). Studies using a qualitative approach should provide greater insight and understanding of what menopause means to women and how different women conceive the menopause.

The research study

Aim

The aim of this study was to explore, with a qualitative approach, whether the conceptions of the menopausal transition vary between women seeking medical advice due to climacteric symptoms and, if this is the case, to describe these different conceptions.

Informants

Twenty-six women who had a scheduled consultation for a first-time visit to discuss climacteric symptoms and HRT were consecutively invited to participate. We estimated that this sample size, as well as using three outpatient clinics would be sufficient to be comprehensive enough in both breadth and depth to support the variations of conceptions of menopause, since the aim of the study was conceptual rather than numerical (Giancomini & Cook 2000). When the women contacted their outpatient clinic of gynaecology, they were invited by the nurse at the outpatient clinic and informed both orally and by letter about the purpose of the study using audiotape-recorded interviews. The criteria for participation were strategically formulated to ensure breadth of the selection of menopausal ages. The women should have climacteric symptoms, be non-users of HRT, be of varying ages, understand and speak Swedish and give their informed consent. No other inclusion or exclusion criteria were used. Four women could not participate because of scheduling problems and one woman refused to participate. One of the interviews could not be analysed due to technical problems. This meant that 20 interviews remained to be analysed. The interviews took place after women had met the gynaecologist. The 20 women saw five different gynaecologists, two at an outpatient university clinic of gynaecology and the three others at two different community-based clinics.

Method

A phenomenographic method (Marton, 1981) was used to determine the qualitative variations of women's conceptions of menopause. The method is empirical and searches for qualitatively different ways people experience phenomena in the lived world. Fundamental to phenomenography is how something is perceived to be, that is, a way of experiencing something. This means that there is a distinction between the first-order perspective that deals with the reality as it is observed from the outside and the second-order perspective that is

concerned with how an individual perceives something, or how something appears to him or her. Phenomenography describes conceptions using the second-order perspective. Marton (1981) argues that a conception is something that a person is not always aware of, has not always expressed or consciously thought of, as it has not previously been the subject of reflection. When the issue is brought to the surface, e.g. during an interview, subconscious conceptions often become conscious and may be expressed. The conceptions constitute the framework on which the argument is built.

Data collection

In a qualitative study using interviews, the interviewer constitutes the scientific tool.

According to Kvale (1994) a good interviewer is a person with good knowledge in the field and with skills and experience from interpersonal communication. The semi-structured interviews were performed in a quiet room at the outpatient clinic. A nurse experienced in menopause medicine did all the interviews.

An interview guide with open-ended questions was used throughout the interviews to minimize the influence of the interviewer in answers given. e.g. 'What does the climacteric period mean to you?' Additional questions used included 'Which symptoms related to menopause did or do you experience during this period?' and 'Can you describe how these symptoms affect you?' A number of questions, adjusted to the women's responses, were added and followed a similar structure. Three pilot interviews were performed with women who met the inclusion criteria, in order to test the questions in relation to the aim of the study. Since the questions seemed to be understandable and relevant, no changes were made. None of the pilot interviews were included in the study. The interviews, each 30-60 minutes long, were audio-taped and transcribed in a broad transcription format including every spoken

word, but also capturing pauses and listener support. Two investigators then validated the transcriptions independently.

Data analysis

The analyses were performed based on the phenomenographic procedure, which consists of seven steps (Dahlgren and Fallsberg, 1991):

1. *Familiarisation*: Each transcribed interview text was read through and the tape-recording listened to several times in order to understand the meaning of the content and gain a sense of the whole.
2. *Condensation*: The most significant statements made by the women were selected to give a short and representative version of women's conceptions of menopause.
3. *Comparison*: Significant statements from all interviews were compared to identify differences and similarities between them in relation to the study aim.
4. *Grouping*: Statements, which seemed to have similarities, were grouped together into categories. Each quotation was provided with a code to make it possible to track it during further analyses.
5. *Articulating*: The essence of each group was described in a preliminary category.
6. *Labelling*: Each category was assigned a suitable name to express the essence of the understanding.
7. *Contrasting*: The categories obtained were compared with regard to similarities and differences in order to avoid overlapping. Quotations were used to illustrate the statements.

Accuracy in a qualitative study can be ensured by letting two of the authors analyse the results independently (Fridlund, 1998). Accordingly, the 'grouping', 'articulating' and 'labelling' steps were performed by two of the authors separately and the results were then compared. After an initial analysis it was found that significant overlapping occurred, i.e. that suggested

categories could not discriminate conceptions. Further analyses were performed, until we found no overlapping and good agreement between the two separate categorizations. A third author with knowledge and experience from the area evaluated the suggested categories and subcategories and found them to be reasonable and relevant. The data program QSR NUD*IST VIVO® (version 1.3. 146, Qualitative Solutions & Research Pty. Ltd) was used for analysis.

Ethics

The study was approved by the local ethical committee at the Faculty of Health Sciences, University of Linköping, and all participants gave their informed consent. Participation was voluntary, an informant could withdraw from the study at any time and anonymity was guaranteed.

Results

The women were between 44-59 years of age (mean 52 years). Demographic data are summarized in Table 1. All women were Swedish except one woman born in Asia. The menopausal status among the women studied varied. Six women were postmenopausal (more than 12 months since last bleeding), four women were perimenopausal (between 6-12 months since last bleeding), seven women had irregular bleedings during the last six months (premenopausal) and four women were hysterectomized. The most common reason why women asked for medical advice and for an appointment was hot flushes and sweating reported by 16 out of 20 women. Sleep disturbances ($n = 6$), mood disturbances ($n = 6$), palpitations ($n = 4$), pain in joints and muscles ($n = 3$), headache ($n = 2$) and urogenital symptoms ($n = 1$) were also reasons why women sought medical advice. Only one woman had no symptoms and wanted primarily to discuss prevention of osteoporosis.

Table 1. Demographic characteristics of the women (n=20)

Age group	No in age group	Civil status		Employment	
		Single	Married/cohabiting	Working	Retired/sick listed
< 45	1	1	0	1	0
45-50	9	1	8	8	1
51-55	6	1	5	6	0
56-60	4	0	4	4	0
Total	20	3	17	19	1

The different conceptions of the menopausal transition that appeared could be broadly grouped into two main categories, including mainly physiological or psychological alterations, respectively. The 20 women presented a total of 103 conceptions about the menopause transition. By the analysis these conceptions could be put into seven subcategories and the subcategories into two main categories (Table 2). This meant that, on average, each woman presented about five different conceptions, which could be grouped into one or both of the main categories for each woman. Most women actually presented conceptions representing both physical and psychological alterations but with different emphasis.

Table 2. Categories of women's conceptions of the menopausal transition.

Main category	Subcategory
The menopausal transition as a physical alteration	Hormonal changes
	Cessation of menstruation
	Fertility disappears
	Symptoms due to decreased oestrogen production
	Physical changes related to ageing
The menopausal transition as a psychological alteration	Emotional changes
	A new phase of life

The menopausal transition as a physical alteration consisted of five subcategories and the psychological alteration category consisted of two subcategories (Table 2). The subcategories represent the presentation of the variation in women's unique conceptions. Quotations from the interviews have been used to describe the results.

The menopausal transition as a physical alteration

This category was based on the conception that the menopausal transition consists of mainly physical change. The women considered some of the changes to be related to the lower production of oestrogens, the cessation of menses and the childbearing period, whereas other changes were related to ageing.

Hormonal changes. Common beliefs were that the menopausal transition was a result of the hormonal changes. Most women were aware of the drop in oestrogen production around menopause, but some women thought that the menopausal transition was caused by a changed interaction between several hormones.

'But it has something to do with hormones. That they decrease or stop altogether. A change. ;Informant 7'

Cessation of menstruation. For most of the women, the cessation of menstruation seemed to be a strong marker of the menopause transition. Several women had positive feelings related to the cessation of menses. These women usually had a history of troublesome menstruation with heavy bleeding or menstrual cramp. One of the women had negative associations related to the cessation of menstruation because she thought that having menses was a sign of youth.

'It's nice being rid of one's period. Yes, it's really nice, that's almost the most positive thing about it; Informant 17'

Fertility disappears. Several women emphasised the relation between the menopause transition and loss of fertility. For some of these women, it was a natural phase of development in life when a woman is no longer able to become pregnant, give birth or raise children. One woman said that her sex life was better when she did not have to worry about pregnancy and another woman said sex was better because she did not have to bother about birth control. Other women seemed only, in a neutral way, to realise that the fertile period had ceased.

'Well, it has to do with fertility, that you can't get pregnant anymore and have children; Informant 5'

Symptoms due to decreased oestrogen production. Most women in the study had more or less severe physical symptoms, which they related to decreased production of oestrogens. These symptoms were usually the typical climacteric symptoms such as hot flushes and sweating, but also sleep disturbances, urogenital dryness and palpitations.

'Yes, it is... the hot flushes and sweating, and yes, the vaginal dryness; Informant 3'

Bodily changes related to ageing. Many women had noticed physical changes, which they interpreted as being associated with normal ageing. These included joint stiffness, general pain in the body and less physical capacity, which limited their professional and leisure time activities. A number of the women associated wrinkles, grey hair and rolls of fat with becoming middle-aged. Some women regarded these changes as natural and possible to accept, whereas others regarded them as troublesome and frightening.

' Well, for me it's always something getting weaker in my body; Informant 10'

' And then I guess it's sad to be getting...when you look at yourself in the mirror and you see that the years are leaving their mark. Both in your face and when you start getting dimples on your thighs. It's physical decay; Informant 8'

The menopause transition as a psychological alteration

This category consists of conceptions of emotional changes and development leading to a new phase of life.

Emotional changes. Some women reported that the menopausal transition was affected by emotional changes, mainly increased emotional instability and feelings of sadness. One of the women was depressed. On the other hand, one woman felt that the menopausal transition had made her braver and given her greater self-confidence.

'I feel I'm emotionally unstable, more unstable. I'm more sensitive; Informant 19'

'And mentally as well, you change your way of thinking and temperament and that part too.

You become a little bit different person in some way, you change, yes; Informant 9'

'In a way, maybe there's something a bit positive about anyway... a bit braver, you dare put your foot down more at work; Informant 8'

A new phase of life. In this category, women described their changing situation and role as mother and family member, with the children growing up, becoming independent and leaving home. Some women experienced these changes as positive, associated with relief and having more time for themselves, their husbands, etc., whereas others expressed feelings of emptiness. Aspects of old age and being the eldest in the family were also described both as positive and negative. Some women were worried about ageing and deteriorating health. It was evident that some women had been preoccupied by worries about ageing and entering a new phase of life whereas others merely regarded ageing as a natural process not to worry about. The conceptions in this category seemed to vary according to cultural differences.

'But quite suddenly you start thinking about, your parents are getting old and soon I'll be eldest. I think about a lot of things. I think... well, it's hard to take in. At the same time, it does

feel a bit nice. It's a nice feeling knowing that the children will soon be grown up. I'm looking forward to spending some time with my husband then; Informant 19'

'I'm an Oriental and I get strength from being married in the Chinese culture where old age is considered to be a valuable period in one's life. So now, for the first time, I'm getting confirmation of how valuable I really am in conversations with my husband; Informant 10'

Discussion

This qualitative study in a Swedish setting showed that women seeking medical advice due to climacteric symptoms held a wide variety of conceptions related to the menopause transition, based on psychological as well as physical aspects of this phase of life. It should be emphasized that the objective of a qualitative study based on phenomenographic methods is not to establish the prevalence of a number of conceptions or to arrange these conceptions in order of magnitude. The objective here was instead to identify different conceptions and to try to identify their underlying thoughts in order to be better prepared to counsel individual women seeking health advice.

The sample size may be a limitation of the study. If more women had been interviewed, a larger range of categories would possibly have emerged, but with more data there is a risk that the analyses become superficial (Giacomini & Cook 2000, Mårtensson *et al.* 1997). The corpus of data of this study consisted of 243 pages of written text. We consider this amount of data sufficient to permit us to suggest different conceptions of the menopause transition.

Women's conceptions differed and no single dominating view could be identified. Probably, the informants' different experiences, expectations and knowledge about menopause cause this variation. This assumption is in accordance with previous studies, which have shown that women regard the menopausal transition as a multifaceted process and that a number of factors influence women's aspects on and experiences of the menopausal transition (Du Chen

et al. 1998; Fugate Woods *et al.* 1998; Jones 1997). Most women actually expressed a combined biological and psychosocial view on the menopausal transition, which according to the model suggested by Olazábal *et al.* (1999) would place their views in the holistic, bio psychosocial model. This model conceives the menopausal transition as a complex, multifaceted process that responds to the interaction of different bio psychosocial factors, that lead to varying degrees of changes and subsequent adaptations (Olazábal *et al.* 1999). For many women, the cessation of menstruation was of central importance and often associated with positive feelings (subcategory: Cessation of menstruation). One woman, however, had negative associations since monthly bleedings had made her feel young, which, in turn, was of great importance for her. The fact that loss of menstrual bleeding could be negative for certain women is important to be aware of when discussing different HRT regimens, which could either lead to or avoid bleeding. George (2002) reported that most women were relieved by loss of menstruation, but that one woman expressed that loss of menstruation and fertility made life meaningless. With increasing globalisation, insight into different cultural perspectives on menopause is becoming increasingly essential. In many non-western societies loss of menstruation seems to be central, making women more accepted and more involved in society. As a result, women gain higher status and more freedom (Avis, 1996). One of the women in our study, with an Oriental background, had a very positive attitude towards the menopausal transition because in her country, older women were more respected and valued than younger women both in the family and in society. It would have been advantageous had more women from other cultures been interviewed in the present study.

Physical, age-related changes seemed to significantly affect women's views on the menopausal transition (subcategory: Physical changes related to ageing). Their reports about ageing were often given in a negative way when they described symptoms and changing

appearance related to aging. Others looked at ageing as a natural part of life, which should be accepted, and not to worry about. Jones (1997) also found that women looked upon their symptoms related to the menopause both as consequences of hormonal changes and as a part of natural ageing. Making use of experience of life and maturity gained around midlife creates better circumstances for an aging process with high quality (Busch *et al.* 2003), rather than placing too much emphasis on physical abilities, which decrease with ageing. Consequently, it seems important to discuss both experience and maturity together with endocrine and age-related physical and cognitive changes related to midlife, when counselling women around the menopause.

Women reported positive as well as negative psychological changes related to the menopause (subcategory: Emotional changes). Emotional changes such as increased emotional instability and depressed moods were negative examples. One woman, on the other hand, reported that her self-confidence had increased since menopause, something that has been found in other studies (Jones, 1997). Women in our study described the menopausal transition as a new phase of life with adult children, ageing parents but often more time for their own activities and a professional career. This is in line with findings in other studies, e.g. George (2002) who reported that many women looked at the menopausal transition as the end of one period of life but the beginning of something new. Thus, the menopausal transition could be viewed as one of many transitions in life, with the potential to affect well-being in different directions (Ballard *et al.* 2001, Berterö 2003). It should be emphasized that there is no definite association between menopause and clinical depression and HRT has not been shown to be effective in the treatment of depression (Avis *et al.* 1994). Although most women sought medical advice in order to discuss typical climacteric symptoms, many of them expressed the view that the menopausal transition is a natural process and a part of ageing as such. Nevertheless, these women were interested in discussing and trying HRT and actually all of

them were willing to consider, and were prescribed, HRT after their very first visit to the gynaecologist. This is an example of an agenda driven strategy often seen in counselling situations, meaning that, irrespective of what is taken up by the patient in the specific encounter, there is a strong tendency to move from patients' symptoms to the doctor's agenda of the counselling (Hoffmann *et al.* 2005), all women received HRT. This also shows that symptom intensity and how it affects everyday life could counteract the opinion that the climacteric period is a natural phase of life and persuade women to seek medical advice. Our findings show that every woman has an individual conception about the menopausal transition. This varies from one or a number of physical or psychological symptoms to the more holistic view that the menopausal transition is a natural process of life with physical and psychological components and affected by endocrine and life-style factors as well as by aging *per se*. In an English study, about 75 % of all women sought medical advice at least some time with questions related to the menopausal transition (Hope *et al.* 1998). Ejeby *et al.* (1997) found that the conception about the menopausal transition differed between women and their physicians. This, together with conflicting data on risks and benefits from HRT, suggests that awareness and identification of women's different perspectives is important for health professionals when counselling her for climacteric problems. It is essential to be able to give each woman correct and, if available, evidence-based knowledge about physical and psychological changes often encountered during the menopausal transition as well as about ageing as such and possible decay of health. Furthermore, identifying cultural differences is essential in today's multicultural society.

Perhaps women who do not seek medical advice despite climacteric symptoms have another profile of concepts about the menopausal transition and that women without symptoms have yet another profile. The present study did not, however, include such women, and qualitative studies are not intended to yield results for generalisation to a wider population, but only for

the specific population studied (Polit & Hungler, 1999). It may also be that the conceptions about the menopausal transition vary between pre- and postmenopausal women and even change during the passage through the climacteric period. Previous studies have suggested that women's conceptions about the menopausal transition are influenced by the severity of their climacteric symptoms and by their menopausal status; i.e. whether they were pre-, peri- or postmenopausal (Fugate Woods *et al.* 1998; Avis, McKinlay 1991). Furthermore, it would be of interest to know whether factual knowledge about the menopause and ageing affects women's conceptions about the menopausal transition. This, however, remains to be studied further in other populations of women, as well as how symptoms affect the experience of the menopause. Another area important for further studies would be how different cultural perspectives influence the menopausal transition.

Conclusion

In conclusion this qualitative study showed that women's conceptions of the menopausal transition were individual and varied from physical or psychological symptoms to a more holistic view of the menopausal transition as a natural process affected by endocrine and lifestyle factors as well as by aging *per se*. Knowledge of women's conceptions is important in order to optimally communicate, support and empower middle-aged women in different health care situations.

Relevance to clinical practice

The health care provider should use open questions and ask both for the woman's knowledge, expectations and opinions about endocrine and age-related physical and psychological changes related to midlife in order to identify her conceptions and provide her with updated, evidence-based, knowledge. In this way women can receive the optimal capability to make a well-informed choice concerning changes in lifestyle or use of HRT.

Sources of found

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